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"THE ABORTION PILL"

**RU 486/PG and the Response of Canadian Feminists:
Chemical Abortion as More Than a Question of Choice**

by

Julie C.M. Johnstone B.A. (Hons.)

**A Thesis Submitted to
the Faculty of Graduate Studies and Research
in partial fulfilment of
the requirements for the degree of**

Master of Arts

School of Canadian Studies

**Carleton University
Ottawa, Ontario**

August 18, 1995

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"The Abortion Pill"
RU 486/PG and the Response of Canadian Feminists:
Chemical Abortion as More Than a Question of Choice

submitted by Julie C.M. Johnstone, B.A. Hons.
in partial fulfilment of the requirements for
the degree of Master of Arts

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September 1995

ABSTRACT

This thesis is an examination of the Canadian feminist response to the chemical abortion procedure, RU 486/PG. It traces the evolution of abortion from a women's health issue to a medical issue, and addresses how RU 486/PG perpetuates the medicalization of women's bodies. Central to this work is a discussion of the changing feminist understanding of "choice" and "control", which considers how those concepts have been influenced by an increasingly medicalized approach to women's reproductive health. The response of Canadian feminists to RU 486/PG may have been inhibited by the different interpretations of "choice" and "control", as well as opinions on the appropriate place for the medical profession's involvement in the provision of abortion services. The information for this thesis is based largely on interviews and correspondence with Canadian feminists, both abortion rights activists and women's health activists, as well on mainstream newspapers and periodicals.

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ABBREVIATIONS

CACSW	Canadian Advisory Council on the Status of Women (Ottawa)
CARAL	Canadian Abortion Rights Action League (National)
CPA	Canadian Pharmaceutical Association
CSF	Centre de Santé des Femmes (Montréal)
CWHN	Canadian Women's Health Network (National)
DAWN	Disabled Women's Network (Ontario)
EHF	Emergency Health Fund (Saskatoon)
FQPN	Le Fédération du Québec pour le Planning des Naissances (Montréal)
NAC	National Action Committee on the Status of Women
NRTs	New Reproductive Technologies
OCAC	Ontario Coalition of Abortion Clinics (Toronto)
PPFC	Planned Parenthood Federation of Canada (Ottawa)
RCNRT	Royal Commission on New Reproductive Technologies
RCSFQ	Regroupment des centres de santé des femmes du Québec (Montréal)
SARA	Saskatoon Abortion Rights Association (Saskatoon)
SOGC	Society of Obstetricians and Gynaecologists of Canada (Ottawa)
TAC	Therapeutic Abortion Committee
TWC	Toronto Women's Caucus
TWHN	The Toronto Women's Health Network (Toronto)
VWHC	Vancouver Women's Health Collective (Vancouver)
WHAC	Women's Health Action Committee (Regina)
WHC	Women's Health Clinic (Winnipeg)
WHEN	Women's Health Education Network (Nova Scotia)
WHI	Women's Health Interaction (Ottawa)
WHPN	Women's Health Promotion Network (WHPN)

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INTRODUCTION

I can clearly remember the day that RU 486, the abortion pill, was introduced to the French market. I was in my best friend's basement watching the evening news, which accompanied the story about RU 486 with video of a woman purchasing drugs from the shelf of her local drug store. From the outset, RU 486 has been presented as an at home abortion pill that could be purchased over the counter. The broadcaster said nothing of adverse effects or health risks; this was merely the ultimate convenience for women¹. In 1988, the year RU 486 was introduced, I was eighteen and was already an uncritical user of oral contraceptives. Chemical abortion seemed like a logical progression for women who were already in the practice of using chemical birth control. This was clearly a step in the right direction for women. To us, this was, in fact, revolutionary, as it reduced much of our angst about the possibility of unplanned pregnancy. Furthermore, we felt that we had won something, that women were one step closer to controlling our fertility. In hindsight, I am not at all sure what we won.

As I travelled through university, abandoning my first home in public administration for more feminist oriented courses, I came to question the benefits of hormone-based fertility control. After my first Women's Studies course I knew that my uncritical acceptance of oral contraceptives was potentially dangerous for me and for other women, and that various levels of oppression compounded those risks. This thesis is, in part, the result of my own quest to understand and interpret chemical contraceptives, both theoretically and personally.

In 1994, while in the process of investigating the response of feminists to the New

Reproductive Technologies (NRTs), I began to question why it was that the NRTs were the subject of such discussion, while RU 486, which I deemed to be an NRT, was being so overlooked. This question prompted a term paper for my graduate women's studies seminar, and ultimately grew into this thesis. Since then, this question has grown in importance to me, as I now consider RU 486/PG to be a turning point on the continuum of chemical contraception. RU 486/PG represents the first time, since information has surfaced about previous pharmaceutical "wonder drugs" such as DES and thalidomide, that feminists have actively lobbied *for* increased chemical intervention in women's reproductive health. Thus, when I first began this thesis, I could not understand why feminists, who were otherwise extremely sceptical of the medical and pharmaceutical industries, were lobbying for RU 486/PG without first participating in much more discussion.

My ultimate goal for this thesis is to provide a clear overview of what RU 486/PG is and how it works, but also of how Canadian feminists have responded to this form of chemical abortion. As well, I question why it is that Canadian feminists, have, to date, not participated in an open discussion of RU 486/PG. Throughout this thesis there is a consideration of how feminists define "choice" and "control", and how those concepts have been influenced by the increased involvement of the medical profession in women's reproductive health. The feminist uncertainty of how to define and work in a framework of "choice" may, in fact, be inhibiting feminist discourse on RU 486/PG and other forms of chemical abortion. Underlying my main goal is a critique of the continuing medicalization of women's bodies, and how RU 486/PG may perpetuate that

medicalization. Ultimately, I hope that this research re-introduces RU 486/PG to Canadian feminists in a more critical framework which may in fact assist in starting a dialogue.

It has been difficult to find the appropriate place to locate myself or my personal viewpoint in this work; however, I feel it is important to do so. My feminist politics and pro-choice position have unquestionably influenced my approach to this topic. Furthermore, as a young heterosexual woman, pregnancy, whether unplanned or unwanted, is an ever-present issue in my own life. These choices and this lack of control affect and frustrate me at an almost daily level.

METHODOLOGY

The methodology for this thesis has been influenced by the methodology of researching from the margins, within a greater context of a feminist methodology.² There are a number of advantages to this methodological framework, including a more obvious role for the researcher and the writer. It has been my personal experiences with abortion and frustrations with chemical contraception that motivate me to question why these are the "choices" of women sexually active with men. In addition, margin methodology determines that traditional forms of research usually only serve to maintain the status quo of control and unbalanced power relations, as they do not acknowledge the existence of those on or outside the margins.

Margin methodology understands that knowledge, which is in and of itself a political process, can be gathered and analyzed to encourage social change, and that until those on the margins are involved and accounted for no true change will occur. I have attempted in this thesis to "gather and analyze" in a fashion that will contribute to feminist

social change I have tried to shift the traditional research process by considering feminists to be the experts in this instance, framing this work around what they are saying on the issue. This transition in approach has been facilitated by the lack of materials written on both the issue of RU 486/PG and the feminist understanding of "choice" and "control"

When I began this thesis, I quickly discovered a huge lack of sources on this topic in a Canadian context. Thus, I was forced to seek out the Canadian situation for myself, which was at times a long and time consuming process. After an initial feminist periodical search, I completed a review of the mainstream Canadian press which covered the period of January 1988 to June 1995. For this examination I utilized the Canadian Business and Current Affairs (CBCA) on-line service. Using these newspaper and magazine articles I established the basis of the Canadian situation regarding RU 486/PG, as well as who was active on the issue. From there I began a national search for feminists involved in RU 486/PG, which meant ultimately searching through both the abortion rights groups and the women's health groups. Using the Canadian Index of Organizations, the resources of the Canadian Women's Movement Archives, and a number of phone books, I uncovered a possible 44 Canadian groups whom I felt might have been active on this issue (See appendix II). In addition I contacted ten American groups and three international women's health groups to assist me in my quest for background information.

Initially I sent each organization a request for information on policies or positions, as well as suggestions for a possible interview participant. As is often the case with research by mail, many groups did not respond. After six weeks, I began to phone the Canadian and American groups who had not responded. This increased my return rate

significantly. What I found was that of the Canadian groups, with whom I did ultimately connect, few of them were involved on this issue. This may be a reflection of their reluctance to address the issue, or its low priority to the Canadian women's movement. It may equally reflect the fact that most feminist groups are activist groups who do not prioritize the production of positions and policy.

When it became clear to me that there was insufficient information for a policy analysis, I decided that interviews, in conjunction with the newspapers and periodicals would form the basis of my research. After creating a loosely structured set of questions (See appendix I), I began to seek out participants. From the beginning I chose to interview only pro-choice feminists to avoid any confusion of the issue; I did not want to become embroiled in the traditional pro-choice/anti-choice debate. Also, I had originally intended to give priority to groups who had established an anti-RU 486/PG position as this was the most scant area of publication or discussion. Limited by research funds I chose to interview feminists from some of the biggest and most influential feminist organizations supporting RU 486/PG: Amanda LeRougetel, President of CARAL and long-time abortion activist, Bonnie Johnson, Executive Director of Planned Parenthood, and Madeline Boscoe of the Winnipeg Women's Health Centre, also a long-time activist in abortion and women's health organizing. As feminists presenting a supportive, yet more sceptical view, of RU 486/PG, I recruited Connie Clement of Toronto's Public Health Department. Connie was a founding member of the Healthsharing Collective, and author of one of the only Canadian articles suggesting that women could control both the decision and the provision of abortion. With the help of my advisor

Katherine Arnup, I also enlisted Amy Gottlieb as a sceptical supporter. Amy is currently the editor of *The Pro-Choice News*, and was the former editor of *Healthsharing*. Finally, I travelled to Québec to meet with women from two of the three organizations lobbying against RU 486/PG. Anne St Cerny, representing the FQPN, is a sexologist at UQAM who has been actively working on issues of contraception and abortion for many years. Ginnette Bastien and Karol O'Brien volunteered to represent the CSF, as well as assist me in understanding the separate women's health movements in Canada. This sample, while not national, did include: English-speaking women, French-speaking women (who made for challenging interviews!), abortion rights perspectives and women's health perspectives. In addition, I have where possible, quoted the French participants in French. Translations are available in the corresponding endnotes.

The interview process, which I initially thought would be very intimidating, was probably the best part of this entire process for me. The dedication of these feminists to women's right to abortion and women's health was the assurance I needed to keep me going in what seemed like an overwhelming challenge. Visiting the CSF and seeing a feminist abortion clinic felt like coming home. And although it was a typical rainy day for me in Montréal, it will remain one of the most memorable parts of this process.

Finally in March of 1995 I actually sat down to face my blank computer screen. Using the interviews, correspondence, as well as the newspaper and periodical articles as primary sources, I began to frame what I saw as the Canadian situation regarding RU 486/PG. This information forms the basis of almost all of chapter three and the analysis of chapter four. In addition to that, I have completed a more limited review of feminist

publications from 1973 to 1985 to determine how "choice" evolved as a feminist concept in Canada

In presenting the medical evidence on RU 486/PG, I have drawn upon original studies, as, at this point, few studies have been duplicated. I am indebted to the work of Janice Raymond, Renate Klein, and Lynette Dumble, whose book *RU 486: Misconception, Myths and Morals*, clearly outlines the inherent medical risks of RU 486/PG, and provided me with the direction to seek out more current medical findings. Crossing from the social sciences to the physical science has been perhaps one of the most difficult parts of writing this thesis

Finally, the first chapter is based on a combination of sources. Secondary sources form the foundation of the historical chapter, based largely on a literature review of Canadian historical publications. However, little has been written on the Canadian women's health movement, which compelled me to return to the Canadian Women's Movement Archives, and the early feminist periodicals of Toronto, to try and uncover how that movement evolved in Canada

Before concluding with a brief outline of the chapters that follow, I would like to turn for a moment to the limitations of this analysis. Perhaps the most obvious weakness is the absence of diversity in the groups and individuals upon which I have based my analysis. While this has been limiting, I have, to the best of my ability, attempted to create as wide a discussion as possible. The groups and the individuals represented here are the current key players who have established positions or were willing to speak with me. Thus, "Canadian feminists" are presented here as a reflection of majoritarian

feminists, loosely divided by language lines, provincial lines and feminist approaches to organizing. This absence has hindered a more in depth and fully representational Canadian analysis. Hopefully, it will be possible for future research to redress this limitation

This thesis has been further restricted by a lack of sources which address RU 486/PG in a Canadian context. This is one of the drawbacks to researching such a recent development. I had hoped to include a wider selection of interviews from across Canada, but a lack of financial resources and of willing participants, has restricted this thesis. As a result, it is inevitable that some information and perceptions have been overlooked or excluded.

CHAPTER OUTLINES

The first chapter provides a brief historical overview of the evolution of abortion in Canada. I suggest that abortion has been transformed from a women's issue to a medical issue, and consider how feminist organizing has adjusted to medically based abortion. The goal of this chapter is to establish the diverse positions on abortion that feminists held prior to the advent of RU 486/PG. The mainstream English abortion rights groups have accepted a medical definition of abortion, defining choice and control of abortion based on an assumed interaction with the medical profession. At the same time, abortion as a main issue has been dropped by mainstream women's health groups, leaving abortion as a political issue for abortion rights groups, rather than an issue of women's health. Finally, an element of Québec feminism has resisted the medicalization of abortion, having maintained a clear connection between abortion and women's health that was not drawn in other parts of Canada.

Chapter two introduces RU 486 and the RU 486/PG procedure, addressing both their composition and function. Included in that discussion is an examination of its effectiveness, possible adverse effects, and the current international use of RU 486/PG. In addition, I discuss the medical controversy that has developed around RU 486/PG and suggest that feminist positions may have been established on the basis of faulty findings or misrepresented information. Finally I consider the unresolved medical issues of the chemical abortion procedure. The purpose of this chapter is to explain the medical issues of RU 486/PG and to suggest that there is sufficient medical controversy to warrant debate among feminists interested in this abortifacient.

In the third chapter I review the positions that have been established by Canadian feminists on RU 486/PG. This includes an overview of the advantages and disadvantages of the RU 486/PG procedure as viewed by both supporters and opponents. I have grouped this discussion under the headings of access and privacy. While both supporters and opponents agree these issues are integral to women's abortion services, they suggest varying interpretations. I have purposely excluded any discussion of choice and control as advantages or disadvantages from this chapter, reserving this for the final chapter. In essence, I have attempted in this chapter to create the Canadian feminist debate on RU 486/PG, which I have found is not occurring elsewhere.

In the fourth chapter, I argue that the distinct positions established on RU 486/PG are a reflection of opposing definitions of "choice" and "control", definitions which stem from feminists' acceptance of, or resistance to, medicalized abortion and fertility control. Through a discussion of "choice" and "control" as feminist concepts, I argue that for RU

486/PG supporters "choice" and "control" are individual concepts based on a clear role for medical involvement; for the Québec groups who oppose RU 486/PG real choice and control requires separation from the medical industry. The Québec groups argue that RU 486/PG will in fact reduce women's collective choices and control, and encourage feminists to address RU 486/PG in a larger context, questioning what women's future choices will be if RU 486/PG is accepted. Finally, I argue that the construction of choice has in fact prevented Canadian feminists from participating in an open dialogue on RU 486/PG's potential for Canadian women.

The concluding chapter summarizes the current situation of RU 486/PG in Canada, and offers my own assessment of how Canadian feminists should, at this point, proceed. I have ended this thesis with some ideas for additional research, encouraging future work to assess the return of women's health to women's hands, beyond the scope of medical control.

CHAPTER ONE
PRE-RU 486/PG: THE EVOLUTION OF ABORTION AS A MEDICAL ISSUE

INTRODUCTION

From the time of the first conception, countless women have struggled to free themselves from the constraints of unplanned pregnancy. Historically, women have been the healers of their societies and have used a variety of methods to curb their fertility. Abortion has always been one of those methods. With the help of male-dominated legislatures and courts, physicians have for the last hundred years been slowly eradicating women's role as healer and their connection to their own knowledge and control. This chapter examines how abortion has been transformed from a women's issue to a medical issue, how Canadian feminists have organized around the concept of medicalized abortion, and how this in turn has influenced feminist understanding of "choice" and "control" as feminist concepts

While abortion evolved into an increasingly medical procedure, it slowly became less central to the women's movement as a whole.¹ Many Canadian feminists struggled with where to place abortion on the feminist agenda, questioning whether it should be the sole focus of the movement, part of a larger movement, or an entirely separate movement. Ultimately there was a division concerning abortion's importance in feminist organizing. While remaining fundamental to women's liberation, abortion in English-speaking Canada became increasingly defined as a political issue, one left to abortion rights groups who accepted the continued involvement of the medical profession. In Québec, however, many feminists continued organizing for demedicalized abortion, identifying abortion as part of

the women's health movement. This was not the case with most English-speaking women's health groups, who, while they did consider abortion and issues of reproductive health important, appear to have left abortion organizing to the groups focusing solely on the issue of abortion. In fact, as I will argue, Québec feminists have a longer and more complex history of resisting medicalized abortion

These different approaches to organizing have meant that for most feminists, abortion, once a fundamental element of women's health, is no longer a women's health issue, with Québec presenting the exception. Furthermore, the separation of abortion and women's health has influenced how Canadian feminists view the concepts of choice and control in relation to the medical profession. The varying interpretations of those concepts, as I will discuss later in this thesis, have influenced the Canadian feminist response to the chemical abortion procedure RU 486/PG. This chapter will serve to illuminate some of the complex factors that underlie the Canadian situation regarding RU 486/PG

THE EARLY YEARS

In many societies women have traditionally been healers and midwives. Prior to the rise of the medical profession in the late 1800's, women assisted each other with contraception, abortion, childbirth and other health issues. Evidence of women's knowledge and practices can be traced back to the early ages of humanity.⁷ It has only been in the last sixty years that physicians have begun to play a larger role in women's efforts to control their fertility. Prior to medical interest, women relied on a variety of methods to curb fertility. Although physicians had knowledge of the prevalent contraceptive methods (condoms, douches, and pessaries) as early as the 19th Century,

they "would not discuss their use because such appliances were associated with the libertine, the prostitute, and the midwife, and were thus outside the realm of respectable medicine"⁴ Thus, for many women, home made contraceptives were the first line of defence.⁴ If their limited contraceptives failed, many women turned to the use of patent medicines to restore menstruation by inducing abortion.⁵ If chemical options were unsuccessful many women attempted to induce abortion through other more physical means.⁶ Barring all else, infanticide was also considered a possible option for controlling fertility.⁷ These four methods were all considered options on the continuum of fertility control that Canadian women turned to in their struggle to limit reproduction.⁸ However, as the medical profession became increasingly recognized as an authoritative science, women began to turn away from each other to university educated physicians. This was perhaps most obvious in the acceptance of physician-assisted childbirth.⁹ Women's changing approach to health care seriously diminished their knowledge and use of less medically defined or created fertility options, ultimately reducing women's self-control.¹⁰

This loss of control was also influenced by the state's move to eradicate more traditional healers, thereby ensuring the prominence of university educated physicians. The exclusively male Canadian governments of the late nineteenth and early twentieth Centuries supported these physicians by implementing restrictive legislation. Legal distinctions were created to protect the "regulars" (the university educated and apprenticed physicians) from encroaching "quacks and midwives". In their efforts to regulate the medical practice in support of "regular physicians", the government designated abortion

to be a criminal act. This reinforced the distinction between the two types of healers as the university educated physicians were unwilling to provide abortion services, whereas the non-university educated healers were more accepting of such procedures. While this legislation met the government's goal of promoting a particular form of health care, it also resulted in the prosecution of women seeking fertility control.¹¹ Legal scholars Constance Backhouse and Shelley Gavigan agree that "abortion prohibition was intended primarily to regulate medical practice rather than the conduct of women seeking to terminate their pregnancies."¹² Although historically neither government nor religion has supported women's unquestioned ability to control their fertility, it has only been in the last hundred years that abortion has been specifically targeted.¹³ In doing so, the state also set in motion the foundations for the medical profession's refusals to acknowledge and support women's choice and control.

A woman's decision to terminate pregnancy was often met with hostility from the medical profession.

Doctors referred to women seeking abortions as 'unnatural mothers' and to married ones as 'degraded' and 'inhuman' for attempting to avoid maternity, and demanded punishment for those who were perverting 'the highest function of women's nature, and [turning] blessings into cursings.'¹⁴

Physicians were opposed to abortion for a number of complex reasons. Beyond their concerns about legal sanctions, and their distinction from the "quacks and midwives", doctors were concerned about women's attempts to thwart the "natural order". As women were still considered non-persons at this time in Canada, and essentially the property of their husbands, there must have been some concern that women's ability to control their

reproduction would undermine a husband's right to control his wife and his subsequent children. This would clearly have been a threat to men of this era, and a greater threat to a struggling male medical profession.

As medicine became a professionally recognized science, it began to expand into other areas of health and sexuality. Obstetrics was perhaps the largest supplier-driven medical market ever created.¹⁵ From obstetrical practice physicians continued to expand their services through their involvement with contraception and family planning. This was largely due to the work of the original birth control activists, Marie Stopes and Margaret Sanger, who, during the 1930's, involved the medical profession in birth control to give it an air of respectability.¹⁶

The shift from women centred fertility control to medical control, which started with the demise of women healers and midwives, was further cemented with the rise of the family planning clinic as a medical service. As the medical profession expanded into this and other areas of women's reproductive health, they secured respect for their trade and increased their control over women's fertility. Ultimately, this development resulted in the increasing dependency of many women on the medical profession. What is evident is that women throughout Canadian history have had both the knowledge and the ability to control their own reproduction. They have shown their determination to be in control through the actions they have taken in the face of great personal risks.

A shift in the concept of control grew out of these initial transitions. As doctors became increasingly involved in matters of women's reproduction, women in search of more efficient methods of contraception and supposedly healthier births and children,

began to turn to the medical profession, who were in fact the only legal option ¹⁷ The concept of modern day birth control as it developed through the medical clinics laid the foundation for the belief that women were still in control of their fertility, except that now the medical profession would be their moderator. It is here that women first started to accept the concept of self-control within the medical paradigm. From here the concept of medicalized fertility control grew, to the point that abortion was legally confirmed a medical procedure, and "choice" became tied to medical consumerism.

LEGAL REFORM AND THE MEDICALIZATION OF ABORTION

In the early 1960's, lawyers, doctors, and clergymen began to support reform of the existing criminal abortion law. This movement was in some ways an outcome of doctors' concerns about women turning to illegal abortion and the deaths and injuries that often resulted. Between the years 1954 and 1965, there were "an estimated additional 50 000 to 100 000 illegal abortions" in Canada.¹⁸ Dr. Donald Low, of the Ontario Medical Association, found that, in 1965, "half the admissions to gynaecological wards in Ontario were the result of injuries suffered from illegal abortions."¹⁹ From 1946 to 1968, abortion-related deaths accounted for one out of every five maternal deaths in British Columbia.²⁰ Other physicians were troubled by the state's intervention in what they saw as a medical issue, an issue that should ultimately remain at the discretion of medical practitioners. The Canadian Bar Association (CBA) was concerned primarily with the needs of their physician clients on the issue of abortion. Abortion was already taking place at the will of agreeable doctors and there were concerns about physician liability. Jane Jenson argues that while both the United and Anglican churches were concerned primarily

with issues of morality, "they also used a discourse of medicalization, claiming that the state should defer to the professional judgement of doctors."²¹ In 1967, the CBA, the Canadian Medical Association (CMA), and the Humanist Fellowship of Montréal made separate presentations to the federal government's Health and Welfare Committee. They both requested more liberal abortion laws while, at the same time, arguing that the medical profession (to varying degrees of involvement) was the most "acceptable" arbiter on the question of abortion.

It was in that same year that, then Minister of Justice, Pierre Trudeau, introduced an Omnibus bill that incorporated a number of changes to the *Criminal Code*. The first bill expired on the order paper, and a similar bill was later re-introduced, in 1969, during Trudeau's first year as Prime Minister. The passing of that second bill revised s.251 of the *Criminal Code*, and created legal access to abortion if an established Therapeutic Abortion Committee (TAC), consisting of three medical professionals, in an accredited hospital, deemed it a necessary medical procedure based on health concerns.²²

The new criminal law framing abortion as a medical issue, met with the approval of the larger medical associations. In 1970, the CMA illustrated its growing support of the relaxed laws when it deleted all reference to abortion from its code of ethics. The Canadian Psychiatric Association had the position that abortion should not be in the *Criminal Code*, "suggesting that it be made a strictly medical procedure to be decided by the woman and her husband, if she has one, along with a physician."²³ Beyond the dispute about its criminal nature, abortion was seen by both organizations as a medical matter

As health care is a provincial responsibility, the federal government had to convince the provinces that this new legislation legalizing birth control and abortion would be beneficial for them. McLaren and McLaren concluded that "provincial authorities were attracted by the assertion that contraception could lower social welfare costs, not by feminist or libertarian arguments."²⁴ Thus Canada's new liberal abortion laws were the result of male-dominated legislatures, supported by equally male-dominated professional organizations, implemented in part as a cost-saving measure. The government had effectively resolved the legal and moral issues of abortion by shifting responsibility for the problem of abortion on to the medical profession. The result was that abortion became strictly a medical matter on the basis of an unclear definition of health. It is no wonder that the amendments were met with hostility from many Canadian feminists.

FEMINIST ORGANIZING

The "second wave" of the Canadian women's movement started in the earlier 1960's as part of the larger trend towards social change, but it was not until the late 1960's and early 1970's that "the women's liberation movement emerged as a separate activist movement in Canada".²⁵ From the beginning, the Canadian women's movement has considered abortion as fundamental to women's liberation. Nancy Adamson, Linda Briskin and Margaret McPhail wrote in their history of the Canadian women's movement that "[a]bortion was one of the issues around which the women's liberation movement organized in the early 1970's. Many women's experiences of illegal abortions and the difficulty of obtaining birth control made it a powerful personal as well as political issue."²⁶ These authors remember "[t]he dominant mood", of this period of organizing,

"was one of anger as the enormity of our oppression dawned on us".²⁷

Many feminists were angry and frustrated by the new legislation that maintained abortion was a criminal offence unless deemed appropriate by three medical doctors. Although it would appear that some feminists had problems with the increasing prominence of the medical profession concerning abortion, most were preoccupied by the fact abortion remained a criminal offence. During the period of legal reform, feminist groups had been discussing the issue of abortion and recognized that its availability was central to ending women's oppression. Many groups moved towards a lobby for abortion on demand. In its 1970 report, *The Royal Commission on The Status of Women* recommended that women should have access to abortion, without restrictions, in the first twelve weeks of pregnancy.²⁸ In a "Statement to the Abortion Caravan", Doris Power, of the Just Society Movement, wrote in 1970 that "Every pregnant woman, married or single, should be able to obtain an abortion on demand without being compelled to give any reason for her decision. What control can we have over our lives if we have no control over our own bodies?"²⁹ However, as Jane Jenson has argued, during the period of legal reform, "women's voices were diffused and weak during the development of the discursive compromise establishing the institutions within which the practices of abortion politics would occur for the next two decades."³⁰ Thus, women's demands for self-control went unheard.

Eleanor Pelrine, one of Canada's first feminist authors on abortion, referred to the new law as "the reform that hardly was", arguing that there were a number of problems with the 1969 legislation.³¹ Hospitals were not required to establish committees,

effectively ruling out all Catholic hospitals. Only hospitals that were federally accredited or provincially approved could establish committees, and some hospitals had an insufficient number of physicians to establish a committee. These obstacles were compounded by the fact that varying interpretations of "health" were leading to diverse and inconsistent implementation of the committee process. Perhaps the largest problem was the lengthy waiting period. Eight years after passage of the legislation, a government commission, the Badgley Committee, "found it [the new law] to be unworkable, a bureaucratic obstacle that endangered women's health by prolonging the approval process and increasing anxiety about the outcome."³² By the late 1970's, there was less availability of abortion services than prior to the change in legislation.

Kathleen McDonnell said of the new law that.

the government's strategy was effective. It knocked the wind out of the sails of the reform movement at a critical time, saddling it with a half-measure that made abortion just accessible enough to neutralize pressure for the outright appeal of the law.³³

Professor Larry Collins argues that the government's abortion reform strategy protected doctors' "monopoly over the delivery of abortion services and . the doctors and their hospitals from legal liability."³⁴ In earlier years the state had protected the physicians through restrictive legislation. With no one left to contest their monopoly, the state reinforced, again with legislation, medical control over women's reproduction.

Prior to and during the initial legal changes, women were starting to organize more formally around the issue of fertility control. Abortion became one of the most focused issues of the women's liberation movement, with many women's groups and labour organizations working towards the decriminalization of abortion. Events such as the

Abortion Caravan of 1970 worked to stir national momentum on the issue of abortion. In November of 1970, the Saskatoon Women's Liberation group stated that "in Canada the abortion caravan was a catalyst for the movement, generating new groups and increasing women's awareness of their collective strength."³⁵ Out of this period of mobilization developed the beginnings of the Canadian women's health movement, and the abortion rights movement. Abortion continued to be a primary issue for the Canadian women's movement well into the 1970's. For the most part it would, however, remain a legal issue for the next 21 years, based on an implicit acceptance of medical involvement in abortion.

DIVISION WITHIN THE MOVEMENT

As Canadian feminism evolved, the importance of abortion was never completely forgotten; however, some feminists began to question abortion as the primary focus of the women's movement. Some argued that abortion should be the sole issue of feminist organizing, while others felt it should be one of many other important issues. Within the movement focusing on abortion there were also divisions regarding working within or outside the medical profession, and whether or not to engage in legal strategies, clinic activism, or some combination of the two. Although there were differences within the Canadian women's movement from its inception, the debate around abortion heightened some of those differences into respectful divisions.

Evidence of the division over abortion as a primary issue can be found in the records of some of the 1970's feminist publications from Toronto. Abortion rights were the main concern of the Toronto Women's Caucus (TWC), the group that published *The*

Velvet Fist: A Women's Liberation Newspaper. The TWC "played a big part in establishing the Toronto Abortion Campaign committee and ..put a lot of effort into the struggle to win freely available abortion for all women."³⁶ In 1971, their campaign slogan was "Free Abortion on Demand", and they were instrumental in the organizing of the February, 1971, Abortion Campaign. The following passage illustrates abortion's centrality to their group:

In the past one and half years, the women's movement has progressed a great deal, as has our understanding of how that future mass movement will be built. It is now evident that the route to the movement lies directly through the movement for abortion law repeal. It is around this issue that women of very different backgrounds and very different levels of consciousness are uniting across the country...The one issue on which educational material is not generally available is the abortion issue. What is available is hardly ever from the point of view of a woman's right to choose. This is the area where there is a real void -- and where we do have something unique to say.³⁷

Liz Angus, the author of the above passage from "Central Task for Feminists: Building the Abortion Repeal Movement", argued that the next step for *The Velvet Fist* was to merge with a paper that focused solely on abortion.³⁸ Angus had proposed a paper where women could share experiences, information, education, and potentially "how-to" articles. Her proposal was later withdrawn after TWC members expressed a number of concerns. Beyond their apprehension about having a single issue focus, members were worried that abortion would not widen the women's liberation movement, but would rather narrow it to reflect what they saw as the middle class nature of the abortion issue.

During its brief existence between 1970 to 1972, *The Velvet Fist* was largely focused on the issue of abortion. The paper did not include a great deal of "health" related

issues. Near the end of its publication run, the centrality of abortion lessened, as more articles on international issues and women and labour began to appear. Its last issue resembled another Toronto feminist paper, *The Other Woman*, with which *The Velvet Fist*, and another Toronto based feminist publication *Bellyful*, merged in 1972. *The Other Woman*, which ran from 1972 to 1977, sought to produce a "collectively run periodical which addresses women's issues from a feminist, anti-capitalist perspective."³⁹ The collective did discuss issues of women's health and abortion, but these were not central issues. The experience of these Toronto feminist publications reflected the opinions of many English-Canadian feminists.

As the Canadian women's movement struggled with different methods of organizing and with its recognition of other equally important issues, the focus on abortion shifted. With abortion no longer the central issue of feminist organizing, feminists who continued to work on the issue of abortion looked for other ways to keep the issue viable, and for ways to make the issue more acceptable to other social activists. The result was that organizing for abortion in English-Canada, and in some elements of French-Canada, shifted from a call for abortion on demand to abortion as a question of choice.

Kathleen McDonnell argues that in the mid 1970's the language of "choice" was adopted as a way "to deflect the discussion away from the image of feminists as anti-men, anti-children, pro-abortion."⁴⁰ Struggling for a way to defuse the beginning of the feminist backlash, choice seemed to be a concept that would allow room for feminist ambivalence. "They were not saying that abortion was a good thing, or that anyone should

have an abortion. They were simply arguing that each person had the right to decide, but not to impose his or her personal beliefs on others "⁴¹

The concept of "choice", although not addressed in those terms, was already being used by women in their interactions with the medical system for contraception, and it had worked to help secure some sense of fertility control for many women. Furthermore, Canada's post-World War Two liberal consumer-based society encouraged women to understand their interactions with the world through the concept of choice. Thus, "choice", appeared to be a strategy that would allow women and men to have diverse opinions on abortion, yet continue to lobby for women to have the option of abortion.

While women wanted the "choice" of pregnancy or abortion, few were willing to question the role of the medical profession in the provision of that choice. This was evident in the lobby that would make abortion a decision between a woman and her doctor. The issue for most feminists was to ensure that the procedure was decriminalized and accessible, few took the additional step of questioning how medical involvement would influence their choices, or of what this medically based concept of "choice" would mean to feminism. Given the times, and the lack of services, it seems understandable that women would not want to question what appeared to be the most viable option for ensuring safe and effective abortion. However, as the lobby for abortion shifted to one of "choice" in the 1980's, the acceptance of the medical profession in the provision of reproductive health care was perpetuated, and women again moved further from self-control.

After the Abortion Caravan, the divisions in the women's movement became more

apparent. It was out of this initial activism that both the abortion rights groups and women's health groups developed. From the outset, there appears to have been a separation between health groups and abortion rights groups in English-speaking Canada. As feminism grappled with the issues of strategies and priorities, organizing for abortion again shifted, this time from the women's movement to the abortion rights groups. The women's health groups in English-Canada, as I will illustrate, chose to leave the bulk of abortion organizing to the groups which had developed specifically for that purpose. Only Québec appears to have maintained a clear connection between women's health and abortion.

ABORTION AND REPRODUCTIVE RIGHTS - A SINGLE FOCUS

The Canadian Association for the Repeal of the Abortion Laws (CARAL) was formed in 1973.⁴² This organization would go on to fight for abortion as a right of women, a focus that is reflected in the name it adopted in 1980, Canadian Abortion Rights Action League.⁴³ CARAL focused its efforts on lobbying the federal government to ensure that abortion remained decriminalized. CARAL defines its organizational purpose as ensuring that:

no woman in Canada is denied access to safe, legal abortion. Our aim is to keep abortion out of the *Criminal Code*. We want to see the establishment of comprehensive contraception and abortion services, including appropriate counselling, across the country. We regard the right to safe, legal abortion as a fundamental human right.⁴⁴

CARAL's goal was to achieve women's legal right to abortion as a medical procedure, framed in the discourse of choice.

Just as safe, legal abortion services are basic to women's reproductive health and well-being, reproductive choice is fundamental to women's

social equality. A society that denies women the fundamental choice of whether or when to reproduce is one that denies women their place as full-status human beings. If one does not have control over the uses to which one's body is put, one is not autonomous ⁴⁵

In an effort to achieve their goals, CARAL has been heavily involved in supporting Dr Morgentaler in his legal challenges to the now defunct abortion law. CARAL did this in part by working with the "elite fund raising group, The Issue Is Choice", to establish a fund raising network called the Pro-Choice Defence Fund ⁴⁶ Their judicial involvement increased with the prosecutions of Dr. Morgentaler, who was first charged in Quebec in 1973. Women's groups across the nation debated whether or not to support Morgentaler in his legal battles, and many decided that their support and his goals would bring women the legal right to an abortion in Canada. However, the support for Dr. Morgentaler also meant the continued acceptance of medically based abortion services. CARAL's goals reflected their institutional approach. They recommended that the state "move to place abortion in the context of an overarching family-planning policy with better and more equal access to counselling, contraception, and education."⁴⁷ The result of their liberal goals was that they ultimately accepted the presence of the medical system in women's experiences of abortion and wished only to deal with question of equal access and entitlement.

The Ontario Coalition for Abortion Clinics (OCAC), established in 1982, also worked within a rights based discourse. OCAC lobbied for reproductive rights, by "which it meant not only the right to choose abortion but also the right to bear healthy children, for women's health and sexuality to be within their own control."⁴⁸ This was a wider approach than CARAL had established.⁴⁹ OCAC, like CARAL, also accepted the

involvement of the medical profession on the issue of abortion.

In fact, OCAC further entrenched the medicalization of abortion when the group invited Dr Morgentaler to open a clinic in Toronto in 1982. The decision to open medically-based clinics is reminiscent of the work of Sanger and Stopes sixty years earlier. OCAC was prepared to finance the clinic and any support required for its legal defence. Organizers hoped both to provide much needed services and to challenge the 1969 legislation in an effort to expand women's reproductive rights.⁵⁰ Thus, the clinic structure that originally promoted the medicalization of fertility control would now bring the issue further into the hands of the legal and medical professions, thereby reinforcing the shift of fertility control from women to the institutions of the state. Their rationale was that women could have control from within the medical system, if there was health care that "puts control of all key decisions regarding a woman's health and reproduction in her own hands and provides all the services, counselling, information and support to enable her to put her decision into practice."⁵¹ Further evidence of their acceptance of medical involvement can be found in their calls to have the Toronto Morgentaler and Scott Clinics "brought into the public health care system and publicly funded."⁵² For OCAC, then, the issue was not so much who conducted the service, but rather ensuring that it was a publicly funded service.

Although elements of these two abortion rights groups were critical of both the state and the medical profession, they did not call for abortion to be demedicalized. To CARAL the issue was one of choice, where control meant control "over the uses to which one's body is put".⁵³ To OCAC, a socialist feminist organization, real choice meant more

than just the choice to terminate pregnancy, but control remained control of the choice, not of the procedure itself. The result is that two of the largest groups working on the issue of abortion in Canada accepted the involvement of the medical profession from the outset.

CARAL and OCAC's approaches further entrenched a medically based concept of choice. By accepting that women maintained control of their bodies by controlling the choice to abort, and by arguing in terms of women's right to choose, any analysis of "choice" as a feminist concept was overlooked. Perhaps feminists were hesitant to critique choice because, at the time, that strategy was the only one and it was, to some degree, working in women's favour. Ultimately, their acceptance of this medically based definition of choice meant that women grew to increasingly accept the intervention of the medical profession in women's reproductive health. If anyone was going to question the role of the medical profession in abortion, it would have likely been the women's health activists of the time. Feminists active in women's health during this time were critiquing the role of the medical profession and the pharmaceutical industries in many areas of women's health. Any move towards demedicalized abortion, or women's control of abortion, was most likely to come from this element of feminist organizing

HEALTH - ALSO A SINGLE FOCUS

Canadian women's health groups were influenced by the self-help movement occurring in the US, but unlike the US, they appear to have never viewed abortion as something that would fall within that category. The first signs of the feminist self-help movement originated with American women learning to perform their own gynaecological

examinations, and investigating alternative therapies for health concerns. During the same period of the late 1960's and early 1970's, the Boston Women's Health Collective produced their first publication, which grew out of women's desires to challenge the unfettered authority of the medical profession.⁵⁴ Women, with the help of some supportive professionals, began to open women-controlled health care centres. Many offered self-help groups and support groups. Carol Downer, a strong force behind this movement believed that, "We women must take women's medicine back into our own capable hands."⁵⁵ In this context, control meant regaining lost knowledge and, where possible, providing women services from outside the medical model. The experience of the US included women taking actual control of abortion services, going beyond the mere alteration of the circumstances of abortion provision.

Perhaps the most well known experience of women taking control of their reproductive autonomy can be found in Jane, the illegal feminist abortion collective run in Chicago from 1969 to 1973. The collective performed over 11 000 abortions in that four year period, disbanding after the 1973 ruling in *Roe v. Wade*.⁵⁶ The women who ran the service were self-taught practitioners who had been trained by observing physicians performing abortions. All the women in the service were responsible for counselling, although not all performed abortions. Their safety record was "equal to that of New York State following abortion legalization in New York."⁵⁷ Pauline Bart's article on the Jane collective concludes that "Jane proved that abortions could be performed safely, humanely and very inexpensively by non-professional paramedics working [outside traditional medical venues]."⁵⁸

The women's self-help movement developed in Canada as well, but to a much lesser degree.⁵⁹ In 1968 the McGill Students Society published *The Birth Control Handbook*, the first Canadian publication to deal specifically with contraception. The handbook was published in contravention of the *Criminal Code* provision that prohibited the dissemination of information regarding birth control. By the summer of 1969 over 50 000 copies had been distributed.⁶⁰ The authors were also involved in abortion counselling and establishing liaisons with physicians who were willing to perform the service.

Across Canada, similar groups were forming to provide abortion and birth control counselling. Toronto Women's Liberation members held birth control counselling sessions three nights a week, and also helped women work their way through the TAC's, or find physicians known to provide this service for women.⁶¹ The Vancouver Women's Health Collective (VWHC) organized in 1971, conducting self-help groups, and providing counselling on many women's health issues, including abortion and contraception.⁶² The VWHC also established an information and abortion referral telephone line. In the following year they became affiliated with a diaphragm-fitting collective and started weekly self-help clinics where women could come and learn about their own bodies. It was out of these self-help groups that the Canadian women's health movement arose.

Throughout the 1970's and 1980's, women in Canada organized many local, provincial and national groups to fill critical gaps in health services for women or to lobby for such services. They have developed creative models of health service delivery in women's health centres, community health and resource centres, immigrant women's centres, transition houses and in some hospital settings. Some are part of strong regional networks...Self-help groups have supported women with mental health problems, breast cancer, PMS, endometriosis, exposure to the drug DES, and other conditions to explore a range of alternative approaches to their care.⁶³

However, the rise of the women's health movement did not result in abortion being reframed as a non-medical issue. In fact, it would appear that abortion was not a central focus to the Canadian women's health movement.

As the women's health movement began to grow, women's health publications began to be produced in greater numbers. These publications confirmed that abortion was not a core issue of the women's health movement. In its first two years of publication (1979 to 1981), *Healthsharing* did not include any articles focusing on abortion. While the magazine did include news of clinic happenings and ongoing legal battles, abortion was never a focus of the publication. In 1983, *Healthsharing* produced an issue dedicated to reproductive freedom in which abortion was a main issue, but abortion was never really a dominant theme of the publication as a whole. The Women's Health Education Network (WHEN) began its publication *Vitality* in 1979, and although an established pro-choice group and a member group of CARAL, *Vitality* did not include any articles focusing on abortion during its existence. *Womanly Times*, which was started in 1985 by The Women's Health Clinic in Winnipeg, originated as an update on the events of the clinic. In more recent years it has developed into a more in depth women's health publication. However, abortion has never been a focus for that newsletter, nor is it evident from those publications that abortion was a central issue to the clinic itself. In 1986, the clinic started self-help workshops entitled "Controlling Our Bodies and Our Reproduction Ourselves". Of the ten sessions in the series abortion is not listed as a topic. In 1984, the Northwestern Ontario Women's Health Education Project (NOWHEP) began producing a self-titled women's health publication. From its first publication in the spring of 1984 to

December of 1991, there was never an article or a mention of abortion, with the exception of the 1969 law being considered part of the feminist milestones

My review of these four publications would suggest that abortion has not been a central issue to the Canadian women's health movement. This is not intended as a criticism of that movement, as there are arguably many important health issues that were addressed. Rather it demonstrates the separation of the women's health movement from the abortion rights movement in Canada today. The abortion rights groups have traditionally accepted the involvement of the medical profession in the provision of abortion services. The health movement, which did attempt to work outside the scope of the medical profession for many women's health issues, did not encourage the framing of abortion in a non-medical light.

It is difficult to explain why women's health advocates have not been as supportive of lay abortionists and demedicalized abortion, as they are of midwives and demedicalized birth. The sole exception is an article by Connie Clement in *Healthsharing's* issue on reproduction.⁶⁴ Clement argues that midwives and pro-choice groups both share the same ideology of "the right of women to control their own lives", and she questions why the birth reform movement was fighting to demedicalize birth while pro-choice groups were arguing to medicalize abortion.⁶⁵ While abortion rights advocates have worked together in Ontario, they did not promote demedicalized abortion. The Midwives Collective of Toronto has worked with OCAC, lobbying for demedicalized birth and the right to legal abortions; yet it would appear that neither was lobbying for the right to have abortions performed by lay abortionists or midwives.

Clement argues that there are a number of reasons why Canadian activists did not demand literal control over abortion. In her view, the Canadian women's health movement has always lagged behind the US. In 1969, when the Canadian abortion law was liberalized, abortion activists were critical of the medical profession, "but not enough to take things into our own hands."⁶⁶ She quotes Sue Genge, former member of the Young Socialists, who argues that their intention as a movement was to demand abortion services from the state, thinking in hindsight that "the focus was too narrow. We never discussed how abortion fit into the total oppression of women."⁶⁷

Clement further argues that this reclaiming of reproductive control never happened in Canada because, "our social context was different, our politics are different, and the timing of the legal reform of the abortion law coincided differently with the growth of feminism."⁶⁸ However, the US ruling of *Roe v. Wade* was four years after the Canadian law changed, in this respect at least, it is difficult to argue Canada "lagged behind". Perhaps the 1969 legislation in fact discouraged Canadian women from seeking out alternatives beyond the medical profession. This was certainly not the case in all of Canada. Feminists in Quebec were organizing around the question of abortion much sooner than their Canadian counterparts, and from the outset, they took a more demedicalized approach to abortion.

QUEBEC

Québec feminists have had a markedly different experience in organizing around the issue of abortion, and it is this unique history that underlies the anti-RU 486 position held by some Québec feminists. Their distinct history has been influenced by a variety

of social and political movements that occurred during 1960's Québec's Quiet Revolution meant that Québec feminists entered the second wave of feminism with greater momentum than in other parts of Canada. Furthermore, the liberation movement in Québec was influenced by the experience of the US, the Civil Rights movement, and the creation of mixed CÉGEPS in 1967, which gave young women more access to higher learning.⁶⁹ "Tout cela constitue des conditions favorables à l'émergence de mouvements sociaux de revendications."⁷⁰ The tide of change in the 1960's led the way to organizing around abortion and contraception in Québec.

Québec, a predominantly Catholic province, had a legacy of organized woman-controlled contraception. Natural family planning had been the only form of contraception permitted by the Catholic Church and so developed in Québec to a much greater extent than elsewhere in Canada. The first sympto-thermal method service was established by Gilles and Rita Breault in Lachine, Québec, in 1955. The first SERENA (Service de Régulation des Naissances) office was founded in Montréal by the Breault's in 1962, and in 1963 the publication *La Régulation des Naissances* sold 65 000 copies.⁷¹ SERENA's presence in Québec, I would argue, has contributed to the attitude of many Québec feminists that fertility control can be achieved outside the medical profession through women's hands.

In 1967, heeding to the demands of Québec women for access to fertility control, the Centre de planning familial was opened in Montréal to provide direct service and counselling from a multi-disciplinary approach. The centre did community work on contraception and fertility, operating in many regions of Québec. Thus by the time the law

changed in 1969, Québec had a history of organized demedicalized contraception, and a greater availability of contraceptive information than most of Canada.

Like their counterparts in English-Canada, feminists in Québec were also organizing outside of the state's institutions. In 1969 the FLF (Front de libération des femmes de Québec) was founded in Montréal, which was comprised largely of women from Québec independence groups, socialist groups and student groups. Within that organization there was a group working specifically on abortion, who were responsible for the French version of the *Birth Control Handbook*. During the 1970 Abortion Caravan, the FLF refused to participate, "à cause de son caractère légaliste et parce qu'il refuse de s'adresser au gouvernement canadien."⁷² Instead they held their own demonstration in Montréal on Mother's Day. After the FLF disbanded in 1971 over ideological differences, some FLF members went on to found the Centre des femmes de Montréal in 1972. That centre provided both abortion counselling and referral services.

It is no surprise that Québec was the site of the first private abortion clinic operating in contravention of the *Criminal Code*. In addition, that same clinic sparked the first legal challenge of the abortion legislation, what would be the first of many legal battles for Dr. Morgentaler. It was also the home of one of the clearest stands for demedicalized abortion, when in 1972 a number of "left-leaning feminists" withdrew from the Morgentaler Defence Committee. Jenson concluded that they "explicitly rejected the Committee's focus on the rights of doctors, [and] they set out as feminists to articulate their stand toward the abortion issue."⁷³ These feminists were part of the same groups who founded the Centre des femmes de Montréal. Jenson argues that "the analysis of this

marginalized group did not have much public success until later in the decade, when the Comité de lutte...emerged in post-1976 Québec "⁷⁴

Finally, Québec's experience of abortion was influenced by the fact that Quebec was also the site of many of the first women-run, women only, health care centres. The Centre de santé des femmes du quartier opened in a working-class area of Montreal in 1975. Paramedics provided the core labour of the clinic, involved in everything from assisting physicians to administrative responsibilities. The purpose of the centre was threefold: provision of medical services, education, and political action. In 1978 the Collectif d'Auto-Santé des femmes was established, whose primary goal was the reclaiming of women's bodies. They had a more informal establishment offering information services on a range of health and sexuality issues.

In later years the Québec women's movement would be the first to "use the abortion issue as a major focus for mobilization "⁷⁵ In 1978 a large scale coalition was established between women's groups, female trade unionists, and health activists, whose main purpose was free and accessible abortion and birth control. The coalition achieved their goal when, in 1978, the provincial government acknowledged that provincial and private clinics could provide abortions and bill the province for the costs. In 1980 le Centre de santé took the provincial government at its word and began offering abortion services at the centre, which they continue to do today. Bodeur writes that it was "un événement important qui soulignait la nécessité pour les femmes de contrôler des lieux offrant des services de santé pour les femmes "⁷⁶

In the spring of 1981, La Coordination nationale pour l'avortement libre et gratuit

(CNALG) grew out of the former Comité de lutte. At their first membership meeting debate arose as to how to proceed in Québec on the issue of abortion. Some members wanted to work towards achieving services within the traditional health care system, while others argued the lobby should focus on getting abortion services in the more autonomous women's health centres. That debate in Québec has never been disbanded, but Bodeur writes that "beaucoup de militantes concentreront leurs énergies à mettre sur pied et à opérer des centres de santé autonomes."⁷⁷

Québec's unique history has cleared a path for a more demedicalized discourse on abortion. Their connection to natural family planning and their successful history in organizing outside the medical profession to a greater degree than in the rest of Canada has established clear roots for the anti-RU 486 position that many have taken. For women in Québec, control can mean taking the services literally into their own hands; thus it has perhaps been easier to keep the concept of demedicalized services more in the public and feminist eye. By the time the choice strategy was taking off in North America, feminists in Québec had achieved state supported/tolerated abortion services, where some were offered from feminist women's health centres. To some degree then, they have not been as restricted by the concept of choice. Chantal Maillé argues

that it has been possible for the women's health movement in Québec to obtain positive results...because the claims were negotiated with a provincial government which already had negotiated a maximum of autonomy in the definition of policies and programs...for Québec women's groups, negotiating with a provincial government made it possible to reach principles of grass-roots decisions making.⁷⁸

Thus the liberal approach that developed in English-Canada was not as prominent in Québec.

The separation of abortion and health in Québec has not been as dramatic as in other parts of Canada. This is partly due to their unique negotiations with their provincial government, and is a result of the ongoing debates around abortion and their place in women's health centres. It is also a reflection of how women's liberation in Québec has been framed as one of regaining control of women's bodies. A 1990 study of Québec women's groups found that overwhelmingly "Le corps [était le] lieu premier de notre oppression."⁷⁹ The authors of *de travail et d'espoir*, found that, "La réappropriation du corps des femmes continuera de mobiliser l'énergie de plusieurs groupes. Plus particulièrement, la question de l'avortement et celle des n.t.r restent à l'ordre du jour..."⁸⁰ These factors have established a distinct history for Québec feminists on the issue of abortion, which partially explains their attitudes towards RU 486/PG

ON THE EVE OF RU 486/PG

Following the 1988 Morgentaler decision of the Supreme Court, many groups continued to lobby against further criminal legislation, engaging in legal and political debate over Bill C-43. CARAL and other groups continued to lobby for increased access to abortion. The groups that supported service provision and the establishment of clinics have channelled most of their energy into keeping the limited services that are available operating. They have had to remain active in their defence of those clinics, in the face of increasing anti-choice activism, the feminist backlash and the rise of the right

The women's health movement struggles to survive with hopes for a national network within the next few years. The demise of the only national women's health publication, *Healthsharing*, is indicative of the problems that the health movement is

facing"¹ The groups that do exist across Canada are still concerned with issues of reproductive health, but the focus on abortion remains limited. At a 1994 CACSW symposium on women's health, there was no focused discussion of abortion or of RU 486

Abortion rights groups, both left and liberal, and the women's health movement to some extent, are at this time the only feminist groups actively dedicated to the issue of abortion in Canada. It is no longer the focus of the women's movement as a whole. Beyond the division of women's groups regarding strategies and priorities for change, other factors have pushed abortion out of the Canadian eye. McDonnell argues that there are two additional explanations for the dwindling interest in abortion as a main issue for the women's movement. In 1984 she wrote that, "the abortion problem in the country is largely an invisible one. The medical, social and economic costs of our restrictive abortion law are simply not obvious to the vast majority of people."² The second reason in McDonnell's view is the refusal of feminists to acknowledge and address their own ambivalence about abortion. McDonnell argues that because pro-choice women do not address this ambivalence they are unable to firmly assert that they have the moral "right" to abortion. Feminists were far from united on the issue of abortion when RU 486 became the newest element of the abortion debates

CONCLUSION

As we have seen, Canadian women have been the healers of their communities and have attended to the reproductive needs of one another. They have demonstrated throughout their history that they have always been attempting, sometimes with limited

success, to control their own fertility, and that abortion was merely another step on the continuum of fertility control. The rise of the medical profession reduced their control to both provide and receive assistance with reproduction. As the medical profession expanded, practitioners turned to reproduction as an area where they could augment their incomes and their expertise under the guise of science and technology. It is no surprise that the 1969 legal changes, ending 166 years of complete legal prohibition, were designed to serve the needs of the medical profession. For the nineteen years following the limited legalization of abortion, it remained a service that was regulated, overseen, and at the continued discretion of medical personnel and bureaucracies. During the same time, women's dependency on the medical profession for advice and the provision of fertility control grew immeasurably.

As the Canadian women's movement evolved, abortion lost its place as the central issue of women's oppression. Abortion remained and remains important to that movement, but it has largely been left to the groups whose sole focus is the issue of abortion. Canadian's women's health groups, while investigating services outside the medical model, have not extended that to the issue of abortion. The result of this division, is that for most of Canada, abortion remains a medical issue founded in a rights-based discourse, and is no longer viewed as an issue of women's health. Québec has had a somewhat different experience in that their history has permitted abortion to continue to be an issue of women's health. This situation further reinforced the invisibility of the abortion issue.

"Choice" and "control" have evolved in two separate directions in Canada. The abortion rights groups accept choice as a concept to terminate a pregnancy at every

woman's discretion, while more left-leaning groups have tried to define choice as requiring more substantive and structural changes. Both, however, accept abortion as a choice for women that is mediated through the medical profession. For these groups the issue is a woman's right to choose abortion, and her control is maintained through her individual right to make the decision to abort. The unique experience in Québec has paved the way for a more demedicalized approach to abortion, where control refers to the means and the provision of abortion and not just women's capacities as decision makers in dealing with the medical profession.

Through the years of legal, political, and feminist struggle abortion has become increasingly medicalized through the decision to establish clinics and to support Dr. Morgentaler. As a new generation of women grow up understanding artificial hormonal control as part of their female lives, the door for increased hormonal and chemical intervention was already open. This was the Canadian picture when, in September of 1988, the French Ministry of Health gave Roussel-Uclaf licence to market the chemical abortion procedure simply referred to as RU 486. These different players, battling in different forums, would go on to shape the debate surrounding RU 486 and chemical abortion.

CHAPTER TWO
RU 486/PG: FRAMING THE MEDICAL ISSUES

INTRODUCTION

Abortion has increasingly become a medical issue, rather than simply a women's issue. One of the major problems many feminists encounter when examining a medical issue such as RU 486/PG is an absence of the scientific knowledge, or background, required to thoroughly critique such a procedure. Thus, as abortion becomes increasingly medicalized, feminists may be insufficiently versed in the medical field to participate in a thorough investigation of the issue. In this chapter I will cross over from the social sciences to the physical sciences, to address the medical issues of RU 486 and the RU 486/PG abortion. As we will see in the next chapter, some feminists will base their position on RU 486/PG on a more theoretical approach to abortion, rather than on a critique of chemical abortion.¹ However, many of the positions assumed by Canadian feminists are a reflection of their medical assessment, or their faith in the medical assessments done by others.

In the first section I will focus on what RU 486 is and how it works as an abortifacient, the drug's background and the current international situation regarding its use. The second section of this chapter focuses on the medical debate surrounding RU 486 as an abortifacient, as well as its other medical uses. I specifically address how the question of RU 486's other uses have been portrayed, perhaps incorrectly by its supporters. To close, I consider the problems of using RU 486 as it presently exists, and the potential for long-term consequences. My main goal for this chapter is to clarify the

medical issues and properties, and to establish the ground work for the following chapter's discussion of Canadian feminist's positions concerning RU 486/PG.

RU 486: COMPOSITION AND FUNCTION

In 1980, during the course of his employment with the French pharmaceutical company Roussel-Uclaf, Dr. Etienne-Emile Baulieu created mifepristone, referred to by its manufacturer as RU 486.² At the time he had been engaged by Roussel-Uclaf to create a once-a-month form of oral contraceptive for women. In his earlier work in 1970, Baulieu had discovered uterine receptors that bond with the hormone progesterone, which is necessary to maintain a fetus during the early stages of pregnancy. His hopes at that time were to develop a hormonal contraceptive that would block or interrupt that progesterone bond. RU 486 does exactly that.

RU 486 is a synthetic hormone, similar to the body's own progesterone, which acts as an oral anti-progestin or a progesterone antagonist.³ The chemical function is to compete with the natural progesterone produced by the ovaries, attempting to block the uterine receptor cells from receiving the progesterone. Because the drug competes with the natural progesterone it is referred to as a progesterone antagonist, an anti-progesterone or an anti-progestin. Without progesterone, the lining of the uterus breaks down and the gestation of an early embryo is halted (See Illustration). The lining is shed in a manner similar to a menstrual flow, although the amount of blood is greater than that of an average flow.

In the early work with RU 486 it was used alone to induce abortions, acting as a contragestion, but this procedure was found to be effective in only 60-70% of cases.⁴

RU 486 interrupts pregnancy by opposing the action of progesterone at several sites in the uterus. In a normal pregnancy (top), the trophoblast (the future placenta) secretes human chorionic gonadotropin (HCG), which maintains the corpus luteum. Progesterone secreted by the corpus luteum has several effects that support the pregnancy. When that progesterone is blocked by RU 486 (bottom), the endometrium erodes and the embryo is detached and expelled along with the endometrial tissue.

From: Andre Ulmann, Georges Teutsch, and Daniel Philibert, "RU 486," *Scientific American: Medicine (Special Issue)*, 4(1) (1993), 42.

To increase the rate of success a second drug was introduced, making the process two fold. After receiving the initial dose of RU 486, generally 600mg, women returned 48 hours later for some form of prostaglandin, which are:

a group of naturally occurring, chemically related, long-chain hydroxy fatty acids that stimulate contractability of the uterine and other smooth muscles and have the ability to lower blood pressure, regulate acid secretion of the stomach, regulate body temperature and platelet aggregation, and control inflammation and vascular permeability. They also affect the action of certain hormones.⁵

Prostaglandins work by "binding to specific cell-receptors, causing an increase in the level of intracellular second messenger cyclic AMP."⁶ In the case of a chemical abortion the particular prostaglandin used helps the cervix open and the uterus contract, ultimately to expel the embryo. To reflect the fact that the medical abortion procedure includes these two steps, it is often referred to as RU 486/PG.⁷

In France a chemical abortion is presently a four step process. Women must approach one of the select clinics for consultation and registration. At that time pregnancy will be confirmed, a vaginal ultrasonograph will be performed, and consent forms signed. Participants must at that time meet the medical guidelines for the procedure and must have been a resident of France for a minimum of six months.⁸ In addition, anyone using the chemical procedure is required to sign a written agreement which specifies that in the event that the chemical procedure fails the pregnancy will be terminated through conventional methods. After this initial visit, women must then wait one week before returning to the clinic to initiate the procedure.

When they return, women are given three 200mg tablets of RU 486 which must be taken in the presence of a nurse or physician. Patients must then return 36-48 hours

later to receive a dose of prostaglandin, either by injection, suppository or oral tablet. Women remain at the facility for four to six hours, within which time over 95% of abortions are completed.⁹ Sixty percent of women will abort within four hours of the introduction of a prostaglandin, 90% within six hours and 96% within nine hours.¹⁰ When the fetus is expelled in the clinic, the attending nurse will check the contents of the expulsion to verify that the fetus has been completely discharged. If the abortion is not completed in the four to six hour waiting period, women are sent home to wait for the expulsion of the embryo. In some clinics women will be asked to return to the clinic with the passed fetus so that they may verify that the complete abortion has taken place. Women are advised to return the following week to ensure that the procedure has been successful and that there are no complications.

The "side" effects or the adverse effects of the procedure include blood loss, pain, nausea, vomiting, and diarrhea. These effects have been documented at different levels by various researchers, and I will return to them when I address inconsistencies in medical research surrounding RU 486/PG.

The drug, marketed in France by the name Mifegyne, was originally approved for use and distribution in France on 23 September 1988. It was removed almost one month later by Health Minister Claude Evin, on 26 October, after a storm of religious protest occurred about the drug.¹¹ It was returned to the market two days later after the government ordered it back on the shelves, declaring that RU 486 was the "moral property of women". The speedy return may have reflected the leverage of the French government, who had the option of rescinding the company's license for withdrawing a pharmaceutical

proven to be safe and effective.

Beyond their apparent concern for the women of France there were other factors that may have prompted the French government's move. On the day that the French government ordered RU 486 off the market there was an international meeting of obstetricians and gynecologists taking place in Rio de Janeiro. There was a large and concerted response from that audience that demanded the return of RU 486.¹² However, an additional and important factor in the motivations of the French government may reside in the fact that the government of France owns 36% of Roussel-Uclaf.¹³

Effectiveness

A 1990 French survey, done by the employees of Roussel-Uclaf, found that 73 clinics had demonstrated a 96% effectiveness rate.¹⁴ Another informal French survey completed in 1991 on "about 10 000" women found an effectiveness rate of 95-96% if used within seven weeks of the last menstrual period (LMP).¹⁵ Later studies have found similar results using both lower dosages and administering them up to nine weeks LMP.¹⁶ A British study found that women were likely to maintain such high success rates even to the eight or ninth week LMP.¹⁷ After the ninth week RU 486 can no longer compete as effectively with the increasing progesterone supplied by the placenta.

Adverse Effects

The RU 486/PG abortion is not without its risks. As a combination procedure there are two sets of potential side effects, one from the RU 486 and one from the prostaglandin. On a whole, the major studies have concluded that the procedure itself should only be available to women over the age of eighteen.¹⁸ RU 486, the anti-

progestin, is contraindicated in women with the following conditions: adrenal insufficiency, women who have taken long courses of corticosteroids, those with anemia or bleeding disorders, those who are considered moderate to heavy smokers (more than one pack a day), and women who are over 35 years of age.¹⁹

It is the second part of the procedure, the prostaglandins, that presents some of the most dangerous complications. Prostaglandins are considered unsafe for women who are identified as obese, having high cholesterol or diabetes. In addition, there are contraindications for the use of prostaglandins in women who have: the presence of asthma, fibroid tumours, experienced a pregnancy with an IUD in place, and or a cesarean in the previous year. Women with the following cardiac conditions are also excluded: angina, Raynaud's syndrome, arrhythmia, hypertension, and cardiac insufficiency.²⁰

The most serious problems to date have been cardio-vascular in nature. In 1990, two women, who were both smokers, experienced heart related problems. In the wake of these incidents, in 1990 Roussel-Uclaf introduced even stricter guidelines, specifying that women prone to cardiovascular problems be refused treatment. These cardio-related incidents prompted France's government drug agency, DMPH, to issue "treatment directives mandating the proximity of electrocardiogram and resuscitative cardiopulmonary equipment, as well as blood-pressure readings every half-hour after prostaglandin administration."²¹ However, in April of 1991, a thirty-one year old heavy smoker, in her thirteenth pregnancy, died of cardio-vascular complications after the prostaglandin injection.²² The clinic dispensing the procedure appears to have provided it against the warnings of the manufacturers.²³ In that instance the prostaglandin used was Nalador.

Clearly there is room for concern about the health implications of using prostaglandins in this procedure, and the ability of providers to follow the requirements of the manufacturer.

Although not often discussed, there is also a need to question the possibility of drug interactions. At this time there are only two likely interactions, but the Canadian Pharmaceutical Association (CPA) warns that "as experience with mifepristone increases, others may emerge."²⁴ The most likely to occur will be an interaction between the prostaglandins and analgesics with anti-prostaglandin activity, such as ASA or ibuprofen. These drugs may interfere with the uterine contractions caused by the increase in prostaglandin, and could override the initial prostaglandin thereby ending the abortion process. The second, and less likely interaction, is that of RU 486 and large quantities of progesterone, which could be found in oral contraceptives. Large quantities of progesterone would inhibit RU 486's ability to block the uterine receptors.

The Current International Situation

Although the RU 486/PG procedure is presently available in France, China, Britain, Sweden and the Netherlands, I will only be addressing the situations in France, Britain, and the US. This decision is based in part on the fact that Canada is more likely to be influenced by the events in Britain and the US, and because language barriers prevent me from addressing the situation beyond these three areas.

In May of 1990, the French government set the price of a chemical abortion at the same price as a conventional abortion. The current price is approximately \$250 (US), of which the social security system pays close to 75%, so the price for women, prior to child

care, travel expenses etc., is about \$60 (US). Over 400 hundred of the 800 centres providing abortions to women in France offer the medical procedure. Since the availability of chemical abortions there has been no significant increase in the number of abortions in France.²⁵ RU 486/PG is presently used in approximately one third of all abortions performed in France. After the initial protest against RU 486 there has been little action from the anti-abortion forces in France. There have been a few incidents of shouting matches with doctors at some of the clinics, but there has been no reported increase in either boycotts or violence.²⁶

RU 486/PG was approved in Britain in July 1991 and was expected to be widely available in 1992. British regulations dictate that RU 486 can be used up to nine weeks of pregnancy, or 63 days LMP. There is no required waiting period, reducing the process to only three steps. Helen Axby, director of the Marie Stopes Health Clinic in London, said that of all the women eligible to use RU 486/PG only about 6% actually choose to do so.²⁷ In February of 1994, the Marie Stopes Health Clinic reached an agreement with British authorities to allow Canadian and other women who are non-residents to travel to England to receive the procedure. The procedure costs \$650 (Can.) plus travel expenses. Applicants will have to show that they are less than nine weeks pregnant and that they are willing to return for a follow-up visit one week after the termination. Bonnie Johnson, executive director of Planned Parenthood Canada, argues that this will be a positive step for Canadian women, "the fact that Canadian women can now obtain it in Britain is really going to open things up."²⁸

Originally, medical professionals assumed that RU 486 would become available

in Canada prior to the US, and that American women would come here to find that service. UCLA professor Dr. Grimes, one of the most renowned American obstetricians and gynecologists supporting and testing RU 486, said in 1988, "I think it's inevitable that RU 486 will be produced in Canada and that's where Americans will go to get it".²⁹ The opinion of RU 486's supporters in 1988 was that "because suing has yet to become a 'national sport' in Canada, the climate is ripe for the sale of RU 486."³⁰ In addition to this, Canada was considered ideal because of the legal void where abortion is concerned. The Canadian history of RU 486, however, shifted from originally being considered as the testing ground for the drug when the company declared in October of 1988, shortly after the drug was pulled from the French market, that they would not introduce the drug in any country where there was not strong public support. Roussel representatives have reiterated this point, continually noting that because there is no clear legislation supporting the availability of abortion in Canada they are unwilling to start the lengthy and costly testing procedure.³¹

The procedure will ultimately become available in the US first, and Canadian women may go there to find it. After intense negotiations, on 16 May 1994, the American government concluded an arrangement for testing RU 486 in the US. The manufacturer Roussel-Uclaf has donated the patent rights and all the technology of RU 486 to the non-profit, American based, Population Council. That organization began testing the drug in the fall of 1994 on 2000 American women in ten to twelve cities.³² To date no results have been released. Bonnie Johnson thinks that at this point the testing is really only to work out any problems with distribution.³³ After the testing is concluded, and providing

the FDA grants its approval, the Population Council will choose a company to manufacture and distribute the drug in the US.

The donation agreement was the only way that the manufacturer would consider entering the American market, which has had many high profile incidents of civil litigation concerning pharmaceuticals. "In exchange for giving up its patent rights, the French company rids itself of product liability claims and, it hopes, the threat by anti-abortion organizations to boycott its other products."³⁴ The larger anti-abortion groups in the US have threatened to boycott all the products produced by Roussel-Uclaf, its parent company Hoescht, and the other subsidiary companies of Hoescht. Hoescht sells at least \$4 billion worth of products in the US every year.³⁵

RU 486/PG has had substantial support from many forces in the United States. In particular, feminists and feminist organizations have exerted a great deal of effort to bring RU 486 to the US. In October 1991, Peg Yorkin, co-founder of the Feminist Majority Foundation, donated \$10 million dollars to that organization, of which half was earmarked to promote making RU 486 available in the US.³⁶ The National Organization for Women (NOW), and the National Council of Jewish Women as well as many others have also been involved in the move to bring RU 486 to the US. The list of supporters include some of the largest medical organizations including: American Medical Association, American Public Health Association, National Association of Nurse Practitioners. In addition there has been a great deal of interest and promotion from population control groups including Population Crisis Committee, Population-Environment Balance Inc., The Population Council, and Zero Population Growth. However, probably the most important

factor was the support demonstrated by the Clinton administration, without which the arrangement would likely not have succeeded.

After two days in office President Clinton directed his Health and Human Services Secretary to find a way to make RU 486 available in the US. When the negotiations began to falter the American government established a deadline of 15 May 1994. Acknowledging publicly that, should negotiations fail, they might consider using the extreme measure of seizing the patent rights, thereby implementing the often referred to "use it or lose it" legislation of the US. An arrangement was reached on 16 May 1994. The two largest concerns for any American agreement beyond the issue of civil liability, were the potential for boycotts and the response of the Catholic community, both in the United States and internationally. "There was also the question of the precedent. The company was worried that whatever it did here would be a model for the rest of the world...".³⁷ Realistically this is true as many Canadians are now carefully watching the American situation.

THE MEDICAL DEBATE

This section of the paper will focus on the medical debate, which, although it is not entirely severable from the feminist debate, is being presented separately. Here I am focusing on the two main elements of the medical debate which feminists have referred to in their arguments for and against RU 486/PG. The first section addresses RU 486's potential for additional uses, which has been heavily referred to by pro-RU 486/PG supporters. I will examine how the possibility of its other uses have been misrepresented, using Cushing's Syndrome, contraception, and possible new research as examples. The

second part of the medical debate considers the more tangible issues of its use and the long-term consequences of its use, about which RU 486/PG opponents have expressed a great deal of concern.

Other Medical Uses

Part of the medical debate surrounding RU 486 is the possibility it presents for use in other medical treatments. At this time the manufacturers of RU 486 are unsure as to what medical procedures it can assist. In the past ten years medical science has identified it as a possible cure for the following conditions: breast cancer, meningioma, endometriosis, inadequate breast milk production, uterine fibroid tumours, Cushing's Syndrome, glaucoma, uterine cancers, osteoporosis, diabetes, AIDS, difficult labour, hypertension, birth control, and depression. RU 486 has also been suggested as a pretreatment for aspiration abortions.

With RU 486 as a pretreatment before first trimester vacuum aspiration one study found that 35 percent of women needed no mechanical cervical dilation and the rest needed much less dilation. If this pretreatment proves to be effective on a wide scale, it may reduce cervical damage in surgical abortion. Significantly less blood loss also occurred during the procedure in this study.³⁸

Childbirth By Choice, sibling organization of the Canadian Abortion Rights Action League (CARAL), lists sixteen different medical conditions for which RU 486 is a "promising treatment."³⁹ Clearly, by this long and diverse list there is as yet no certainty as to what the properties of this drug are.

However, the usefulness of RU 486 has also been contested by other members of the medical community. Dr. Grimes, the first American researcher on RU 486/PG, was quoted in 1988 on the topic of RU 486's other possible uses as saying many of those

options are "highly speculative", with the exception of cancer treatments which he viewed as "a possibility."⁴⁰ Although it is beyond the scope of this work to detail how it has been proposed to assist in the long list of health conditions, I will briefly consider how some of the arguments of those in support of RU 486 for other uses have potentially misled their supporters. Specifically I will address the situation of Cushing's Syndrome and contraception.

Cushing's Syndrome

The anti-glucocorticosteroids property RU 486 has been marketed by both medical researchers and feminists as a potential cure for Cushing's Syndrome.⁴¹ Several articles produced by RU 486 supporters have indicated that the additional possibilities for the drug are significant to their work of accessing the procedure. These references have been found in both feminist publications and population control publications. In the Yukon Territory's *THE OPTIMIST*, it was reported to be "a means of treating endometriosis, certain types of breast cancer, [and] Cushing's Syndrome".⁴² Lawyer and known supporter of RU 486 Rebecca Cook wrote in *People*, the magazine published by the International Planned Parenthood Federation, that "it can assist treatment, for instance, of Cushing's Syndrome".⁴³ As was previously mentioned, the one main information source in Canada, Childbirth By Choice Trust, has highlighted RU 486's possible use for Cushing's Syndrome in the only Canadian brochure being widely distributed.

Cushing's Syndrome is an "excess of free circulating cortisol from the adrenal cortex", which also means the production of excess glucocorticoids.⁴⁴ RU 486, in addition to acting as an anti-progesterone, is also an anti-glucocorticosteroid. Its effect, as

understood to date, is to block the production of glucocorticoids, "essential hormones which promote the conversion of proteins to glucose and glycogen".⁴⁵

In documented medical studies there has only been success using RU 486 in treating Cushing's Syndrome in one male, who had already received a wide variety of steroid treatments.⁴⁶ In a later study of RU 486 and Cushing's Syndrome by Bertagna et al., two of their seven patients developed both headaches and nausea, while a third became lethargic. Bertagna et al. concluded that the symptoms may have been due to glucocorticoid deprivation, but acknowledged that it is extremely difficult "to evaluate such a situation biochemically since cortisol measurements are of no value in a situation in which cortisol action is antagonized".⁴⁷

Symptoms of prolonged use of steroids include: fatigue, abdominal pain, nausea, dizzy spells and fainting. Raymond, Klein and Dumble point out that "alarmingly, these are some of the symptoms mentioned by women after they have taken RU 486."⁴⁸ In a 1985 study of the use of RU 486 Regine SitrukWare et al. found a loss of energy and weakness in all their ten participants, and suggested that, "all subjects represent subjective evidence of glucocorticoid deficiency".⁴⁹

There has been limited success regarding the use of RU 486 as a form of treatment for Cushing's Syndrome. Studies that have been conducted have had difficulty determining the efficacy of the drug. At this time, there are few results to indicate that RU 486 will be a wonder cure for Cushing's Syndrome. There is certainly not enough medical evidence to support the claims of RU 486 as a "means of treating", or even as a way to "assist in treating" this syndrome.

Contraception

As the original goal for RU 486 was some form of contraception, it seems logical that it would continue to be the primary source of research. RU 486 has been suggested as a once a month birth control pill for women, a daily oral contraceptive for women and possibly men, a menstrual inducer and as a morning-after-pill. Indeed, the possibilities appear endless, and RU 486 has been promoted accordingly. However, these proposals for contraceptive methods are not without some serious problems, about which the promoters of RU 486 have not been equally candid.

Recent experimentation found that if ingested at mid-cycle RU 486 appears to delay ovulation. Studies have considered the effect of taking RU 486 for one week prior to ovulation, whereby the development of ovarian follicles is delayed.⁵⁰ Luukkainen et al. have demonstrated some success with the one week method.⁵¹ Further studies have examined using RU 486 a few days after ovulation, making the endometrium inhospitable to implantation. In their question and answer booklet on RU 486, Population Action International claims,

RU 486 also appears to suppress ovulation when taken in low doses on a daily basis. Even lower doses of RU 486, administered daily, may alter the environment in the uterus enough to prevent pregnancy without blocking ovulation. These approaches could some day become estrogen-free alternatives to currently available oral contraceptives.⁵²

Finnish researchers used RU 486 (25 mg) for twelve days and followed that with a ten day course of a synthetic progestin (5 mg).⁵³

One potential problem with such treatment, though, is that the progestin (which must be given to prevent the women from being exposed to unopposed estrogen late in the cycle) can sometimes fail to prevent ovulation after the effect of the antiprogestin has waned.⁵⁴

However, if used alone as a once a month, or one week a month treatment, continuous use of this drug could lead to incidence of endometrial cancer, which would be the result of "chronically unopposed estrogen on the endometrium".⁵⁴ In addition, it would be difficult to narrow down exactly which one day, or even which five days, represented the appropriate point in mid-cycle given the complexities of the menstrual cycle and the incredible variations women have in their cycles. As a form of oral contraception RU 486 has no new capability that present day oral contraceptives do not already have, with the exception of a different schedule for ingestion. There appear to be some serious health risks if used as a form of contraception, and more importantly, there have been no long-term toxicology studies on the effects of RU 486 when used continuously.

RU 486 also presents the possibility of an oral contraceptive for men. The goal is a drug that could be taken immediately prior to intercourse. Dr. Beaulieu noted, "I can envision a pill that can be effective for varying amounts of time - for one hour to one week a month".⁵⁶ His most recent research shows that chemical properties of RU 486 prevent calcium from penetrating the sperm. Without calcium the sperm become immobile, and as a result cannot reach the egg to fertilize it. To date I have been unable to locate medical evidence to refute or critique this assertion. However, given the relatively recent expression of interest in male contraceptives there are few resources to which I can refer.

There have been studies regarding the use of RU 486 in a very new reproductive use, as a menstrual inducer, to be used prior to a missed period. The drug is given on the

expected day of a woman's period, and then again on a yet to be determined number of days after that. The results of those studies indicate that RU 486 is currently ineffective for this purpose. In the 1987 study by Van Santen and Haspels, two out of eleven women had ongoing pregnancies.⁵⁷ In a later experiment by Couzin et al., two doses of RU 486 were administered to twelve women in a set pattern, the first on the first expected day her period and the second eight days later. Their results indicate 22 pregnancies out of 137 cycles occurred.⁵⁸

RU 486 has often been confused with the already established "morning after pills", which are various combinations of high doses of synthetic hormones which must be taken generally within 3 days of unprotected intercourse. The popular Canadian method is a "regimen of two oral contraceptive tablets containing estrogen and progestogen followed by another two tablets twelve hours later".⁵⁹ In a study funded by the World Health Organization, Glasier et al. found that RU 486 was more efficient than the usual Canadian method, and that it was better tolerated than the oral contraceptive regimen. Their major finding was that there were lower rates of vomiting with RU 486.⁶⁰ The only "apparent" disadvantage that was reported was the delay in the next menstruation cycle for 42% of the participants in their study.⁶¹ The World Health Organization is currently undertaking a multinational study of 2000 women on the effectiveness of RU 486 as a morning-after-pill.⁶²

My main concern about RU 486 as a morning after pill reflects my more general discomfort with morning after pills. Which women are encouraged to use the morning after pill? Morning after pills (MAP) are commonly distributed in University/college

health centres, and family planning clinics. They are offered to women who have experienced a sexual assault, and generally to young women when contraception has failed or was not used. Who is offered MAP's, which are relatively unknown, is open to the biases and prejudices of the those employed in health services.⁶³ Thus, the presence of racism and classism may put some women at a greater risk of exposure to RU 486.

The issue of morning-after-pills themselves is worthy of a serious debate, which is not possible here. What is possible is to indicate the need to consider how these products that already do exist are potential health risks for women, and to merely replicate the same dangerous procedure with an alternate chemical composite is not necessarily progress. Furthermore, to interrupt the biological process of women with no confirmed knowledge of pregnancy, will promote greater unnecessary chemical intervention in women's bodies. The Boston Women's Health Collective suggests, "although abortion is more expensive and more difficult emotionally, it may be safer in the long-run."⁶⁴

Although RU 486 has been widely promoted as having a number of innovative possibilities for birth control, and not just exclusively for women, it has not demonstrated anything revolutionary, nor has it challenged existing problems with chemical intervention. It merely echoes what is presently available with other synthetic hormones. The dangerous part for women and men is that there have not been enough long-term studies on these methods. We must then raise ethical questions about continuing to manipulate women's reproductive cycles for something that is not really anything "new", rather just different ingredients for the same recipe.

New Research

This is not meant entirely to say that there is no clinical value to the properties of RU 486, or to the relevant research. At this time there is presently a Canadian study being done by a team from the National Cancer Institute of Canada on the possibilities of using RU 486 to interfere with hormone dependent breast cancer. Dr. Elizabeth Eisenhauer, who is overseeing the Queen's University clinical trials, says, "RU 486, because of its blocking activity of progesterone, might cause breast cancer to regress or shrink." ⁶⁵ Other studies reflective of the long list of possibilities are under way internationally. Most recently RU 486 has been used to interrupt the replication of HIV infected cells. Dr. David Weiner found that "HIV-infected cells treated with RU 486 produced 70 percent less virus than unmedicated cells."⁶⁶ There is no question that for these diseases for which there is presently no known cure it is important to consider new possibilities. The point that I want to make clear is that there is room to question RU 486 as an abortifacient, which I will do in further detail in the next chapter, and to question how it has been promoted to women.

The second point I want to make is that when RU 486 was first picked up in the late 1980's and early 1990's by feminist groups who hailed the incredible possibilities of this new drug it was based on limited and contradictory research, as is clearly evident in the example of Cushing's Syndrome. In reference to the studies that are focusing solely around breast cancer and meningioma, Raymond, Klein and Dumble wrote in 1991 that "each of these studies are in their initial stages and full of contradictions. In the case of meningioma, researchers have yet to agree which tumors are hormone dependent. One study reported further tumour growth during RU 486 administration."⁶⁷ In 1985 Bardon

et al. examined the use of RU-486 in breast cancer, investigating whether or not the anti-progestin could slow the growth of progesterone dependent breast cancer. "Rather than preventing progesterone receptor activation, they found that RU-486 may work as a cytotoxic agent (a cell poison)."⁶⁸ Paul Van Look of the World Health Organization, long time supporter of the use of RU-486 PG, said in the fall of 1994 that only in the next four or five years will it be possible to say what other uses there are for RU-486.⁶⁹

Despite conclusive evidence, physicians and feminists alike continue to misrepresent the drug's possibilities. Dr. Gary Hodgen, President of the Jones Institute for Reproductive Medicine in Virginia, provides a clear example of this in an article in the *Medical Post*, where he commented: "If you have an *effective* drug that is going to *effectively* treat Cushing's syndrome, breast cancer, or endometriosis, I believe the pressure to see a product developed from these will be so great that it will evolve".⁷⁰ I have found nothing to indicate conclusively that RU-486 presents an effective cure for anything at this point.

Many of the groups, both pro-choice and anti-choice, who are critical of using RU-486 as an abortifacient have not suggested that they are opposed to the use of RU-486 for other purposes. Dr. Paul Ranalli, a Toronto neurologist and member of the Human Life Research Institute said in 1992 that, "both the Canadian and the U.S. branches of the Right to Life have gone on record as not opposing RU-486 testing for these and related conditions; their opposition is limited to its use as a chemical abortifacient."⁷¹

UNRESOLVED MEDICAL ISSUES OF RU-486/PG ABORTIONS

To date most advocates of RU-486/PG have down played the potential medical

risks of the two drugs, both alone and in combination. The medical literature available on these drugs indicates that there are disagreements within the medical profession, and that there are conflicting studies and reports. Almost all of the studies that have been done have been naively non-inclusive, and have ruled out many women with a wide range of medical conditions and histories; thus the bulk of the testing has been done on young, "healthy" women. Beyond the problems with research samples, there is still debate within the medical profession as to the correct dosages of both RU 486 and the prostaglandins, as well as the appropriate type of prostaglandin. Also unresolved remains the lack of consistency within the studies themselves as to what are the various acceptable standards of measure. The inconsistencies have centred around levels of bleeding, vomiting and nausea and levels of pain.

Blood loss is one of the serious and more common side effects of RU 486/PG abortion. Michael Klitsch notes that the blood loss is similar for either medical or surgical abortions, but that "post-abortion bleeding is more prolonged after medical abortion than after surgical abortion."⁷² In contrast, the organization Childbirth by Choice claims that, "Studies have found that blood loss and pain from an RU 486 abortion are not greater than from a surgical abortion."⁷³ Dr. Raymond, however, argues that "a disturbing number of women have experienced bleeding requiring blood transfusions."⁷⁴ Medical researchers reported in 1989 that blood loss was relative to the length of amenorrhea, finding that at eight weeks LMP, "the amount of blood loss is sufficient to cause a decrease in haemoglobin concentration that could affect the health of anemic women."⁷⁵

Inconsistencies are evident in the discussions of vomiting and diarrhea, where

women's experiences of these adverse effects vary or are considered insignificant. In a 1990 French study 34% of women experienced nausea, 15% vomiting, 8% diarrhea.⁷⁶ Other studies have indicated a slightly higher incidence of vomiting and diarrhea: 17% of participants experienced vomiting and 10% diarrhea in a 1987 Scottish trial, whereas 26% experienced vomiting and 13% experienced diarrhea in a 1990 UK trial.⁷⁷ A 1989 study on RU 486/PG determined their findings on vomiting and diarrhea to be *insignificant*.⁷⁸ It seems unlikely that the same procedure would result in a finding of 26% in one study, yet be insignificant in another. The problem is that women are at the discretion of researchers to determine what the adverse effects are, as well as how significant they are. The fact that they are considered "side" effects indicates the low priority of women's experiences versus the larger goal of efficiency.

The determination of "pain" is relative in nature, and whether it is studied or how it is reported will also depend on the researcher. Scientists have generally accounted for pain by determining how many participants required some form of pain relief ranging in nature from more minor treatments to opiate analgesia. In one 1986 study on RU 486 alone (with no PG), the incidence of pain was considered insignificant to the researchers' findings, yet, in a 1990 study done on RU 486/PG, pain was reported by 37% of nulliparous participants.⁷⁹ Most women in that French study, one of the largest done ever, reported abdominal pain with 15% to 50% needing some form of pain relief. The incidence of pain appears to be higher in nulliparous women and in the four hours immediately following the introduction of the prostaglandin.⁸⁰ In addition, the larger the dosage of prostaglandin the more intense the pain levels will be.⁸¹

Researchers have also not yet established which form of prostaglandin is most effective in combination with RU 486. Cardiac problems are more commonly associated with the injectable sulprostone, whereas gemeprost, a vaginal suppository, seems to cause less bleeding and pain than sulprostone.⁸² In 1992, it was reported that sulprostone is no longer used in France as part of the combination procedure. The preferred drug is now the "more gentle-acting Cytotec", which goes by the name gemeprost in France.⁸³ However, the manufacturers of Cytotec have not condoned the use of that product with RU 486.

One of the many unresolved issues surrounding prostaglandins, beyond the correct type, is the issue of dosage. In many of the studies on the prostaglandins the injections of sulprostone were any of the following: 0.500mg, 0.375mg, 0.250 mg, or 0.125 mg.⁸⁴ The lower dosages have been found to be equally effective, with less adverse effects, but the procedure does take somewhat longer.⁸⁵ The injections work faster than the pessaries, which can not be cut down as easily as the injections, but adverse effects are more likely with the injectable because of its immediate introduction to circulation. In Canada the most common prostaglandin is Cytotec, also referred to as misoprostol, which is an oral medication. However the manufacturers have not condoned the use of prostaglandins in abortion, nor do they have any plans to introduce lower dosages to facilitate the purpose of an RU 486/PG abortion. There are additional concerns regarding prostaglandins which I will address in the following chapter, as they form a large element of the concerns expressed by the Québec coalition against RU 486.

There is still debate among members of the medical profession as to what is the

acceptable dosage of RU 486. The present universal dosage is 600mg, but the World Health Organization has established that the effectiveness is not reduced with a decreased dosage.⁸⁶ Another study shows that the rate of efficiency does not drop below 95% whether the dosage is 200mg, 400mg, or 600mg.⁸⁷

There is also disagreement concerning the half-life of RU 486. It had been said that, because RU 486 is used over such a short time, it is quickly metabolized: i.e. half of the drug has left the body twenty hours after it has been injected.⁸⁸ More recent studies have shown that the half-life of the drug is not as short as was originally believed, finding that the half-life can range from ten to fourteen days.⁸⁹ In 1989 Dr. Baulieu reported that the half-life of RU 486 is twelve to twenty-four hours, and the drug is for the most part excreted in the feces.⁹⁰ However, "its complex metabolism in the liver maintains a high plasma concentration for several days after a 600 mg dose."⁹¹

Clearly there remain many unanswered questions regarding the use of RU 486/PG. Until the inconsistencies in data are resolved, as well as the issues of dosages, brands and half-life there will remain room for continued medical debate. The same could be said for the issue of undocumented long-term health risks.

Long-term Risks

Beyond the cardiovascular-related risks and the adverse effects of the procedure, there are additional long-term health risks for the chemical procedure. To date there have been no long-term studies on the use of RU 486, but there is some research that indicates the need for caution.⁹² Most of this research has been related to the menstrual cycle and to the continued fertility of women who have been exposed to RU 486. No studies have

been completed which clarify whether exposure to the drug will result in risks to immature ovum, to present or future pregnancies.

In an attempt to determine whether progesterone was important in the final stages of oocyte maturation, researchers Messins and Templeton super-ovulated forty women, and then administered twenty of these women with 100mg of RU 486.⁹³ They found that "progesterone is not critical for the final stages of human oocyte maturation".⁹⁴ In addition and more relevant to this debate, they found that "the development capacity of the oocytes after fertilization in vitro could not be fully determined since the cleaving embryos were not replaced in a recipient uterus".⁹⁵ In a similar trial done one year later by inventor Baulieu, he found what many earlier studies had found, that "RU 486 and two of its major metabolites can readily cross the blood follicle barrier of human pre-ovulatory follicles."⁹⁶

Medical researchers have not yet determined what effects the presence of RU 486 has on embryos that are not ultimately terminated. This question is extremely important given the fact that an RU 486/PG abortion is a procedure which takes place over a number of days, and its two step requirement raises the issue of what will happen to women who do not return for the prostaglandins. Studies have found that RU 486 is effective alone only in 60-70% of cases, leaving a 30-40% chance that continued pregnancies may have been affected by the presence of a progesterone antagonist. In their 1985 research on second trimester pregnancies, Frydman et al. "conclusively demonstrated that mifepristone crossed the placenta and that the absence of fetal toxicity was yet to be demonstrated."⁹⁷ In 1990 Yang and Wu reported that "the mechanism by which RU 486

acts directly on the embryo is not known at present".⁹⁸ Klitsch discusses early animal studies where newborn rabbits that had been exposed to RU 486 were "prone to skull abnormalities", but finds that similar research in monkeys does not demonstrate the same problems.⁹⁹

At this point there is little data surrounding pregnancies that have gone on to full term after the introduction of RU 486. One case was reported in France where the woman no longer wished to terminate the pregnancy after the RU 486 was taken. She is said to have miscarried at 18 weeks and the fetus exhibited a number of deformities.¹⁰⁰ In 1990, Lim et al. documented two women who delivered normal babies after early exposure to RU 486.¹⁰¹ Presently Roussel-Uclaf is doing a study on possible birth defects in the Paris area, attempting to discover any infant abnormalities in women who may have been lost to follow up studies. By the end of 1991, three infants who are known to have been exposed to RU 486 in utero have not exhibited any signs of malformation or damage.¹⁰²

Cause for concern is present in warnings from an international research team of scientists and doctors in Paris. After reviewing the data of 30 000 women who had used RU 486/PG, they immediately urged the French government to stop distribution because of the "grave secondary effects of chemical abortion which is falsely seen as an alternative to surgical abortion."¹⁰³ Clearly though these brief reports are not substantial enough to conclude that RU 486 will or will not have an effect on present and future pregnancies. Yet Norma Scarborough, of CARAL, wrote in a letter to the editor of *The Globe and Mail* that "women who took RU 486 ten years ago have had normal pregnancies and carried normal fetuses to term in the intervening years."¹⁰⁴ It has been well established

that the experience of a chemical abortion does interfere with the next menstrual cycle, "causing delay of follicular maturation and then disturbing periodicity".¹⁰⁵ As was discussed above, it has the same effect when used alone as a morning after pill. However, the few studies that have been done on teratogenic effects, or on developing oocytes, have largely been done on women who have volunteered to participate during the process of being sterilized. They have been super-ovulated using unusually high dosages of clomiphene, experienced in vitro fertilization, and then the embryos have been aspirated or examined through laparoscopy.¹⁰⁶ The reality is that truly sufficient testing on this topic will require "that some women who did not abort after taking RU 486 carry their pregnancies to term so that the baby could be examined for adverse effects of the drug".¹⁰⁷

CONCLUSION

RU 486/PG, an antiprogesterin contragestion, has been hailed as revolutionary to women's reproduction. From its early days in France it has slowly begun to spread internationally and is now approaching ever closer to Canada's border. As part of the chemical abortion procedure it has been proven highly effective, with the potential for life threatening consequences. It has been hailed for its many other uses, yet the medical evidence does not justify the enthusiasm its supporters exhibit. There remain many unanswered questions about its potential for other uses, as well as its use in its present form regarding adverse effects and correct dosages. The long-term effects on the women who use it and their future children remain unknown. In the last hundred years women have been sold a number of potential panaceas to help in their efforts to control their

fertility. Many of those have killed and maimed women and their children. It is not yet evident that will be the case with RU 486/PG abortions but, as I have tried to demonstrate here, there is room for further medical debate and there is cause for women to question its scientific properties. As we will see in the following chapters, some feminists, in light of the increasingly medicalized fertility control of women, are assuming a more critical position on the issue of RU 486/PG, while others are more accepting of the increasingly medicalized abortions offered by drugs such as these.

CHAPTER THREE
RU 486/PG: CANADIAN FEMINISTS RESPOND

INTRODUCTION

While RU 486 remains unavailable in Canada, what has developed is a political situation where the contestants for and against RU 486 rally for position. Dr. Marion Powell, of Women's College Hospital in Toronto, remarked that "[u]nless individual women, women's groups, physicians, and medical associations launch a vigorous campaign to point out the advantages of RU 486, Canadian women will be denied the opportunity to choose this safe alternative to surgery."¹ Some Canadian feminists have answered the call and have commenced working towards the Canadian availability of RU 486/PG, while others, various Québec groups, have taken a position against RU 486/PG. Still others remain noticeably silent.

In this chapter I will examine the response some Canadian feminists and women's health groups have demonstrated on the issue of RU 486/PG. It is by no means an exhaustive review, but rather a reflection of those groups and individuals whom I was able to contact.² Through this examination, I will establish how feminists interpret the advantages and disadvantages of the RU 486/PG procedure in relation to issues of access and privacy.

NO POSITION

Some of Canada's largest women's health collectives, including the Vancouver Women's Health Collective (VWHC), and Ottawa's Women's Health Interaction (WHI) have not yet established a position on RU 486/PG. Although WHI did not take a specific

"no" position they have written one of the most critical evaluations of RU 486/PG in Canada.³ WHI has expressed concerns about both the procedure and its supposed benefits. While the VWHC's main focus is to "provide information and resources with the broader objective of helping women to help themselves with their health care choices", they are not at this time addressing RU 486/PG.⁴

Other groups in the "no position" category include the Regina based Women's Health Action Committee and the Saskatoon Abortion Rights Association.⁵ Groups such as DAWN Ontario have not established a position on chemical abortions; rather their lobbying efforts focus on the rights of women with disabilities to be mothers.⁶ The Canadian Women's Health Network and the Victoria based Women's Health Promotion Network, both of whom are still in the very early stages of their development, have not taken a position at this time.⁷ The Vancouver Women's NRT Coalition writes that, although RU 486/PG has been the topic of discussion on a number of occasions, they have not established a position on its use or availability. Catherine Martell of that Coalition wrote: "Generally the Coalition has not taken public positions on specific new reproductive and genetic technologies as we are a group of women with frequently disparate views on any given issue; this is, in essence the nature of coalition efforts."⁸ The situation of the Vancouver Women's NRT Coalition perhaps sheds light on the notable absence of positions from women's health groups and collectives.

SUPPORTING RU 486/PG

Among RU 486/PG supporters are some of Canada's most active and established abortion rights organizations and women's health groups, as well as the more

institutionalized women's advocacy groups. There are two main differences in the level of support offered by pro-RU 486/PG groups and individuals. While many supporters' policies call for the testing of RU 486/PG, a few take an additional step and indicate how that testing should proceed. The other distinction between the groups concerns the levels of active lobbying that groups have done towards bringing RU 486 to Canada. Some supporters have taken a very active role, while others have taken a more moderate approach

The Canadian Advisory Council on the Status of Women (CACSW) was typical of supporting groups in calling, as it did in a November 1992 letter to Benoit Bouchard, then Minister of National Health and Welfare, for the testing of RU 486 but without clarifying any requirements for the testing procedure.⁹ The CACSW based their recommendations on the need for increased access to abortion and RU 486/PG's potential for additional uses. Other professional organizations have taken comparable actions. The Planned Parenthood Federation of Canada (PPFC) passed their supportive resolution in 1990, calling for clinical trials. In September 1992, the Society of Obstetricians and Gynaecologists of Canada (SOGC) called upon the pharmaceutical companies to submit an application to the federal government, with no indication of testing requirements. In the following year, The Federation of Medical Women of Canada endorsed SOGC's resolution, accepting the absence of testing provisions, agreeing that RU 486/PG represented "a significant medical and public health gain".¹⁰

The Toronto Women's Health Network (TWHN) established their position of support in October of 1994.¹¹ Their policy is founded in clear concern about the "poor

track record of pharmaceutical companies in releasing hormone preparations and devices for women's reproductive health that have left, at best, an uncertain legacy "¹² They called for "safe and adequate testing" without further clarification.¹³ The TWIN bases their position on the need for greater access:

We will support the approval of RU 486 as an abortifacient to be made available to Canadian women only after careful scrutiny of the experimental data. As well, women must be offered comprehensive counselling about their abortion options so that the choices they make are truly informed choices.¹⁴

Other groups have established policies in support of testing, and have established clearer testing guidelines. In their 1991 resolution, the National Action Committee (NAC), recommended that NAC lobby the federal and provincial governments, as well as Roussel Canada, "to release RU 486 for testing in Canada to include but not focus on immigrant women, racial minority women and women with disabilities".¹⁵

In June 1991, the Winnipeg Women's Health Clinic (WHC) passed their resolution in support of testing and distribution for the purposes of research only ¹⁶ The Clinic's policy clearly outlined what would be required for appropriate testing

Research into the drug should be coordinated nationally and results distributed to all interested parties including consumers. Future research should include randomized client selection, morbidity comparison to surgical procedures, long-term follow-up and an assessment of the psychological/ emotional impact of the process (also in comparison to surgical procedures). Research should take place in community as well as institutional settings, as well as rural and urban areas

Women's Health Clinic strongly recommends that there needs to be a method to ensure standards of counselling, care, and informed consent for women who may partake in clinical trials, and that they be developed if the drug is approved for general use ¹⁷

If the drug is approved by the Health Protection Bureau, the Clinic will support its

availability and its use, and they have offered the clinic as a possible location for testing.

The Ontario Coalition of Abortion Clinics (OCAC) has no stated policies in support of RU 486/PG, however, their supportive position is evident in their briefs to the Royal Commission on the New Reproductive Technologies.¹⁸ OCAC's brief highlights the need for "sound research to demonstrate RU 486's safety and effectiveness."¹⁹ However, they do not express the need for future Canadian testing based on principles such as those put forward by the Women's Health Clinic. In fact, they "demand that the approval process be expedited, it can certainly take account of well-designed research from other jurisdictions."²⁰ OCAC does, however, consider potential problems with distribution, raising a number of questions around the issue of how "RU 486 will be opposed by the same forces that stand in the way of women's reproductive and sexual autonomy in so many other areas."²¹ OCAC proposed that:

The Royal Commission should outline a policy framework within which RU 486 would be equitably available to all women who need it and which would ensure that it is provided in ways that maximize women's reproductive health and autonomy. This means that the drug would have to be provided free of charge, with full information and counselling, and with comprehensive support and follow-up services.²²

Although CARAL has no written policy that details their position on RU 486, their views can be ascertained from their writings and in their publication *The Pro-Choice News*. In their 1990 brief to the Royal Commission on the New Reproductive Technologies they recommended that the Commission "study carefully the material available about RU 486 and recommend that its testing be undertaken in this country."²³ Women's Health Education Network (WHEN), one of Canada's oldest and formerly one of the most active groups, has not established a position on RU 486/PG. However, they

have indicated that because they are members of CARAL they will accept the position CARAL has taken ²⁴

Many of these organizations are actively lobbying for the availability of RU 486. Planned Parenthood, under their past president Dr. Norman Barwin and under their current president Bonnie Johnson, has been working towards bringing RU 486 to Canada. Women's College Hospital in Toronto, under the administration of Dr. Marion Powell, has also been sending letters to Roussel Canada, and the federal and provincial ministries of health, "supporting RU 486 as a valuable contribution to Canadian women" ²⁵. CARAL has, however, been by far the most vocal advocate of bringing RU 486 to Canada. In fact, it is fair to say, they are the largest and most dedicated organization lobbying for RU 486 in Canada. In 1988, then President of CARAL, Norma Scarborough said of RU 486, "it would be a god-send to women, yet little has been heard about it. Maybe what women need to do is start making some noise about it" ²⁶. It would appear that CARAL has taken Scarborough's call to action seriously. Scarborough first met with Donald Buxton in 1989 and since that time CARAL has worked on many different levels in their efforts to bring RU 486 to Canada ²⁷.

Beyond their October 1990 brief to the Royal Commission on the New Reproductive Technologies, CARAL has also published a number of pro-RU 486/PG articles in their publication *The Pro-Choice News*, and has issued various "Action Appeals" to its membership. CARAL has been present at many women's conferences and gatherings across the country with a display table offering petitions and information such as the pamphlet *RU 486: the "abortion pill"*. In addition, they have participated in a

number of postcard and letter campaigns to the various Canadian Health Ministers, as well as to Roussel Canada and their parent company Roussel-Uclaf. At the same time, they have carefully watched Federal elections and Cabinet shuffles. CARAL has sent delegates to all the major international conferences, including The American Society of Law and Medicine's Conference on "Anti-Progestin Drugs: Ethical, Legal and Medical Issues."²⁸ In May 1992, CARAL sponsored a public meeting with Dr. Baulieu, so that he might address the medical community and CARAL's membership.

In that same year, CARAL established a special committee "to spearhead lobbying efforts to get RU 486 tested and introduced in Canada."²⁹ As part of their increased efforts they commissioned an Environics Poll to assess Canadian opinions on whether or not "an abortion is a medical procedure that should rest with the woman in consultation with her physician."³⁰ The poll was part of an effort to convince the makers of RU 486 that Canada was receptive to their product and to apply for a Canadian license. As the 1992 period of rejuvenated interest began to wane, Clayton Ruby wrote that CARAL's talks with Roussel Canada "have been amicable, but ineffective".³¹

CARAL's RU 486 committee is still functioning, although little has occurred since 1992, by which time most of the groups supporting RU 486 had established their supportive positions. For now CARAL has turned their eyes south to the United States.

We look to the States actually with anticipation, because as we both well know what happens in the States will often trickle down or cross over into Canada, and if the experience of the States is positive or at least not too negative for the company, we certainly have hopes that they would apply for licensing in Canada.³²

Supporters of RU 486/PG acknowledge that the procedure is not without some

disadvantages. The length of the procedure and the number of visits required are considered problematic, as is the limited period of use and the various side effects. Their hope is that these problems will be alleviated with further research and testing. Although the groups who are against the use of RU 486/PG also recognize these similar problems, their hope is that no more research will be conducted on women, and that the procedure will be rejected as a possibility for Canadian women.

ANTI-RU 486/PG

To date, all the Canadian groups opposing the introduction of RU 486/PG into Canada are located in Québec. The three groups who have assumed a "no" position on the issue of RU 486/PG are Le Fédération du Québec pour le Planning des Naissances (FQPN), Le Centre de Santé des Femmes (Montréal) (CSF), and Le Regroupement des centres de santé des femmes du Québec (RCSFQ).

The FQPN formally established their no-testing/experimentation position 6 June 1993. Three main reasons underlie their position. They are fearful that if RU 486/PG became available in Québec there would be a reduction of services of conventional procedures, especially in rural and northern areas of the province. Concerns have also been raised about increased risks to women's health and fertility, since little is known about the long term effects of the prostaglandins. Finally, they have concluded that there have not been not enough long term studies.³³

The FQPN has expressed additional concerns about the effect of the combination of drugs on fertility, future menstrual cycles, the health of future embryos and children, the endocrine system, and the immune system. They are also very troubled by the way

RU 486/PG is being tested, and by how women are being experimented on in the process. The FQPN has always had a policy not to promote the utilisation of prostaglandins in abortion, "puisque les effets secondaires sont très dangereux pour la santé des femmes".³⁴

The CSF reflects a similar history with RU 486/PG, as well as sharing a position with the FQPN. They first started receiving information about RU 486 from France in the late 1980's. However, they did not feel that there was significant research to establish that it was safe for women either in the immediate or in the long term. The Centre decided to wait until more research was completed prior to establishing a position on the issue. With the publication of Raymond, Klein and Dumble's book, the Centre had the necessary information to critique the chemical procedure, and established their "no" position in June 1993. The Centre has continued to work with the FQPN jointly publishing pamphlets and organized a meeting in January 1993 of concerned women to address the issue.

Le Regroupement des centres de santé des femmes du Québec also established their anti-RU 486/PG in 1993.³⁵ As part of their quest for discussion on RU 486/PG they produced a critical discussion paper called, *LE RU 486 ET PROSTAGLANDINES: On l'appelle 'PILULE ABORTIVE', On la qualifie de "PROPRIETE MORALE DES FEMMES", On la nomme 'COCKTAIL CHIMIQUE'*.³⁶ In this paper they ask women to question the details of the procedure. They question the safety of RU 486/PG, referring to the continuing disagreement among scientists about side effects and the possible long-term implications. They also question the introduction of prostaglandins into abortion "at this stage when we have been so long fighting against them in later pregnancies".³⁷ In

their Fall 1993 Newsletter, *SANS PREJUDICE...pour la santé des femmes*, they reprinted the article by Ginette Bastien of the CSF in collaboration with women from the FQPN. They are currently involved in creating a brochure critiquing RU 486/PG which they hoped would be available by year's end.

The response by Canadian feminists and professional organizations has varied, ranging from silence to active lobbying. Organizations that have established positions in support of RU 486/PG share similar reasons for their support, but differ in their approach to testing and levels of activism. Supporting groups are largely English groups based in Central Canada. The only groups opposing RU 486/PG are Francophone groups located in Québec. At this point, they are not actively lobbying the federal or provincial governments; they are, however, working together to educate Québec women about the dangers of RU 486/PG. As the first chapter illustrates, there are already two very different histories of abortion organizing in Canada: the English-based liberal groups and the more demedicalized approach of Québec women's health groups. RU 486/PG appears to mark a further distinction in that on-going history, with the Canadian feminist positions on RU 486/PG reflecting yet another difference in abortion organizing between Québec and English-Canadian feminists.

RU 486/PG: THE ADVANTAGES AND THE DISADVANTAGES

The goal of this section is to identify the advantages of RU 486/PG as identified by its supporters, and the disadvantages as identified by its opponents. In some instances, skeptical supporters are clear that RU 486/PG does have a number of disadvantages, although they favour its use and availability overall. Thus the lines of division between

positions are not always clear, with some supporters openly questioning the procedure. The main issues in contention are grouped into two sections: access and privacy. These two issues represent the clearest divisions between the two positions.

1 ISSUES OF ACCESS

Many advocates of RU 486/PG argue that RU 486/PG will result in women's greater access to abortion. Opponents of RU 486/PG, while in agreement that women do need greater access to abortion, do not see RU 486/PG as ultimately increasing access to that service. In fact, some feminists have expressed concern that access to RU 486/PG may limit women's choices in abortion, the very thing that supporters are arguing for.

Greater Availability

One of the biggest advantages, according to supporters, is the early time frame for the procedure, which increases access for women by reducing the waiting period for an abortion. Instead of having to wait until the 6th to 8th week to have a vacuum aspiration, women will be able to obtain an RU 486/PG abortion as soon as pregnancy is confirmed and the decision is made. Because the procedure can be done early, there is a greater likelihood that the abortion will resemble a heavy period rather than an abortion. Connie Clement, one of the founding members of the Healthsharing Collective, argues that for some women it will become more of a pre-abortion.³⁸ Clement argues that this may ease concerns about abortion for women in various religious faiths who believe the soul enters the fetus at a predetermined date in gestation.

Supporters of RU 486/PG abortions are quick to point out the advantages of avoiding surgical intervention. The non-surgical element reduces the risk of physical

trauma for women in a number of ways. The fact that the procedure uses no anaesthesia, either local or general, eliminates any anaesthesia-related complications. As no physical instruments enter the body, there is no risk of perforation, damage to the cervix, or infection. The result is that the procedure is considered less invasive. The Winnipeg Women's Health Clinic concluded that "women would be spared the risks of the surgical intervention as well as the long waits involved."³⁹

Pro-RU 486/PG feminists argue that this non-surgical element presents an even greater advantage by increasing the availability of abortion services, both in location and provision. As a result of its pharmaceutical nature, supporters of RU 486/PG contend that medical personnel will require less medical knowledge to provide this service, and that because surgical equipment will not be necessary, it will be possible to utilize the procedure in more facilities. Supporters also believe that the non-surgical element means more doctors will be willing to provide the service.

Madeline Boscoe, of Winnipeg's Women's Health Clinic, thinks there will be more doctors willing to distribute this drug than are willing to perform surgical abortions, and she is not alone in her opinion.⁴⁰ Physicians' knowledge base will still have to be high, but their technical skills will not have to be as high. In addition, there is, as Clement points out, a psychological difference between prescribing a pill that interrupts implantation and inducing a miscarriage.⁴¹ Boscoe argues that the psychological issue is clearly obvious now in that, "It's a lot easier to get a doctor to do a D&C for an incomplete miscarriage than to do an abortion."⁴² Amanda LeRougetel also thinks more doctors will be willing to provide chemical abortions, "because it's a less evident way of

performing abortion. Doctors wouldn't have to necessarily name themselves as publicly as doctors currently do. They wouldn't have to work in the hospital pregnancy termination unit, or walk into the clinic."⁴³

Clement cautions, however, that an increase in provision will be dependent on the attitudes of physicians' colleges and societies. If there is strong support and national training from those organizations, and if they made an indication that they would legally and/or financially assist doctors beyond a physician's mandatory insurance, she thinks access will increase. She does not think that at this time the societies are prepared to make such overtures. She does feel that "there are doctors who will be comfortable prescribing RU 486 who are not now trained in surgical abortion."⁴⁴

An increase in the number of providers could result in an increased number of locations offering chemical abortion services. Supporters point out that "the service could be provided in an office setting and follow-up done on an outpatient basis."⁴⁵ OCAC sees access being improved by distributing RU 486/PG from women's health clinics and birth control centres.

Women's reproductive health centres could certainly be an optimum means of providing RU 486 in a way that enhances women's control. More generally they could be an excellent location for the extensive counselling and support services necessary to implement reproductive technology according to women's needs and priorities.⁴⁶

Until such a time as women's reproductive health centres exist, OCAC argues that RU 486/PG could be dispensed from doctors' offices, "where women at their prerogative can accept the limited services from physicians".⁴⁷ However, the manufacturers require dispensing locations to have a great deal of back-up medical equipment on site, which

could negate the possibility of physicians providing the service from their offices

Reduced Cost

Many supporters of RU 486/PG highlight the financial savings this procedure will bring, arguing that its reduced cost will help facilitate greater access to abortion. However, estimates of the costs of the drugs and of the procedure, including testing, vary greatly. In 1993, Dr. Art Hister of Alberta reported that "an RU 486 abortion should cost \$75 to \$100 versus \$150 to \$250 for a surgical abortion."⁴⁸ However, he does not indicate if his estimate applies beyond the borders of Alberta. A 1994 newspaper article concluded that the cost of the pills would be \$10.⁴⁹ At this point the Ontario Medical Association (OMA), which establishes the appropriate fees for billing in Ontario, has not evaluated the cost of the chemical abortion procedure.⁵⁰ Furthermore, the OMA is unaware of any government agency that has completed such an evaluation.

It will be impossible to begin to calculate the cost of the chemical procedure until one of the provincial Ministries of Health determines whether they would follow the procedure as currently done in France. If yes, it could be fairly costly given the need for two ultrasounds. On the other hand, the outpatient nature of the procedure could free up both expensive time and space in hospitals. In addition, if one medical staff person can provide the pills and oversee the entire procedure this could significantly reduce the personnel costs.

This has, however, not proven to be the case in England. In accordance with their policy, "Throughout the time a patient is on the premises, a doctor must be present (not a requirement for surgical abortions) and a fully-trained nurse must be in the same room

as the patients "⁵¹ England's policy also requires that beds be available for women using RU 486/PG, in addition to the sitting room, and that one overnight bed must be reserved for every ten women using the procedure. This means an additional nurse is required, and beds remain unavailable for other uses. In 1993 the NHS reported that a chemical abortion was £187.00, whereas an early conventional abortion was £250.00.⁵² "Roussel...claims that most of the cost comes from the need to recoup the ten years of research."⁵³ It is not likely that the cost will come down through mass production, because there is, unlike other pharmaceuticals, a finite number of dosages any one woman could ever take. However, should the drug be targeted towards developing countries, the possibility remains of creating a lower price through a larger market. At this point it is impossible to substantiate the possibility of reduced cost within the Canadian context.

The FQPN does not think chemical abortions will be any less expensive a procedure, and fears it may prove more costly for women in the long run. Anne St.Cerny, of the FQPN, raises the possibility that the state may not provide funding for abortions given the pharmaceutical nature of the procedure. St.Cerny points out that women have a history of purchasing drugs, both for themselves and in their parental role, and that this history may prompt the state to refuse funding for the procedure because "we [already] have the practice of making people pay for [drugs]".⁵⁴ Québec has experienced numerous cuts to health care, as is the case throughout Canada, and is currently considering cutting funding for abortions. Her concern is that more and more women are being forced to go to private clinics, and that as the move toward unpaid abortions grows, it will only make sense to charge women for abortions. St.Cerny argues: "If it's a pill that women are

already used to buying, then it will be that much easier" ⁵⁵ If that situation develops, the question will then become one of increased access for whom. If the state does not provide funding for RU 486/PG abortions, there is a risk that only wealthy women will have access to the service. If the state does provide funding the issue of who has access will become more a question of who has access only to RU 486/PG

Diversity: Access for Whom?

Critics and promoters of RU 486/PG have agreed on the need to consider how the use and testing of this procedure will affect women who are not privileged by Canadian society. Many feminists agree that there is a greater likelihood that women who already find themselves marginalized by Canadian mainstream society will be easier targets for the use of RU 486/PG.

Joan Wright, the current administrator of the Ottawa Morgentaler Clinic said: "RU 486 is attractive just on the basis that it could be brought to women in rural or harder to access communities."⁵⁶ She points out that "many small and rural communities either have no doctor at all or one who doesn't perform abortions" ⁵⁷ LeRougetel agrees that, "[i]n theory it should increase access because you don't need for the procedure itself all the various kinds of machinery etc. you need for a surgical abortion. The back up stuff, of course, one always needs to have."⁵⁸ Clement argues that its use in rural areas will depend on whether or not it can be integrated into rural physicians' practices without political pressures. She argues that there is no reason to think that rural physicians will use it given the fact that they are not performing abortions now. She concurs with LeRougetel's comment on the theoretical possibility of its use: "The boon for northern

women is a theoretical boon; at a strategic practical level of implementation I don't know if we'll see it at all "⁵⁹ Amy Gottlieb, former editor of *Healthsharing*, raises the point that in rural areas any new found privacy will be negated by quick circulation in a small community "⁶⁰

Supporters of RU 486/PG do, however, have concerns about how RU 486/PG would be used in Northern and rural areas. Johnson does see it as a potential risk that RU 486 could go to Northern or rural communities and become the only available option. The issue for her is to ensure that does not happen by ensuring that where RU 486/PG is available, there is also the option of surgical abortion. The bottom line for Madeline Boscoe is that its availability will not solve the rural access issues, because it will require back up facilities, and similar support regarding the process. Indeed, the manufacturer of RU 486 clearly states that, "it should be given under strict medical supervision in specialized centres", which are "equipped with an electro-cardiogram, cardio-respirator, and coronary spasm medication."⁶¹ Few of the Northern and rural area clinics have access to this equipment and to the support services required to conduct this procedure safely, and in accordance with the manufacturer's policy.

Amy Gottlieb's concern around rural issues is that although it might increase options for First Nations and Inuit women, there is also the possibility that abortion would be promoted with greater ease to those women. Her concern is shared by those working against the use of RU 486/PG in Canada. Bastien, policy researcher for CSF, and St. Cerny agree that there is the possibility that the procedure will be more heavily promoted in rural and northern areas because of the existing shortage of services.⁶² In addition to

the already insufficient level of services, First Nations women and Inuit women may face additional language barriers. St.Cerny points out that the shortage of services, the possible language barriers, and the fact that almost all the information they receive comes from medical providers, means that they will likely have first access to RU 486/PG

Cause for additional concern arises from the fact that First Nations women are known to experience a higher incidence of diabetes than women of non-native heritage "As Bonnie Johnson points out: "Some of these drugs have different effects on sugar levels, so there may need to be some testing done in that area "64 However, neither she, nor Planned Parenthood, have called for any testing beyond Health Canada's present requirements, which do not include the need to address any specific Canadian population

Black women in the US have expressed similar concerns about the lack of testing for women known to experience particular health problems. Judy Norsigan, a member of the Black Women's Health Project, argues that women of colour are

far from convinced that RU 486 represents a significant benefit to them, in part because the clinical trials to date have involved primarily white women. In addition there is a mistrust of a system that has so often been abusive and insensitive to the needs of the concerns of women of colour.⁶⁵

Angela Davis argues that Black women have traditionally been suspicious of the abortion movement because of its racist past, a movement that at one time was busily advocating sterilization of Black women and women of colour "66 The health concerns that Black women face are in many ways different from other women of colour Black women are known to have 50% higher rates of high blood pressure, infant mortality, diabetes, teenage pregnancy, cancer and lupus than other parts of the population "67 Yet within the

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published studies on RU 486/PG there has been no discussion of how Black women will be affected by this form of chemical abortion, with the exception of one caveat that such candidates may be ruled out by the guidelines from Roussel-Uclaf. However, concerns about access have prompted the National Black Women's Health Project to pass a resolution supporting the procedure.⁶⁸

Amy Gottlieb points out that for women with disabilities she "could see that there would be an increased possibility that they would be offered this drug more than other women. It will be seen as an 'easier' option."⁶⁹ Traditionally, medical institutions have assumed women with disabilities to be asexual, thus there has been little or no discussion as to how RU 486/PG will impact women with disabilities. It is likely that some physical disabilities will put users of RU 486/PG at increased risk, but I have not found this discussed in available literature.⁷⁰ At this time, women with disabilities are still battling forced sterilization and fighting for the recognition of their right to motherhood. "Occasionally, reproductive rights groups and other women's groups make a mention of disabled women. When we are included, it is usually at the end of a long list. But our particular needs and concerns are rarely addressed."⁷¹ It would appear that RU 486/PG is no exception.

Gottlieb also had concerns that RU 486/PG will be promoted to poor women, especially those who receive family benefits. Her concern reflects the role of the state in the fertility of women on social assistance. If the procedure does prove to be less costly, she worries that state agencies may take the attitude that if "we're paying for them anyway we should spend less on providing abortion services for them."⁷² Many poor

women may find the procedure unavailable to them because of the costs and the time that the process requires. The multi-step system, the costs of possible child care, travel costs, unpaid or limited time off work may prompt women to choose a conventional abortion, which is usually only a fifteen minute procedure, with a one hour post-procedure waiting period.

Clement agrees that women will be targeted differently, based on race, class, and ability. She argues that providers will promote the procedure using culturally based ideas. She used the example of some Asian people and their beliefs around Yin and Yang, as warm and cold. "If you could convince them that the metal one [IUD] warmed up quickly then you would be more likely to sell it."⁷³ She cautions that "[w]e are going to find people who want to know how do you convince the Native population or how do you convince Immigrants that this method will be suitable for them?"⁷⁴ Boscoe's main concern was how the issue would be framed for women from non-privileged positions. She says, "there are assumptions made for you that this is a pregnancy that you don't want, and I find often that those women are encouraged to abort."⁷⁵ Acknowledging these risks, LeRougetel commented that "[w]hen we get to the point where trials are possible in this country, that's the place to ensure that kind of targeting doesn't happen."⁷⁶ Bonnie Johnson agreed that it would be in the studies of distribution where these issues could be resolved.

Health Risks and Testing Issues

Pro-RU 486/PG groups and individuals often highlight the safety of the procedure as one of its biggest advantages. Planned Parenthood's Bonnie Johnson says: "I have

heard people say that this drug is so safe that every woman in the world should have it in her purse "⁷⁷ Many of those supporting RU⁴ 486/PG acknowledge that the possibility of health risks remains, many of which are outlined in the previous chapter, but both supporters and opponents have expressed concerns about the validity of tests that have been done to date and the lack of diversity in their test samples

Le Rougetel expresses confidence in the tests that have been performed OCAC demonstrates a similar faith in the testing in their demand to the RCNRT that the "approval process be expedited", arguing that the RCNRT could "certainly take account of well-designed research from other jurisdictions "⁷⁸ Others have argued similarly that, "the drug needs testing in Canada, but hardly the full test required for a new drug It needs the abbreviated testing routine routinely given for drugs to be introduced into Canada that have proved safe elsewhere."⁷⁹

Amy Gottlieb's concern about testing focuses on the lack of diversity of trial participants She argues that the tests that have been done are not representative of the diversity of Canadian women "There is no generic woman, and we need to be clear about the different kinds of risks that women bring to taking a drug, and what those [risks] are It needs to be made very clear in the testing who can take the drug and who can't "⁸⁰ She is also concerned that the most oppressed women will be the ones to test the procedure. For Johnson the main testing issue is not safety but distribution "I haven't heard Canadian women say this is not a safe drug "⁸¹ In fact, for her the issue is "How are we going to distribute this so that the women that are getting it are informed about it, because it is a procedure that you need a doctor's order for How are we going to

control informed distribution is the testing that we need "82 Johnson concludes that, "It's not without some risks. I don't think we take these things off the market because some people feel they are too big a risk "83

Developing Countries

One of the main goals of population groups and councils is to uncover new and better options for reducing the population of developing countries. It comes as no surprise then to find that many of those groups, prompted partly by the expected lower costs, are currently investigating the use of RU 486/PG in those areas.⁸⁴ Some Canadian supporters have also argued that RU 486/PG will improve access to abortions for women in developing countries, and see this as an additional advantage. The literature produced by CBCT, and distributed by CARAL, highlights their belief that "RU 486 has tremendous potential for use in developing countries where hundreds of thousands of women each year are injured or die from unsafe abortions "85 This advantage has received criticism from both International and Canadian women's health groups.

Amanda LeGrand, of the Women's Health Action Foundation, argues that in its present format RU 486/PG would not be appropriate for use in developing countries.⁸⁶ She bases her conclusion on a number of factors including the shortage of health care facilities, and the high levels of anemia. She argues that the "safety and efficacy of the abortion pill could be adversely affected by the way women perceive its effectiveness, women's beliefs about conception and pregnancy, and their health status."⁸⁷ The TWHN, supporters of RU 486/PG, argue the opposite that the lack of back-up facilities in developing countries should not prevent the availability of RU 486/PG. Certainly both

supporters and critics of RU 486 have raised the issue that it would be unsafe if the back-up facilities did not exist for failed chemical abortions. The TWHN newsletter reports that "many of us disagreed: we believe that the morbidity and mortality rates would be reduced."⁸⁸

WHI concurs with LeGrand and expressed additional concerns for developing countries about how the distribution of RU 486 could be controlled within such a large market. WHI's concern stems from the fact that in developing countries drugs "which are meant to be administered officially only by prescription, are often available over-the-counter."⁸⁹ In some countries, notably Brazil, prostaglandins are available over the counter. WHI cautions that, "once on the black market, women could have access to it but not necessarily to appropriate information on how to use it. With poor information, and limited access to health care providers or treatment, the implications of such unregulated use are enormous."⁹⁰

Currently Roussel-Uclaf has in place extremely strict procedures to ensure that none of their product could make its way to an underground market. Chalker and Downer write:

As for contraband supplies from Roussel stock - forget it! The company literally counts every pill. Each packet of pills leaves the factory with three stickers: one for the hospital or clinic pharmacy records, one for the woman's medical records, and one to kept by the factory -and all must be accounted for at all times.⁹¹

They illustrate the tough security measures with the example of a doctor accessing the drug for a breast cancer patient who was obligated to return the unused pills. However, there remains the issue of how Leona Benten succeeded in bringing the pills home from

England to challenge the import ban in the U S ⁹² Here in Canada there are rumours of the drug's use by a physician in Toronto ⁹⁴ Considering these instances, perhaps there is the possibility that an underground market could develop

(2) PRIVACY

There are a number of issues which are captured under the issue of "privacy". Both geographical privacy, and privacy in the individual woman's experience are considered advantageous by RU 486/PG supporters. Some supporters are critical of how the issue of privacy has been framed as an advantage, arguing that the issue of privacy has been created in an attempt to win support. The Québec groups can see only negative implications for women when they are returned to the private sphere to abort.

Increased Privacy in Location

Based on the access arguments that more physicians will distribute RU 486/PG, it has been assumed by supporters that there will in turn be a greater number of locations that will provide the service. LeRougetel considers this new flexibility in location to be one of the greatest benefits of RU 486/PG, since it will "enable women to access the procedure not necessarily in a free-standing abortion clinic."⁹⁴ To LeRougetel, "that is the most public demonstration of the benefits of the privacy around RU 486"⁹⁵

LeRougetel and other supporters hope that the procedure will become integrated with other women's health facilities. However, whether the procedure would be available outside already designated abortion facilities remains to be seen. Bonnie Johnson is quite clear about her hopes that the procedure will be made available in the offices of Canadian physicians. "We want to get it out of the public realm and into being a decision between

a woman and her doctor, where it should be ⁹⁶ Her hope is that women will be able to reduce the trauma of an abortion by reducing the possibility of public knowledge of her decision. However, one of the criticisms raised about the procedure would be the lack of privacy brought on by the number of trips to the medical provider

Reduced Violence

LeRougetel, Boscoe and Johnson all believe that, by getting abortions out of strictly designated clinics and hospitals, there will be a significant decrease in the violence targeted at physicians, clinics and hospitals. Supporters also hope that this will benefit the women who use these services since it will reduce the possibility of confrontations with anti-choice demonstrators where abortions are provided. In reality, it is unlikely that anti-choice supporters could picket all the hospitals, clinics and physicians' offices where RU 486 could be distributed.

A representative of the FQPN questioned the influence of the increasing violence on the position of RU 486 supporters. She notes that the largest increases in violence have been in recent years, whereas many groups have supported RU 486 since the early 1990's. Connie Clement reflects that

To a large extent feminists jumped on the bandwagon before we would have admitted that the potential for extreme violence was as great in Canada as it has currently been shown to be. I think that potential threat of violence [increases] that sense of the need for getting abortion out there however we can do it, this provides a new edge for the fight ⁹⁷

Increased Privacy in the Experience

Madeline Boscoe points out that there may be some additional privacy through the procedure in that women will not be lying on a table with their feet in the stirrups. Some

supporters argue that it will be a more positive experience for many women to not have a large number of people involved in the abortion. "For some women that will be a big advantage because abortion is a big deal and not something that they necessarily want to come into a lot of contact with a lot of people around."⁹⁸ LeRougetel does acknowledge that there is a down side to the issue of privacy

that is that some women who intellectually believe that they are physically and emotionally capable of going through this procedure on their own will find the privacy associated with the RU 486 procedure may be more daunting in practice than they thought it would be when it was more theoretical. We would be foolish not to acknowledge that there is a potential down side to privacy.⁹⁹

Amy Gottlieb concluded that "the issue of privacy seems to have been created."¹⁰⁰ For her the issue would not be about privacy but about care and support, the ability to process what was going on, and the availability of counselling. On this issue, Gottlieb seems to be more in agreement with the Québec groups.

I would be concerned if I was going off to my room to abort on my own I wouldn't want to. It seems to be feeding into some notion that women want to be doing this on their own, and I don't understand where that comes from. Privacy is not the issue at all, that seems to be a created issue. I don't think that the way to deal with our feelings of either embarrassment or shame or just a sense of trauma about something is to necessarily offer women some way to do it where they're completely isolated and in private. I don't think that's the alternative.¹⁰¹

Part of the lure of "the abortion pill" has been the possibility that women might be able to abort in their home. Boscoe raises the issue that for some women aborting outside the medical institutions may be a better experience for those women who have had bad experiences with the health care system in the past. "A drug that you can use in the privacy of your own home has an attraction and probably therefore they would be more

prepared to tolerate some of the discomfort issues, because what they see as an alternative has other kinds of meanings for them "¹⁰² Although, at this time, the manufacturers will not release the product to anyone acting outside the required guidelines, for some women this is the ultimate goal for RU 486/PG Rebecca Chalker and Carol Downer, authors of *A Woman's Book of Choices*, write "Another project under research is the production of a time-release prostaglandin that will enable women to abort at home if they wish, much as they do now with normal miscarriages "¹⁰³

In June 1993, Dr. Elizabeth Aubeny, who dispenses RU 486/PG in France, came to a Québec conference organized by the Coalition Québécoise pour le Droit à l'avortement Libre et Gratuit, to speak on the merits of RU 486/PG She confirmed during her talk that roughly 40% of women in her practice do not expel the fetus in the clinic, meaning 40% of women may be presently having their abortion at home, or at work "¹⁰⁴ Dr. Aubeny clearly indicated that women do not like having the expulsion take place at home "Les femmes n'aiment pas avorter chez elles Il y a du travail à faire en ce sens, parce qu'on ne peut les garder en centre hospitalier longtemps Fantasmatiquement, l'expérience de l'expulsion est dure à vivre Mais il nous faut les éduquer" "¹⁰⁵

The Québec groups are not questioning that women need to have alternatives in how they conduct pregnancy termination, but they are questioning how women could possibly benefit from the private nature of this particular procedure Ginette Bastien makes the point that to push women back into their homes to abort means that at the same time they are enduring the expulsion, they may also have to deal with parents or partners who do not support their choice to terminate the pregnancy The support that they may

need may not be available to them at home

In direct contradiction to Bonnie Johnson's goal, Bastien emphasizes that women cannot now abandon all their gains to be seen and heard in the public realm, to suddenly return to the private to avoid confrontations with the anti-choice. To Bastien, there is no going back, she argues that "we cannot negotiate a return to the private".¹⁰⁶ Bastien encourages women to reconsider the issue. "You can't say women want to have abortions in private without [asking] why. If you don't do that you miss the point."¹⁰⁷ For the CSF, similar to the FQPN, they view this interpretation of privacy as isolation. A recent publication of le RCSF found that women's largest problem was isolation: social, emotional and economic.¹⁰⁸ For the Québec groups, to purposely ensure women are isolated during abortions clearly perpetuates women's oppression.

The Québec groups are also concerned about how isolation will be compounded by the use of prostaglandins. They are extremely critical of a procedure that mimics the experience of labour, and questioned why any woman in the process of terminating a pregnancy would want to endure the process of labour, and endure it alone. A Québec woman who had an RU 486/PG abortion in France said, "J'ai demandé un avortement mais ce que j'ai vécu pendant trois jours, c'est un processus d'accouchement. L'attente, les contractions, l'expulsion. Et ça, ce fut émotivement douloureux à vivre. Avoir été en quelque sorte en travail le jour 1, le jour 2, et le jour 3."¹⁰⁹ Québec groups argue that this procedure is not healthy for women, and to isolate them in the course of it is unconscionable.

CONCLUSION

Many Canadian feminists are split on the issue of RU 486/PG and the use of the chemical procedure in Canada. There is clearly a great deal of support for making the chemical abortion procedure available in Canada, fuelled by concerns about improving access and making the experience more tolerable for women and providers. There is, however, a great deal of concern from both critical supporters and the Quebec groups who have established a position against the use of RU 486/PG in Canada.

There is a possibility that RU 486/PG will increase access to abortion due to the nature of the procedure and the possibility for lower costs, but this remains uncertain. In addition, access may ultimately mean greater problems for marginalized women who may, in the face of increased health risks, have access only to RU 486/PG. The increased privacy, highlighted as an advantage by supporters, has met criticism from feminists who see another side to the issue of privacy. The Québec groups see the acceptance of this form of privacy as detrimental to women emotionally and politically, finding no advantages in the further isolation of women.

Clearly, there is disagreement among and between RU 486/PG supporters and opponents. As I will discuss in the next chapter, there has to date been minimal discussion among Canadian feminists on the issue of RU 486/PG. This silence, and this disagreement over RU 486/PG may be the result of changing concepts of "choice" and "control." The varying interpretations of choice and control may ultimately explain the underlying differences between the two positions. Those concepts, which have been central to women's right to abortion, and in the evolution of feminist health care, have perhaps evolved into new concepts, which in some ways restricts the discussions feminists are

having about RU 486/PG

CHAPTER FOUR

RU 486/PG: MORE THAN A QUESTION OF CHOICE

INTRODUCTION

The positions that Canadian feminists have established concerning RU 486/PG reflect the historical evolution of the mainstream abortion rights groups and Quebec's women's health groups. These diverse positions reflect their varying opinions on what the role of the medical profession should be in the provision of abortion services. Chapter One examined the way in which abortion has become defined as a political issue by mainstream abortion groups, while remaining a more clearly defined women's health issue in Québec. The result is that RU 486/PG supporters argue that the procedure is another acceptable medical choice for women, which will ultimately provide women with greater control over abortion. Québec's anti-RU 486/PG groups argue the opposite: that RU 486/PG is an unacceptable medical option that is not an improved choice for women, that it in fact will reduce the control that women will have over abortion. Opponents in Québec base their concern on what the future will bring for women's reproductive health if increasingly medical abortions are accepted by women. This chapter examines how these diverse approaches to choice and control underlie the two positions on RU 486/PG. I will argue that the current uncertainty about how feminists define "choice" is what may in fact be inhibiting feminist dialogue and debate about RU 486/PG.

PRO-RU 486/PG: INCREASING CHOICES FOR WOMEN

From the outset, supporters of RU 486/PG, ranging from professional groups, physicians and scientists, as well as feminists, have argued that this procedure represents

an additional choice for women, an acceptable alternative to conventional abortion methods. Many organizations' policies reflect their concern about women's needs for more reproductive choices.¹ The Women's Health Clinic offered its facilities and clients as a location for research "in its support for more choices for women."² The Society of Obstetricians and Gynaecologists (SOGC) and the Federation of Medical Women of Canada (FMWC) base their recommendation of RU 486/PG on their continuing support of "a woman's right to choose safe abortion services".³ Dr. Baulieu, the creator of RU 486/PG, argues that "this is a significant advancement in women's health and that women have the right to this choice."⁴ Norma Scarborough, of the Canadian Abortion Rights Action League (CARAL), maintains that RU 486/PG is really "about the right of women to make informed choices regarding their own health care", further arguing that "[c]hoice covers all areas of our lives."⁵ From the beginning, RU 486/PG has been framed as a question of choice, based largely on the choice strategy of the pro-choice movement. If abortion itself is a woman's choice, then supporters argue that the method of abortion is equally a matter of women's individual choice. For supporters, additional choice means women will have two avenues for increased control. Women will have greater control over not only the procedure itself, but also of the choice of procedure, thus ensuring women have a more active and involved role in the abortion process. Supporters hope that this more active role will help secure a greater social, medical, and personal acceptance of abortion.

Connie Clement finds one of the problems with the conventional abortion procedures is the lack of participation by the woman herself in the transition from

pregnant to unpregnant.⁶ She thinks that this passive role makes it increasingly difficult for some women to accept their decision. Bonnie Johnson, of Planned Parenthood, concurs with Clement that the conventional procedure provides women with very little sense of control over the process.⁷ Johnson states, for example, that "Lying flat on your back with your feet in the stirrups with a gas mask over your face and some physician doing something that you are unaware of is not being in control of the procedure."⁸ For Johnson, "[s]itting in a doctor's office with some pills in your hand that you put in your mouth is much more control."⁹ Clement agrees that RU 486/PG will give women a more active role in the abortion itself, possibly easing the ambivalence some women experience. Indeed, one French woman who experienced an RU 486/PG abortion in France found that the chemical abortion was a much better experience for her than a previous conventional procedure. "This time, I felt like I was in control, and taking the pills felt so much safer than having anaesthesia and having some doctor poke at you with instruments."¹⁰ It is difficult, however, to compare the experience of conventional abortion in France with abortions performed in Canada. In France conventional abortions are done with general anesthetic, so when French women "talk about the benefits of being conscious" as part of the advantages to the procedure, it does not necessarily represent an advantage for Canadian women.¹¹ Both the Montreal Women's Health Centre and the Ottawa Morgentaler Clinic use only local anesthetic, and Vancouver's Everywoman's Health Centre uses only mild tranquilizers and relaxation techniques.¹²

Beyond arguing that women have greater control over the physical abortion experience, supporters also contend that RU 486/PG will provide women with more

control over abortion by ensuring a larger decision making role for women. Beyond the initial decision to terminate a pregnancy, women will have increased options as to how they wish to pursue their decision. This move to arguing for increased medical options, is, I would argue, a reflection of supporters' acceptance of medical involvement in the provision of abortion. With a clear role for the medical profession already accepted, the only control that can be acquired is in negotiations with the medical profession. This concept of control, which presupposes medical involvement, is shared by all the organizations supporting RU 486/PG.

CARAL's acceptance of medicalized abortion is evident in their recommendations to the Royal Commission on New Reproductive Technologies (RCNRT). Arguing against judicial intervention in pregnancy, CARAL's brief raised the following question: "what will become of the doctor-patient relationship and what will become of women and their babies when women take themselves out of the medical system and away from its doctors?"¹³ One of the clearest indications of their views appears in a letter to the editor of *The Globe and Mail* by Norma Scarborough. In her response to an article on RU 486 she wrote that:

Abortion is a women's health care issue and a medical procedure. Of course, the medical profession will be involved. But rather than the medical profession being able to broaden the informed choices for women, in this case it is the pharmaceutical company's refusal to release the drug for testing that is limiting a woman's choice to make her own decision about her health care.¹⁴

Kit Holmwood, former President of CARAL, expressed their acceptance of medical choice in an article entitled "The Broader Ramifications of Choice," in which she said: "Women must have control over their own bodies. We in the pro-choice movement, understand this

is a, if not the major building block in the struggle for basic human rights " ¹⁶ She argues that this control will be achieved with "equal access to medical procedures " ¹⁶ Bonnie Johnson also outlined a clear role for the medical profession. Rejecting the views of women's groups who are "anti-medical everything", Johnson argues that women will have to seek out the "good doctors" and learn to make demands of the medical profession. ¹⁷ While some supporters acknowledge that RU 486/PG will not "entirely free women seeking abortions from the medical profession", they argue it will instead ensure women have greater control in their negotiations with the medical profession ¹⁸

The Ontario Coalition of Abortion Clinics (OCAC), whose acceptance of the medical profession was outlined in the first chapter, defines control as

the empowerment of women...[health] care provided in such a way that enhances women's control over their lives -- that contributes to their autonomy. ***This is health care that puts control of all key decisions regarding a woman's health and reproduction in her own hands*** and provides all the services, counselling, information and support to enable her to put her decision into practice. ¹⁹

OCAC's policy represents one of the fundamental differences that exist within the discussion of "control". OCAC implies that control for women can be found in their ability to control their own decisions, leaving unchallenged the issue of who provides the service, or how it may be promoted.

For supporters, RU 486/PG will provide women with more choices from the medical profession, and with more control over the experience. This position, I would argue, is the result of mainstream feminism's traditional acceptance of the medical profession in women's struggle to acquire and maintain safe and effective abortion services, part of the evolution of medically defined choice. However, supporters may in

fact be purposely trying to shift the concept of choice away from discussions of women's right to choose abortion. Their goal may in fact be to frame discussions of RU 486/PG as an "additional choice" to divert attention from the ongoing debates about women's right to choose. If the issue now becomes women's right to choose an abortion technique, it presupposes that women have the right to choose abortion and deflects away from the traditional pro-choice/anti-choice positions. Additionally, **increasing** medical involvement in abortion, in part through on-going medical discussions, does frame abortion as more of an accepted medical procedure. This, supporters may believe, might ultimately increase women's access to abortion, and cement women's initial right to choose abortion.

The Québec groups rejecting RU 486/PG view control as more than the ability to make decisions, and see choice, in the context of abortion, as becoming increasingly defined by the medical profession. It is their different view on the involvement of the medical profession that perhaps most clearly explains the difference between the two positions.

ANTI-RU 486/PG: REDUCED CONTROL/CHOICE

Opponents of RU 486/PG question how women can truly regain control over their reproductive lives within the present social context, in which they currently have so little control. The position of the Québec groups on control has been strongly influenced by their own history of organizing for demedicalized women's health services. For the Centre de Santé des Femmes (CSF) the questions should be: "where are we going with all this? Is it greater control to have a greater chance of isolation? Is it a greater advantage to have fertility problems? How can there be control when we have become the experimental labs

of science?"²⁰ The Québec groups see RU 486/PG as another step towards the medical/pharmaceutical control of women's fertility, not women's control

In addition to their concerns about the lack of long term studies and the possibilities of health risks for women, their primary concerns centre around the continuation of increasingly medicalized abortions. For the Québec groups, RU 486/PG is not the only issue; a central issue for them is the revived usage of prostaglandins. Bastien argues that RU 486 is only a pretext to allow further research on prostaglandins. She says that abortions are going on now with new prostaglandins, in lower dosages than were used in earlier years, but that they are going on without RU 486.²¹ At a Montreal conference in 1993, Bastien asked Dr. Aubeny where science was ultimately going with the RU 486/PG procedure. Her response, according to Bastien, indicated that their ultimate goal was a prostaglandin-based contraceptive. Bastien cautions that women must remember that prostaglandins do not inhibit ovulation, so any prostaglandin-based contraceptive will promote uterine contractions and expulsion monthly. While the Québec groups are concerned about the health implications of using prostaglandins, the issue of RU 486/PG represents a bigger issue: the unnecessary involvement with the medical profession and the pharmaceutical industry. For these groups, whose history indicates a preference for woman controlled services and abortions provided by lay women or paramedics, RU 486/PG does not offer any increased control for women. They argue there is nothing here that shifts control back to women; in fact, they argue that this will only further shift control away from women.

Originally, framing abortion as a medical issue was arguably the only route

available to feminists for gaining some form of legal access to abortion. Court rulings and recent legislation have further entrenched abortion as a medical issue.²² Feminists in Canada are far from agreeing on the issue of medical involvement in abortions, and these divisions, in large measure, reflect the positions for and against RU 486/PG. The largest Canadian abortion rights groups supporting RU 486/PG have advocated a clear role for physicians in the provision of abortions; in contrast, the Québec groups who oppose RU 486/PG emphasize the need to continue moving away from medical involvement and medical dependency. Anne St. Cerny of the Fédération du Québec Pour Le Planning Des Naissances (FQPN) argues that "[i]t doesn't give women any more power than before. You have the same process with the medical profession, not only one time, not only two times. RU will mean more medical control of abortion."²³

The position of the Québec groups is in part a reflection of their unique history of linking the issues of abortion and health as one issue. Some of the first women's health groups in Canada began in Québec and these groups have a legacy of working for demedicalized women's health care. That legacy is apparent in the philosophy of the CSF:

the Centre de sante has developed health care services to fulfil its objective of counteracting the increasing over-treatment of women by demedicalizing, deprofessionalizing and eliminating the sexism in health care services. That is, returning to women what is theirs by making knowledge available and by breaking the monopoly of the "experts".²⁴

The FQPN and the CFS are concerned about the larger context of medicalization, questioning what RU 486/PG will mean to the future of women's health in Québec. "De ce point de vue, accepter l'entrée du RU 486/prostaglandine constitue l'acceptation de l' 'hormonisation' du corps des femmes, d'un controle bio-médical encore plus grand du

corps des femmes et d'une dépendance aux médicaments et hormones "²⁵

RU 486/PG, if utilized as it is in either the UK or France, will mean that abortion will continue to be a medically defined procedure. An additional medical option for abortion will further entrench women's fertility control within the medical model, specifically the treatment model, and such an option will risk a reframing of the political issue of abortion into a particularly unfeminist position.²⁶

If abortion continues to be defined by and within the medical industry, the issue of abortion may become increasingly individualized and ultimately depoliticized. RU 486/PG will allow the medical profession to continue defining abortion as a medical problem, much like a "disease" with a specific cause. The primary medical model is the treatment model, which "emphasizes that normal, or healthy, functioning can be restored through mechanical procedures, and technological and pharmaceutical fixes"²⁷ This medical approach to health care encourages pharmaceutical manufacturers to "literally create new diseases", which in turn creates markets for new products.²⁸ To achieve their goals for expanding markets, drug companies work intimately with the medical profession, "encourag[ing] the medical profession to look first to drug therapy for medical problems."²⁹ The model does not encourage preventive health measures, nor does it work to eradicate the social inequities that are the basis for many health problems. It does not question the relation of women to the medical-industrial complex, either as patients or workers, and it offers little room for alternative approaches.³⁰ "The medical model tells women: 'The problem is with you, so you must do the changing.' This approach is myopic: it treats the female, but leaves dominant patriarchal conceptions of femininity

untouched" ³¹

Obviously the presence of a gestating fetus is the cause of pregnancy; however, to focus attention on treating the pregnancy alone will divert attention from the many other causes of unintended pregnancy. Other considerations such as the lack of safe and effective contraception, or of affordable housing and child care, factors that contribute to a woman's decision to abort, will remain invisible. To continue addressing unintended or impossible pregnancy within the medical model will not alter the structures that lead to either the situation or the decision to abort.³² These important issues will remain unexamined. Furthermore, if society and the medical industry continue to portray abortion as successive individual incidents, it will be less likely to focus on women's wellness and preventative health care. If the issue is considered individual in nature, the door is left open for woman-blaming for unintended or impossible pregnancy. At this stage in Canada, with limited services under attack from anti-woman protestors and deficit-obsessed governments, Canadian women cannot afford to let abortion be depoliticized.

Québec's RU 486/PG opponents argue that RU 486/PG will perpetuate the medicalization of women that has been occurring since the rise of the medical profession in the early Nineteenth Century.³³ Many feminist health critics have argued that expansion in medical services targeted at women, primarily through the growth in gynaecology and obstetrics during that time, continues today in new forms and under new guises.³⁴ Today reproduction and women's health have been almost completely appropriated by the medical-industrial complex. In fact, women continue to form part of the largest growing medical market. The Québec groups fear that RU 486/PG will merely

add another layer to this already intolerable level of medicalization.

Some proponents of RU 486/PG claim that it will in fact be a demedicalized procedure. Marge Berer writes:

Many women feel the abortion is more under their control, and they find this important. It is the woman who takes the drugs, and her body makes the abortion happen. No one else does the abortion for her. The role of medical staff is reduced to giving her drugs, monitoring her progress, and giving her support. This is the "*demedicalization*" women experience with this method.³⁵

As I have demonstrated in the two previous chapters, this form of abortion is far from demedicalized. The procedure itself involves numerous interactions with the medical profession, and requires the presence of medical personnel and equipment at all times. It will not alter the fact that the availability of abortion still requires the approval of a physician, maintaining abortion as a decision between a woman and her doctor. Thus this additional method does not empower women to control the most fundamental choice of abortion, the decision to abort itself, nor does it move women closer to controlling all facets of the procedure. Women will still be dependent on a physician to access the necessary pharmaceuticals and provide medical facilities. Thus women are still forced to rely on the medical profession for safe and legal abortions. For the Québec groups, who work from a different concept of control, RU 486/PG offers no real improvement.

Feminists who have raised questions about the long-term effects of RU 486/PG, and about the control by the medical profession and the pharmaceutical companies, have met some unfavourable responses. Marge Berer, an RU 486/PG supporter, claims that individuals who raise such concerns are overreacting, and are becoming "dangerously close to [having] a knee-jerk response to whatever new method of reproductive technology

is developed "³⁶

This response grew out of a period (not so long ago) when we did not know where to find out about clinical trials, had fewer tools for assessing their results, did not hear the views of women participants in trials because no one asked them, and certainly did not have access to researchers to make our opinions as a movement heard. That time is becoming part of the past. We can and do have better access to both information and the researchers who produce it. It is our role to take a critical view. But we do women a disservice if we forget that all of us accept certain disadvantages and less than 100 percent safety and efficacy in pursuit of what we need or want ³⁷

The problem with this approach stems from Berer's interpretation of "we". Women as a whole do not all have this access or the necessary time or skills to research and critique as Berer is suggesting. Berer's view subtly criticizes feminists who raise important questions as "anti-technology," and attempts to convince them that it is now possible for women, presumably as a unit, to interact with the relevant industries in a critical and equal fashion.

Berer's acceptance of "certain disadvantages and less than 100 percent safety and efficacy" denies the reality of women's diverse life experiences. Such a general statement dismisses concerns about who suffers greater disadvantages and who is more at risk in terms of efficacy and safety. White, middle class women, living in urban areas, are not facing the same disadvantages as a First Nations woman, who speaks Cree and lives in northern Canada. It is dangerous to accept propositions which disguise the systemic discrimination embedded in the medical industry with such sweeping affirmations. Furthermore, although some women have reached the position of accepted critic on new medical issues, this new found role does not appear to have made a serious impact on the relevant industries as technologies such as NORPLANT and Depo Provera are available

despite the objections of many concerned feminists.

Certainly women have reason to be wary of scientific findings, as well as of the development of new technologies. Janice Raymond cautions that "the enchantment with new reproductive technologies is, in part, a contest of memory versus forgetfulness - forgetfulness of past failures versus a memory of promise."³⁸ Technology is not neutral, nor will it be received that way. Kathryn Strother Ratcliff argues that, "for women technology has often reflected and reinforced the power asymmetries in health care and society."³⁹

Québec feminists and those who advocate similar concerns have met hostile criticism from other feminists. Bonnie Johnson says, "I just don't understand any of the women who are calling themselves feminists who are trying to play *big sister* and say women shouldn't have this option and their preferring a surgical abortion to this".⁴⁰ In response to the concerns expressed by the Québec groups, she says: "I have seen their critique of it and it just doesn't hold any water, in my opinion."⁴¹ Scarborough finds that the anti-RU 486 position, such as the one adopted by the Québec groups, "smacks of the kind of control of women's health care that feminists have fought against for more than 20 years."⁴² Statements such as this one by Scarborough add yet another level to the complex issue of control. Feminists who raise questions about RU 486/PG, or who fight against it, risk being faulted for attempting to control other women by limiting their "choices".

RU 486/PG: Not Simply a Question of Choice

When the strategy of choice was developed in the 1970's, it was a strategy for

women to gain the right to choose abortion.⁴³ It would have been too radical to appear pro-abortion, and it would have been easily misinterpreted as anti-child. Kathleen McDonnell has argued that an additional factor was the feminist ambivalence towards abortion that prevented women from demanding abortion. Framing abortion as a matter of individual women's choices left room for more women to lobby for abortion rights, regardless of their personal decisions. The choice strategy originally aimed for women's collective right to abortion and the right of women to individually determine the course of their own lives. However, the individual nature of the strategy may have established the ground work that has moved abortion organizing away from collective choice to individual choice.⁴⁴ "Choice" as a concept now looks very different from those early days of organizing

Feminists have increasingly fought for women to have increased options in their lives, working for increased alternatives that would help appease the oppression women face. Thus, as the "choice" issue has developed, there is an element whereby women have gained some increased control over their lives through their expanding choices. However, among the choices that women have both created and accepted, there are increasingly medicalized choices regarding women's reproductive health. RU 486/PG and the NRTs are a clear example of the new choices women are acquiring. Choice has shifted from women's right to choose, to how women can control their biology within an increasing number of largely medically defined options.

Janice Raymond refers to this new concept of "choice" as "reproductive liberalism", which, she explains

provides women with a supposed liberty that requires women to give up more freedom than we get; an individualistic inventory of reproductive rights in which almost anything can be claimed as a right, a gender-neutral theory and reality of rights and freedoms; a concept of choice that is reduced to the option to consume...⁴⁵

Choice as a concept has grown to become a "choice" of consumer options Raymond points out that "corporate America has collapsed choice and consumption to sell questionable products."⁴⁶ Our choices, however, are only what the medical-industrial complex chooses to offer. As their bodies become increasingly medicalized, women find that now their "choice" is cafeteria-style medical options, which are becoming increasingly technological and invasive.

Judy Rebick, former President of the National Action Committee on the Status of Women (NAC), was one of the first to begin questioning the language of "choice" as a strategy for achieving legal and accessible abortions ⁴⁷ She says, "by focusing on choice we have created the mistaken impression that feminism is about freedom of choice in all spheres."⁴⁸ But for Rebick, and many others, this is not the case.

By turning one argument for abortion rights into the very definition of the movement itself, I believe we have identified feminism with the civil libertarian notion of the supremacy of individual rights. The idea that individual choice is the most important social value is not particularly feminist. In fact, in a society of unequal power, an emphasis on individual choice alone usually gives those with power the only real choices ⁴⁹

Rebick argues that the framework needs to be changed from "choice" to one of control She argues that such an approach would clarify "feminist opposition to the new reproductive technologies and genetic technologies."⁵⁰ She is "now convinced that the framework of our position on reproductive rights must be the right to control our bodies and reproduction rather than freedom of individual choice" ⁵¹ Rebick does not expand

on her point to illustrate whether by "control" she means literal control over the provision of reproductive health services, or that women should have greater control within the existing systems. She does, however, clearly indicate the need to push any framework for reproductive rights beyond the current approach of individual rights, and I would argue, individual choice.

Elisabeth Beck-Gernsheim argues that individual choices, to the extent that they are individual, are also influenced by society's view.

In the beginning, new technologies come as options. Whether we take them or leave them is up to us. But gradually they become part and parcel of the socially accepted and expected pattern of behaviour. In many ways, subtle or not so subtle, choice turns into pressure.⁵²

Women have been offered new technological or medical options prior to RU 486/PG, that, although they started out as "new", have come to be a "normal" part of women's lives. Initially amniocentesis or ultrasound were considered as options for women. Currently few obstetricians advise against ultrasound, or discuss how prenatal care could proceed without ultrasound. Women are now expected to submit to as many as four ultrasound procedures during "healthy" pregnancies. While the benefits of that procedure remain uncertain, that new technology has slowly become part of the expected routine of pregnancy, redefining what is accepted as appropriate prenatal health care.⁵³

Choice itself is not a neutral concept, as women are still only able to choose from the options that are offered by a capitalist market founded in patriarchy. Furthermore, nothing is really an individual choice. The choices women make are structured by a plethora of factors: existing information, services, personal means, who decides what to research, a history of medicalized reproduction, and a history of interacting with health

services. It is not really about a simple individual choice.⁵⁴ Choices are structured by a multinational pharmaceutical industry that is constantly seeking new opportunities to maximize profits and increase consumption. Current medical choices have not generally been developed so that individuals can control their own fertility, increasingly they are developed so that the medical industry can regulate human existence.

By presenting the issue as one of individual choice, discussions of the collective good are diminished. The FQPN has based their position on "raisons qui sont de l'ordre des choix collectifs."⁵⁵ Thus, for the FQPN and CFS, RU 486/PG has been addressed from the standpoint of what is good for women collectively, questioning what, if this choice is accepted, women's future choices will be. The Québec groups encourage any RU 486/PG analysis to address the larger context of medical and pharmaceutical control, because, they argue, there is more to the issue than just increasing choices. Women, and men, are not in equal positions to determine what options they will choose from those industries, and RU 486/PG opponents contend it would be dangerous to think that women could accept just this one medical intrusion, and reject so many others. History has shown that even when women have lobbied against the same industries some are now working with, women have come out on the bottom.⁵⁶ It is important to address briefly where these industries are going next to contextualize what a medically-based concept of choice will mean.

At this time pharmaceutical corporations are developing contraceptives that are increasingly chemically or hormonally based. These include a reversible male contraceptive that will be injected into the scrotum to inhibit male fertility,⁵⁷ and

antifertility vaccines which induce temporary infertility "by turning the immune system against body components which are essential for human reproduction."⁵⁸ In their literature, the CFS and the FQPN mention tamoxifen as one of their biggest fears about what future choices the medical industry holds for women. Tamoxifen is an anti-estrogen drug that is being clinically tested, by healthy women, for breast cancer prevention.⁵⁹ The tamoxifen trials were supported in 1992 by the National Cancer Institute (NCI), which in the same year had cancelled a project to investigate the causal relationship between high fat diets and the likelihood of breast cancer.⁶⁰ Susan Rennie of Norwich University argues that there are more reliable data indicating a relationship between a high fat diet and breast cancer, than there are to assume that chemical prevention will be possible. She argues:

The clinicians who dominate NCI were simply not going to give ground to research that emphasized such public health strategies as dietary changes at the expense of their research priorities. If the NCI were to back prevention studies, this group believed the research should emphasize disease control through medical intervention and technology - keeping the funding pipelines flowing along their customary routes."⁶¹

Rennie's point, which the CFS and the FQPN are reiterating, is that the medical industry is not guided by feminist principles in their research and development. They are, instead, motivated by self-promotion and the maintenance of their own industry. The pharmaceutical industry is not guided solely by concern for healthy people. Their focus is clearly mediated by profit. In her discussion of tamoxifen, Rennie prompts readers to "imagine the potential for profit in having half the healthy population on yet another prescription drug for ten to fifteen years".⁶² Using this example, the CFS and the FQPN question what future choices women will have, expressing concern that women's choices

will be increasingly medicalized.

The Québec groups argue that women should, at every turn, resist the medicalization of their **healthy** bodies. They argue that abortion is not an illness, and that healthy women should not be subjected to risky procedures such as RU 486/PG when other less medical approaches are available.⁶³ Their fear is that RU 486/PG, under the guise of choice and control, will open the door to further unnecessary medical intervention.

The preceding discussion of tamoxifen illustrates that the issue of RU 486/PG does not exist in a vacuum. On the contrary, it represents the acceptance of the continued medicalization of women's bodies. Some feminist authors argue that women can not go back now, that they should learn to participate with the medical industry by working with it to determine the best treatment possible.⁶⁴ Bette Vanderwater argues that resistance is the best form of action for feminists. She argues that such a position will

enable a view of complex societal influences on individual choice in reproduction. It allows a realistic appraisal of the strength of the current medical model in affecting women's choice. It more adequately confronts concerns about health by refusing to view technologies as benign. And above all, it removes us from the roller coaster of technology by saying that collectively we can resist and collectively we can regain reproductive control.⁶⁵

According to Raymond, opposition to these new reproductive technologies must be premised on women as a class working to reclaim the female body.⁶⁶ This class, she says, is not based on female nature, but on the goal of "refusing to yield control of [our bodies] to men, to the fetus, to the state, and most recently to those liberals who advocate that women control our own bodies by giving up control".⁶⁷ Feminists who oppose these

new technologies, such as RU 486/PG, are now being branded "anti-choice", while still others do not offer any opinion for fear of being considered "anti-choice" on the issue of abortion itself. This dilemma is part of the reason there is such overwhelming silence among Canadian feminists on the topic of RU 486/PG.

RU 486/PG: THE UNSPOKEN ISSUE

Although the existence of various positions established by Canadian abortion rights groups and women's health groups suggests that some debate has occurred, overall RU 486/PG has not been a central issue for many Canadian feminists. To date, major Canadian feminist publications have included only nine articles on the topic; only the abortion rights groups have published extensively on the RU 486/PG procedure. Beyond brief notes, and an occasional update on the international situation, RU 486/PG seems to have been largely overlooked. *Healthsharing*, formerly Canada's only national feminist health publication, had no policy on RU 486/PG, and never published anything on the issue of RU486/PG.⁶⁸ When the mainstream media first discussed RU 486/PG it was framed as pro-choice, versus anti-choice groups, with anti-abortion groups lobbying to keep it out of Canada with threats of boycotts. My research did indicate that some groups had organized discussions specifically on RU 486/PG, while other groups reported that it had been discussed in passing at their meetings. Overall, Canadian feminists do not appear to have identified RU 486/PG as an issue of concern.

During the interviews conducted for this thesis I asked participants to assess the debate on RU 486/PG in Canada to date. My question received a host of responses, but most agreed that little or no debate was taking place, especially if contrasted with the

debate that has occurred on issues such as Depo Provera and NRTs. Interview participants did identify a number of reasons why the debate has not transpired

Prior to the Supreme Court ruling in 1988, abortion was a central focus for Canadian feminists. However, since attempts to recriminalize abortion failed in 1991, feminist activism on abortion has been altered. For many feminists, the focus of organizing has turned now to maintaining and protecting the few gains that women have achieved. This time consuming process has left little time for investigating alternate abortion methods. Some feminists have moved on to other issues, such as NRTs, which have captured much attention. Anne St.Cerny suggests that the lack of debate on RU 486/PG is symbolic of the lack of debate on women's reproductive health as a whole.⁶⁹ Connie Clement felt that the issue was being "sidestepped" because of the focus on the NRTs.⁷⁰ I would argue that while these points are valid, the biggest factor inhibiting discussion on RU 486/PG is the current feminist struggle with "choice"

Certainly the construction of "choice" has had an impact on the lack of debate on RU 486. What Raymond refers to as "reproductive liberalism", Clement refers to as "the false liberalization of choice".⁷¹ Like Judy Rebick, Clement points out that the choice strategy was originally criticized for amounting to little more than choices for white middle class women. Clement says:

The choice argument has stayed high-profile and really not been highly tarnished. Where that comes back to haunt us now is our failure to deal with that question originally, is through the NRT movement. Where women are coming back and saying who are you to limit choice...⁷²

That same question has also been applied to RU 486/PG. Bonnie Johnson certainly raises the issue of "feminist big sisters". To her, "the women's movement has always been

working towards more choice: more choice in contraception, more choice in methods of abortion, in our lifestyles."⁷³

This construction of choice suggests that every choice is a valid choice, thus, any move to deny choices as inappropriate could be seen as restricting women. When RU 486 was removed from the shelves by the French government in 1988, the current Health Minister argued that RU 486 was "the moral property of women". In light of the fact that RU 486/PG has, from the beginning, been presented as another choice for women, statements such as the one by the French Health Minister imply that to deny women RU 486/PG is to deny them one of their fundamental rights to choose abortion. This argument is made possible by the link that has been established between the pro-choice movement and RU 486/PG as an element of that pro-choice approach. That, in the context of abortion as an issue of individual choice, founds the argument that women have the right to every choice, regardless of its possible consequences. Thus to deny women RU 486/PG could be interpreted as denying women the right to choose abortion.

The pro-RU 486/PG choice argument has meant that anyone publicly criticizing RU 486/PG risks being considered against the availability of abortion, a charge that gives anti-choice an entirely new meaning. Amy Gottlieb argues, "the way the discussion has been framed means that if you raise questions that you are not pro-choice, that you are not in favour of women having another choice."⁷⁴ She concludes that "the discussion is framed that way so there isn't a debate."⁷⁵ Bastien commented, "Paradoxal et inquiétant, non? Piégées dans un concept (le libre choix) que nous avons élaboré!"⁷⁶ The problem arises with the continuing focus on RU 486/PG as an issue of women's individual choice.

Framing the issue as such will increase the feminist departure from questioning what is best for women as a whole, rather than as individuals. Feminist health care will hinge on feminist principles, which, as Rebeck argues, are not founded in individual rights

Furthermore, to argue against individual choices for women may also be interpreted as arguing that women are too ignorant to make this choice.⁷⁷ The FQPN's Anne St.Cerny argues: "[c]'est l'argument de choix individuel: 'Laissons chaque femme décider; si elle a l'information sur les effets secondaires connus et sur l'état de la recherche, elle est assez intelligente pour décider'.⁷⁸ Norma Scarborough, in a discussion of RU 486/PG with the TWHN, calls the attitude of the FQPN "paternalistic".⁷⁹ When RU 486/PG is presented in this fashion, as a question of women's intellectual capacity to choose, to deny the option of choice seems to imply a lack of confidence in women's ability to choose. The FQPN writes, "nous nous n'avons aucun doute sur l'intelligence des femmes. Nous doutons plutôt de la qualité de l'information qui leur est donnée."⁸⁰ This distinction between the two positions is again a reflection of the varying degrees of medical acceptance in the provision of abortion. Amanda LeRougetel argues further that CARAL's "first instinct was not to say 'oh it's a big pharmaceutical industry that's invented this, it's a drug company, therefore we don't want to be in bed with them'."⁸¹ This, she says, is a reflection of the centrist politics of CARAL and the largely white middle class women driving the operation "who believed in opportunities presented by a drug such as RU 486", and who were less critical of the involvement of the medical and pharmaceutical industries.⁸²

An additional problem with the choice argument is its vulnerability to the

traditional pro-choice/anti-choice debates. Feminists certainly do have reason to fear the mark of anti-choice, since, prior to the intervention of the Québec groups, the only organizations against RU 486/PG were anti-choice/pro-life groups. When RU 486/PG first became an issue in the mainstream publications, it was presented as a continuation of the struggles between feminist pro-choice groups and anti-choice religious groups. In fact it was the anti-choice organizations that first began to publicly question the possible health risks for women that RU 486/PG entails. June Scandiffio, former president of the Toronto Right to Life, claimed that they were concerned about the lack of long-term studies, fearing it could turn out to be the next DES or thalidomide.⁸³ Alliance for Life published a pamphlet concerning RU 486/PG that included arguments by the feminist authors of *RU 486: Misconceptions, Myths and Morals*.⁸⁴ REAL Women of Canada have taken a similar approach in their position paper against RU 486/PG, also incorporating the work of anti-RU 486/PG feminists.⁸⁵ The actions of these anti-choice groups do confuse the issue of "anti-choice", and perhaps explain why some feminists have been hesitant to criticize RU 486/PG publicly.

There have been other factors beyond the construction of choice that may have inhibited the feminist dialogue on RU 486/PG. The debate, or lack thereof, has also been influenced by the presentation of the issue by RU 486/PG supporters. In the only Canadian publication being widely distributed in support of RU 486/PG, authors made the following observation about feminist concerns:

So far, feminist groups have strongly supported the testing of RU 486 as a promising development in the much-threatened area of women's reproductive choice. They see RU 486 as a significant medical breakthrough which has the potential to improve the health of women

around the world. A few feminists have criticized RU 486 and painted the drug as a cumbersome and risky medication. According to feminist supporters of RU 486, these criticisms seem to be premised on a more general ideological opposition to all hormone-related drugs and new reproductive technologies.*⁶

While there is some truth in this passage, there is also an unfair generalization that anyone who raises a question about RU 486 is immediately anti-technology and anti-pharmaceutical. It leaves no room for any other possibilities, polarizing the debate into an all or nothing framework, leaving few openings for any discussion of how RU 486/PG effects women's concept of choice or future choices. Women's Health Interaction comments that such a stance "puts advocates who favour reproductive choice for women in the position of having to defend the RU 486/PG abortion without critically reviewing its drawbacks."⁸⁷

In their lobby efforts CARAL has also framed the issue so as to ward off any opposition. Most notably they have established their pro-RU 486 position by publishing only one side of the debate that has been taking place at an international level for the past seven years. In the Spring 1992 edition of *Pro-Choice News*, CARAL published an article by Janet Callum about RU 486, which had originally been printed in *The Network News*, produced by the National Women's Health Network (US).⁸⁸ In the original publication, it was accompanied by a response article by Klein, Dumble, and Raymond. While both articles were reproduced in their entirety in *Ms. Magazine*, CARAL, however, refused to include the response of the anti-RU 486 authors.⁸⁹ In the same Spring 1992 edition, CARAL also published an article by Francine Coeytaux, from the Population Council, entitled "RU-486: Misinformation and the Creation of New Myths", and a review of

Etienne-Emile Baulieu's book *The Abortion Pill*. Presenting RU 486/PG as an extension of women's right to choose abortion, and only focusing on what they view as the advantages of RU 486/PG, leaves little or no room for feminists to engage in dialogue about this choice. One feminist health critic said of CARAL's position:

I think that organizations like CARAL take as strong a position as they do in order to be able to head off a kind of debate and discussion about this, because they feel that in fact if there is a debate and a discussion about it, it will show-up pro-choice voices to be weak in response to the anti-choice movement, and when there is division it will weaken our movement.⁹⁰

Many of the interview participants indicated that concern over division in the pro-choice movement **did** have an impact on the lack of public discussion. Anne St.Cerny commented that "the feminist movement is trying to have common ground to stand together against the right wing. So sometimes we decide not to have the debate in public, because we are not the enemy."⁹¹ Anne St.Cerny was hopeful that the issue would be raised at NAC's annual gathering, but with the 1995 AGM completed and nothing said on the issue, that idea does not look promising. Any large scale discussion is more likely to develop out of the women's health groups, who generally have a more critical approach to medicine than the abortion rights groups.

This reluctance of Canadian feminists may in part reflect a larger concern about access to abortion. As Canadian women currently have no guarantee of abortion services, and are facing continual cut backs to health care funding, there may be a reluctance to raise the issue of RU 486/PG out of fear.⁹² A rejection of RU 486/PG may be misconstrued as a rejection of pro-choice attitudes. An open discussion of RU 486/PG at this time may threaten the already unstable situation of abortion in Canada.

The fact that Canadian feminists have been unable to discuss RU 486/PG to any great extent is puzzling given the attention that NRTs have received in Canada. Helen Bequaert Holmes, editor of *Issues in Reproductive Technology*, defines new reproductive technology as: "methods that prevent conception, that stop reproduction after conception, that cause conception when it does not occur naturally, that monitor or attempt to 'improve the conceptus, that are used during labour and delivery, and that handles problems with compromised newborns."⁹³ While RU 486/PG satisfies this definition, there has, however, been a largely unspoken reluctance to incorporate RU 486 into the NRT debate, a debate which has attempted to address the meanings of choice and control. Anne Pappert, a Canadian women's health writer, has asked some tough questions about women and NRTs.

Do they give women more control rather than less; are they beneficial, how invasive are the methods employed and do they carry with them any additional risk of physical and psychological damage?...Is this technology women-centred in its approach and philosophy: and in whose interests is it being used [sic]?⁹⁴

Although RU 486/PG merits the same questions, it has, for the most part, been omitted from discussions on NRTs.

To some degree all of the interview participants agreed that RU 486 was, in fact, a new reproductive technology. Anne St.Cerny, of the FQPN, was the only participant to argue that RU 486/PG should be considered a new reproductive technology, and that it should be debated in the same terms as NRTs. To St.Cerny, NRTs have come to be associated only with issues of infertility, thereby excluding abortion. However, when taken at its definition, RU 486 falls under the same rubric as the NRTs. She commented that

to the FQPN "[i]t's all [a] question of reproductive health, so we put RU on the same plate as NRTs."⁹⁵ The question then is why have feminists avoided debating RU 486 in the same terms as NRTs? What would it mean if they did? The CACSW and NAC briefs to the Royal Commission on New Reproductive Technologies provide an interesting view as to how Canadian feminists are side-stepping the debate on RU 486/PG.

The Advisory Council wrote in their March 1991 brief that "Canadian laws and regulations governing prescription pharmaceuticals and devices do not sufficiently protect women's reproductive health."⁹⁶ They argued further that:

HPB pharmaceutical control and regulation is inadequate for monitoring the pharmaceuticals currently used in IVF and related conceptive technologies. The complete lack of public participation in monitoring and the secrecy of information pose risks to women's reproductive health. The post marketing follow-up of drug adverse reactions is particularly weak. The CACSW recommends a general restructuring of the procedures used for approving and monitoring pharmaceuticals at the Bureau of Prescription drugs.⁹⁷

However, in their letter to then Health Minister Bouchard, just over a year later, the CACSW recommended:

that Health and Welfare Canada formally invite the French pharmaceutical company Roussel Uclaf, inventor of RU 486, and/or its Canadian subsidiary, Hoescht-Roussel Canada, to apply for the testing of RU 486 in Canada. Interest is high among women and medical practitioners in making the pill available in Canada, *should it pass the standards set by Health and Welfare.*⁹⁸

By their definition, the testing procedures that were inadequate for women's reproductive health one year earlier, were now adequate testing procedures for RU 486, despite the fact that there had been no changes in either procedure or legislation.⁹⁹

A similar paradox has happened with NAC. In 1991, the same year that NAC

resolved to lobby the relevant parties for the release of RU 486 for testing in Canada. NAC also recommended a moratorium for all NRTs. Yet in their 1990 brief to the RCNRT they wrote of their concern about women being used as experimental subjects, and based their concern on the past incidents of DES, the Dalkon Shield and other similar reproductive disasters. Why, then, is it acceptable to subject women to testing RU 486, as they have recommended in their 1991 resolutions, one year later? NAC also expressed concerns about the motivation of the medical industry in developing NRTs. "We are not predisposed to believe the reassurances of scientists, doctors, and pharmaceutical industrialists, because their perspectives are fundamentally shaped by their vested interests in the technologization of procreation."¹⁰⁰ Why would the same concerns not be extended to technological contragestation?

If RU 486/PG were to be approached as an NRT, supporters such as NAC and the Advisory Council might be forced to redefine their positions on RU 486/PG, as there are clearly some inconsistencies in their approaches to the two issues. While both NAC and the CACSW express concerns about the control of the medical profession in the area of infertility, they do not extend this same concern to issues of abortion.¹⁰¹ I have argued that this apparent contradiction may be the result of the separation that has occurred between reproductive health and abortion politics. Thus, feminists are comfortable critiquing the medical profession and the medical consequences of NRTs because the issue has consistently been framed as one of health, rather than one of politics. Furthermore, their inconsistencies may represent their belief that choice and control are in fact not the main issues of abortion; that access and availability through any relatively safe means is

the primary goal. Perhaps when abortion services are recognized as an undeniable women's right and are guaranteed to be effective, available, accessible, and free, feminists will then return to the health implications of abortion methods. In the mean time, some feminists, such as those of the women's health groups in Québec, will continue to place abortion within the category of women's health, ensuring that a feminist health critique of procedures such as RU 486/PG are contributed to the ongoing abortion debates.

CONCLUSION

To date, Canadian feminists seem to be reluctant to participate in open discussion of RU 486/PG for a number of reasons. The complex issue of choice restricts discussion by adding another level to the politics of pro-choice and anti-choice. Critical positions may imply that groups are not supportive of women's right to choose abortion, and may indicate association with the anti-choice groups. Feminists who are pro-choice but critical of the medical profession are accused of attempting to control women's choices by deciding for women what is best for them, or implying that women lack the necessary intelligence to make their own decisions. Almost everything about RU 486/PG has been presented as polar opposites, and this, assuredly, has not been conducive for open dialogue.

"Choice" and "control" as feminist concepts remain largely unexamined. Canadian feminists have, however, demonstrated two different approaches to these concepts, and these diverse approaches have meant drastically different things to the feminist acceptance of RU 486/PG. As RU 486/PG supporters perpetuate the idea of women's individual choices, they equally perpetuate the involvement of the medical profession in women's

reproductive health care. This is the result of their medically based understanding of "choice", and "control" within "choices" Anti-RU 486/PG groups in Quebec have framed the issue of RU 486/PG as one of collective choice, working from a more demedicalized approach to women's reproductive health care. This approach has in turn meant an evaluation of RU 486/PG which considers what the future choices will be for Canadian women in the wake of RU 486/PG.

CONCLUSION

RU 486, "the abortion pill", while still unavailable in Canada, provides an important view of how Canadian feminists are responding to increasingly medicalized abortions. It may, in fact, represent the first occasion since pharmaceutical related tragedies such as DES and thalidomide, that some Canadian feminists have actively lobbied for increased chemical intervention into women's reproductive health. When I began this thesis, I wanted to find out how such a situation had come to be, given the reluctance of Canadian feminists and health activists towards new chemical contraceptives such as Depo Provera and NORPLANT. At this point, I can only offer a few tentative conclusions as to what has prompted such an uncritical acceptance of RU 486/PG. As so little written has been written on RU 486/PG in the Canadian context, I cannot discuss how this analysis differs from the work of others. I can, however, offer this as a starting point for the Canadian debate. This conclusion contains a brief summary of the thesis, offers my own assessment of RU 486/PG and ends with some thoughts on what future research may grow from this work.

In the first chapter I reviewed how abortion has shifted from a women's health issue, controlled by women, to an increasingly medicalized procedure, controlled by the state via the medical and legal professions. While feminist organizing has mainly focused on challenging the state, a feminist health analysis of abortion has been somewhat neglected, as feminists have left the issue of abortion to the more politically oriented abortion rights groups. Feminist organizing in Québec, however, has not been as severed from the women's health movement as the abortion rights groups have been in central

Canada. As a result, when RU 486 first appeared on the scene in 1988, Canadian Anglo-feminists were generally focused on abortion as a legal and political issue, rather than a health issue. Québec feminists were more inclined to maintain abortion as a women's health concern.

RU 486, or RU 486/PG (the procedure), was introduced in chapter two, where I examined the medical issues of RU 486/PG and the possible health risks that procedure may entail for women. Here, I illustrated that Canadian feminists may have established their pro-RU 486/PG positions with inadequate and perhaps misleading information on RU 486/PG. I have concluded that there are a sufficient number of "unknowns" to merit concern about RU 486/PG, and to warrant Canadian feminist discussion of RU 486/PG.

In the third chapter, I outlined the positions that Canadian feminists and health activists have established on RU 486/PG. I have examined the positions both for and against, addressing their different approaches to "access" and "privacy" as the determining factors for their acceptance or rejection of RU 486/PG. To date the only organizations opposing the Canadian introduction of RU 486/PG can be found in Québec, where organizations, while concurring with proponents that access and privacy are imperative, propose radically different interpretations of those concepts.

Finally, in chapter four, I offer an analysis that explains the different positions that Canadian feminists have taken on the issue of RU 486/PG. I have argued that groups and individuals who accept RU 486/PG as an additional medical choice presuppose a central role for the medical profession in women's reproductive health. This, I argue, is a perpetuation of women's understanding of choice as it evolved in conjunction with the

growth of the medical profession. The Québec groups opposing RU 486/PG, who have been influenced by their demedicalized approach to women's health, are concerned about how medical choices are defined and what it will mean to women's autonomy to permit an additional level of medicalized abortion. For these groups the issue is not just that women need more choices, but that they need better choices than the medical profession is willing to offer.

I argue further that feminist approaches to the concept of "choice" have also affected both their positions and the underlying reasons for them. Supporting groups argue that women are competent people who should have the right to individually choose if, and how, they terminate pregnancy. Québec opponents want to shift the issue of RU 486/PG into a larger discussion of individual choice versus collective choices, questioning what women's future choices will be if RU 486/PG is accepted.

Finally I have argued that the Canadian feminist silence on RU 486/PG has also been influenced by the construction of choice as a concept. By framing RU 486/PG as an additional choice for women, Anglo-Canadian feminists have linked RU 486/PG to the concept of pro-choice, meaning women's right to choose abortion. Thus any refusal of RU 486/PG may be interpreted as a rejection of pro-choice principles. This is further compounded by the fact that anti-choice groups were originally the only groups voicing public concerns about RU 486/PG, often using the work of pro-choice, anti-RU 486/PG feminists. The lack of a clear conceptual framework for "choice" has influenced how this issue has been received, framed, and silenced.

At this point, this analysis remains tentative. The issue of RU 486/PG, and of other

NRTs, will have to play itself out further before any conclusive arguments can be drawn. Should RU 486/PG become available for use with little controversy in the US, it is likely that the manufacturers of RU 486/PG will reconsider making a Canadian application. At that point, Canadian feminists may be forced to reconsider their analysis, or perhaps develop alternative ones. However, because the opposition to RU 486/PG is centred in Québec, the promotion of national resistance is unlikely.

There remains the possibility that any discussion of RU 486/PG may be circumvented by the use of a chemical abortion procedure presently available in Canada. Vancouver's Dr. Ellen Wiebe is currently testing two inexpensive drugs known to induce abortion. Women participating in her clinical trials receive an injection of methotrexate (normally used to treat cancer and psoriasis) which has been found to interrupt the development of a fetus. Three days after the initial injection women receive a vaginal prostaglandin to assist in the expulsion of the fetus. Proponents of this chemical abortion argue that its early time frame (four to seven weeks LMP), the fact that it can be done at home and in remote communities, with less complications than conventional abortions, and at a much lower price, makes it "definitely an option for some women."¹ There are clear parallels between this chemical procedure and RU 486/PG, both in the procedure and its supporting arguments. There has been little or no concern voiced about the methotrexate/misoprostol abortions, with the exception of the opinions expressed by anti-choice groups. The TWHN wrote that its availability "could mean a real choice for women who live in areas where they cannot obtain surgical abortions or who have other reasons to avoid surgery."² The lack of concern expressed about these tests, sanctioned

by the UBC medical ethics committee, is perhaps indicative of the extent to which Canadian feminists are willing to engage on the issue of chemical abortion.

How feminists define "choice and control" as feminist concepts is worthy of future research. The factors that underlie our interpretations are as varied and diverse as the goals for which we use them. Perhaps, as Rebeck suggests, feminist goals should focus more on control than on choice. There is clearly room for further research on demedicalized, women-controlled, abortion services and the feasibility of such an arrangement in Canada. Perhaps the recent revival of midwifery will assist feminists in their understanding of "control" and our struggles to maintain control in a society that has consistently worked to eradicate women's self-control.

I would argue that women will never have the power to influence the medical-industrial complex to the extent that we are all truly in control of our own bodies. Those industries have achieved great gains for humanity in many areas of illness and disease. However, abortion, like child birth, does not belong in an environment that classifies women's reproduction as a medical issue based on a model of disease and treatment. If Canadian feminists accept RU 486/PG, they will be embracing the continued medicalization of women's reproduction. In contrast to the feminist fight against the increasingly invasive and technological interference in women's bodies of the 70's and 80's, in this instance feminists will be advocating increased medicalization.

At this juncture women should stop to consider the future of women's health beyond the immediate situation of chemical abortion. The increased acceptance of chemical intervention in women's bodies, where less technological and more women-

centred options exist, may ultimately lead us to reduced control of our bodies. Currently the pharmaceutical future does not appear to be moving women any closer to self-control or self-determination. Women do not have the means to alter the inequities that capitalism creates and sustains. How, then, can we control the new technologies that arise from those industries? As Janice Raymond argued, "Feminists must go beyond choice and consent as a standard for women's freedom. Before consent, there must be self-determination so that consent does not simply amount to acquiescing to the available options."¹ My hope is that Canadian feminists will slow down and debate what choosing RU 486/PG will mean for Canadian women.

APPENDIX I

SEMI-STRUCTURED INTERVIEW QUESTIONS REGARDING RU 486 AND CANADIAN WOMEN'S REPRODUCTIVE AUTONOMY

1. Maybe we could start with some background information on yourself and the organization you represent?
2. Why did you become involved with the ♀'s health movement?
3. Do you consider yourself/organization to be pro-choice?
4. Do you consider yourself a feminist? (self-defined)
5. Do you think that mifepristone/chemical abortions should become available in Canada? Why?
 - 5a. Do you think the procedure will afford women greater privacy? Both in her decision to choose abortion and in the procedure itself?
 - 5b. Do you think the procedure will facilitate greater control for women seeking to end a pregnancy?
 - 5c. What other advantages do you see regarding chemical abortions?
6. Why do you think the procedure is not presently available in Canada?
7. Do you have any concerns about short term health risks?
Do you have any concerns about long term health risks?
8. Do you have any concerns about the possibility that different women will be treated differently when it comes to research, use, promotion? ie. Women with disabilities? Women of Colour? Black women who have higher rates of blood pressure and diabetes?
9. Have you any concerns regarding the situation in the USA, where the Population Council is in charge of research, distribution...
10. One of the arguments to make mifepristone available in Canada is the belief that it will be an additional option for rural women. Do you have any thoughts on that?

11. There has been some discussion that this procedure is merely the continuation of the medicalization of women's bodies? What do you think?

11a. If mifepristone was to become available do you think more physicians would distribute it, more than those performing surgical abortions?

11b. Do you see any validity to the arguments that women are susceptible to harm if they rely on science and/or pharmaceutical industries for reproductive control?

11c. Do you consider RU486 a "new reproductive technology"?

11d. Does the approval by organizations such as the Federation of Medical Women, Society of Obstetricians and Gynecologists influence your opinions?

12. How do you feel about alternatives such as menstrual extraction or menstrual regulation? Or lay women performing abortions in women's health clinics?

13. Will the availability of this procedure bring Canadian women closer to a better definition of "health"?

14. Do you think the lobby movement for RU 486 would be different if Canadian women had guaranteed availability and real access to abortions?

14a. Do you have any concerns that women are attempting to claim this option in an attempt to stop the right's anti-choice agenda?

14b. Do you think there is any possibility that Canadian pro-choice feminists are hesitant to question this alternative because they are unsure ground?

15. What have been some of the major sources of information you have consulted regarding mifepristone and the chemical abortion procedure?

16. It would appear that only a few groups from Quebec are willing to take a public "no" position to RU 486 - why do you suppose that it is? What do you think of the positions taken by other Canadian feminists, in support of RU 486.

17. How do you see the debate around RU 486 developing in Canada? Do you expect it will ever come to Canada?

18. Do you have any lobby plans or plans for mobilization on this issue beyond the groups you are working with?

19. In closing, what do you feel is the most important opinion you want to leave with me? Ideally what do you hope to see regarding mifepristone and the chemical abortion procedure in the coming future?

APPENDIX II

CONTACT LIST

CANADIAN ORGANIZATIONS

Abortion By Choice Society of Alberta (No longer Operating: NLO)
Action Life (Responded: R)
Bay Street Centre For Birth Control (Dr. Marion Powell) (No Response: NR)
Black Women's Association of Alberta (NR)
Canadian Abortion Rights Action League (R)
Canadian Advisory Council on the Status of Women (R)
Canadian Conference of Catholic Bishops (R)
Canadian Disability Rights Council (NR)
Canadian Pharmaceutical Association (R)
Canadian Women's Health Network (R)
Catholic Health Association of Canada (R)
Catholic Women's League of Canada (R)
Centre de Santé des Femmes de Montréal (R)
Congress of Black Women of Canada (NR)
DAWN Canada (NR)
DAWN Ontario (R)
DAWN Toronto (NR)
DES Action Canada (R)
Dr. Carolyn DeMarco (R)
Edmonton Women's Health Collective (NLO)
Everywoman's Health Centre (Vancouver) (R)
Federation du Québec des Planning des Naissances (R)
Greater Victoria Women's Health Promotion Network (R)
Health Action Network Society (BC) (R)
Health Canada (Diane Marleau) (R)
Herspectives (R)
National Action Committee on the Status of Women (R)
North Western Ontario Women's Health Information Network (NLO)
Ontario Coalition of Abortion Clinics (R)
Pauktuutit, National Inuit Women's Association (NR)
REAL Women of Canada (R)
Regroupement des centres de santé des femmes du Québec (R)
Saskatoon Abortion Rights Association (NLO)
Simcoe Women's Wellness Centre (R)
The Society of Obstetricians and Gynaecologists (R)
Toronto Women's Health Network (R)

Vancouver Women's Health Collective (R)
Vancouver Women's New Reproductive Technologies Coalition (R)
Women Health and Medicine (NS) (NLO)
Women's Health Action Committee (Regina) (R)
Women's Health Clinic (Winnipeg) (R)
Women's Health Education Network (NS) (R)
Women's Health Interaction (Ottawa) (R)
Women's Health In Women's Hands (Toronto) (NR)
Women's Network Inc. (PEI) (NR)

AMERICAN ORGANIZATIONS

Abortion Rights Mobilization (NR)
Feminists For Life (R)
Federation of Feminists Health Centres (NR)
Melpomene Institute For Women's Health Research (R)
National Abortion Rights Action League (NR)
National Black Women's Health Project (NR)
National Women's Health Network (R)
National Women's Health Resource Center (R)
Physicians for Choice (NR)
The Population Council (R)

INTERNATIONAL ORGANIZATIONS

Health Action International (R)
International Women's Health Coalition (R)
Women's Health Action Foundation (R)

INTRODUCTION ENDNOTES

1 Throughout this thesis my references to "women" as a homogeneous group represents women who are voluntarily sexually active with men. While lesbian women or celibate women may find themselves faced either personally or politically with this issue, it will be a more primary issue to women who are at a more constant risk of pregnancy

2 Sandra Kirby and Kate McKenna, *Experience, Research, Social Change: Methods From the Margins* (Toronto: Garamond Press, 1989). Rosalind Edwards argues that there are three underlying principles to feminist methodology: a feminist methodology starts from an examination of women's experiences, it should be for the benefit of women, and it should involve a way of including the researcher in the process. Rosalind Edwards, "Connecting Method and Epistemology: A White Woman Interviewing Black Women," *Women's Studies International Forum* (1990) 13(5):477-490.

CHAPTER ONE ENDNOTES

1 My references here and throughout the thesis to the women's movement refer to the majoritarian, largely white, middle-class, heterosexual women's movement. Although I recognize that women immigrants, women of colour, and women with disabilities have had drastically different experiences with both abortion and organizing around the issue, time and space limitations prevent me from investigating that further. The distinctions that I do discuss concern differences in organizing and approach, primarily drawn between the majoritarian anglo-women's movement and a more radical element of the franco-women's movement in Québec.

2 Muriel Joy Hughes, *Women Healers in Medieval Life and Literature* (New York: Books for Libraries Press, 1943), Barbara Ehrenreich and Deirdre English, *Witches, Midwives, and Nurses: A History of Women Healers* (New York: Glass Mountain Pamphlets, 1972); Sheryl Burt Ruzek, *The Women's Health Movement* (New York: Praeger, 1978).

3 Angus McLaren and Arlene McLaren, *The Bedroom and the State* (Toronto: McClelland & Stewart, 1986), 15-31.

4 Ibid, 21.

5 Ibid, 33-35, Peter Gossage, "Absorbing Junior: The Use of Patent Medicines as Abortifacients in Nineteenth Century Montreal," *The Register* 3(1) (March 1982):1-13

6 Andrée Lévesque, *Making and Breaking the Rules* (Toronto: McClelland & Stewart, 1994), 85-89

7 Constance Backhouse, *Petticoats & Prejudice* (Toronto: The Women's Press, 1991), 112-139; Lévesque, 95

8 For more on women's efforts to control fertility see: McLaren and McLaren, Backhouse; and Lévesque

Perhaps one of the greatest indicators of women's perseverance is reflected in the declining Canadian fertility rates between 1851 and 1891. Despite the fact that no new methods of contraception were introduced the fertility rate fell by 30% and continued to decline until the 1930's (McLaren and McLaren, 11)

9 Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991).

10 Ibid

11 See Backhouse and Lévesque

12 Shelley A M Gavigan, *The Abortion Prohibition and the Liability of Women: Historical Development and Future Prospects* (LLM Thesis, York University, 1984), 83.

13. See Gavigan and Bernard Dickens, *Abortion and the Law* (Bristol: Macgibbon & Kee, 1966), Mary Ann Glendon, *Abortion and Divorce in Western Law* (Boston: Harvard University Press, 1987); Angus McLaren, *A History of Contraception* (Oxford: Blackwell, 1990), Linda Gordon, *Woman's Body, Woman's Right*, revised edition (New York: Penguin, 1990).
14. Mitchinson, 133.
15. Ibid.
16. McLaren and McLaren, 104.
17. For more on this see Mitchinson.
18. Alison Prentice et al., *Canadian Women* (Toronto: Harcourt Brace Jovanovich, 1988), 323
19. Eleanor Wright Pelrine, *Abortion in Canada* (Toronto: New Press, 1971), 85
20. Prentice, 323.
21. Jane Jenson, "Getting to Morgentaler: From One Representation to Another," in Janine Brodie, Shelley Gavigan, and Jane Jenson, eds., *The Politics Of Abortion* (Toronto: Oxford University Press, 1992), 30.
22. *Criminal Code*, R.S.C. 1970, c. C-34.
23. Pelrine, 86.
24. McLaren and McLaren, 136.
25. Nancy Adamson, Linda Briskin, and Margaret McPhail, *Feminist Organizing for Change* (Toronto: Oxford University Press, 1988), 42.
26. Ibid., 45.
27. Ibid., 42.
28. *Royal Commission on the Status of Women*, Resolutions #126 and #127, Canada, 1970. The Royal Commission did accept the unquestioned presence of the medical profession once the pregnancy was in a more advanced state. After 12 weeks they recommended that it would depend on a doctor's assessment that the woman's or the fetus's life was at risk.
29. Doris Power, "Statement to The Abortion Caravan," in Discussion Collective No. 6 of the Toronto Women's Liberation Movement, eds., *Women Unite* (Toronto: Canadian Women's Educational Press, 1972), 124.
30. Jenson, 21.

31 Quoted in Kathleen McDonnell, *Not An Easy Choice* (Toronto: Women's Press, 1984), 18.

32 Ibid , 19

33 Ibid

34 Ibid , 18

35 Nancy Adamson, Linda Briskin and Margaret McPhail, 46. See also: Myrna Kostash, *Long Way From Home: The Story of the Sixties Generation in Canada* (Toronto: Lorimer, 1980).

36 Papers of the Toronto Women's Caucus, Records in the Canadian Women's Movement Archives Collection, Morisset Library Special Collections, University of Ottawa. Collection Name: Toronto Women's Caucus.

37 Ibid.

38 Ibid

39 Margaret Fulford, ed., *The Canadian Women's Movement, 1960-1990: A Guide to Archival Resources* (Toronto: ECW Press, 1992), 53.

40 McDonnell, 68.

41 Ibid.

42. CARAL was an outgrowth of ARCAL, the Association for the Repeal of the Canadian Abortion Law, established in Ottawa in 1969. When CARAL was organized its founding members included June Callwood, Kay Macpherson, Esther Greenglass and Eleanor Pelrine. Worthy of note is the fact the organization was launched with a speech by Dr. Henry Morgentaler at the Toronto Men's Press club, the last men only press club in Canada. This is perhaps indicative of who was running the organization at the outset. See: Kathleen Rex, "Group formed to support legal abortion," *The Other Woman*, July/August 1973, 22.

43. In 1990 CARAL had 35 chapters, with a minimum of one in each of the provinces and territories, 300 member groups, and 18 000 individual members. "Member groups were overwhelmingly from feminist organizations, although they included health services, religious groups, women's committees of the NDP, and very few unions. The staple activities of CARAL consist of lobbying, political education, and fund raising, but chapters have a wider action repertoire, including running abortion referral and information phone lines, publishing a research report on abortion access in Halifax, and forming a support group to open a clinic in Edmonton." (Lorna Weir, "Left Popular Politics In Canadian Feminist Abortion Organizing, 1982-1991," *Feminist Studies*, Summer 1994, 256-257.)

44 CARAL, "Freedom of Choice" (September 1989), 1, quoted in Weir, 258.

45. CARAL, *Brief to the Standing Committee on Legal and Constitutional Affairs* (December 1990), 3, quoted in Weir, 258.
46. Weir, 257.
47. Ibid., 259.
48. Jenson, 52.
49. For more on OCAC see Carolyn Egan, "The Right to Choose," *Our Times*, June 1985, 30-32
50. Jenson, 52.
51. OCAC, *Guiding Principles of Reproductive Health Care* (Toronto: nd)
52. OCAC, *The Way Forward for Abortion and Reproductive Health Care: OCAC Response to the Proposed Women's Health Centres* (Toronto: January 1988), 5.
53. CARAL, *Brief to the Standing Committee on Legal and Constitutional Affairs*, quoted in Weir, 258.
54. For an excellent discussion of the early years of the American women's health movement see Sheryl Ruzek, *The Women's Health Movement* (New York: Praeger, 1978).
55. Ibid., 2.
56. *Roe v. Wade*, 410 U.S. 113 (1973).
57. Connie Clement, "A Case for Lay Abortions," *Healthsharing*, 5(1) (Winter 1983), 10
58. Pauline Bart, "Seizing the Means of Reproduction: An Illegal Feminist Abortion Collective - How and Why it Worked," *Qualitative Sociology* 10(4), 355.
59. The differences in funding for national health care programs between Canada and the USA meant that Canadian women already had superior access to health care services, even if they were not necessarily superior services.
60. Donna Cherniak and Allan Feingold, "Birth Control Handbook," Discussion Collective No 6 of the Toronto Women's Liberation Movement, eds., *Women Unite* (Toronto: Canadian Women's Educational Press, 1972), 109
61. Papers of the Vancouver Women's Health Collective, Records in the Canadian Women's Movement Archives Collection, Morisset Library Special Collections, University of Ottawa Collection Name: Vancouver Women's Health Collective.
62. Ibid.

63 Winnipeg Consultation Organizing Committee, *The Strength of Links: Building the Canadian Women's Health Network* (Winnipeg, 1994), 5.

64 Clement, 9-14

65 Ibid , 12

66 Ibid , 11

67 Ibid , 12

68 Ibid., 11.

69 Violette Bodeur et al eds., *Le Mouvement Des Femmes Au Québec - étude des groupes montréalais et nationaux* (Montréal: Composition Solidaire, 1982), 23.

70 Ibid Translation. "All of these things provided favourable conditions for the emergence of social movements."

71 SERENA, *SERENA Canada - Historical Highlights* (Ottawa, 1994).

72 Bodeur, 29 Translation: "Because of its legal nature and because they refused to address the Canadian (federal) government."

73 Jenson, 46.

74 Ibid , 47

75. Ibid , 51.

76 Bodeur, 65. Translation: "An important event that underlines the necessity for women to control the locations which offer health care for women."

77 Bodeur, 64. Translation: "Many of the more militant feminists concentrated their energy on getting autonomous women's health centres up on their feet and operating."

78 Chantal Maillé, "The Women's Health Movement in Québec Society: An Analysis for the purpose of the Constitutional Debate," *Conversations* (Alberta: Centre for Constitutional Studies, 1991), 78-80.

79 Femmes en Tête, *de travail et d'espoir* (Montreal: Les Éditions du remue-ménage, 1990), 94.

80 Ibid

81 Amy Gottlieb, "Saying Good-bye to Healthsharing", *Canadian Woman Studies*, Summer 1994, 117-118

CHAPTER TWO ENDNOTES

1. There has been a great deal of debate as to how to define the increasing forms of abortion. Proponents of RU 486/PG abortions prefer to distinguish abortions as either medical (RU 486/PG) or surgical. Some feminists have objected to these terms arguing that a surgical abortion is in fact a medical abortion, and that the term "surgical" is frightening to women. Others propose that RU 486 abortions should be referred to as chemical abortions, and that the more traditional vacuum aspiration or D & C procedures be referred to as "conventional" procedures, pointing out that prior to RU 486/PG the term surgical abortion was rarely used. In this thesis I have chosen to illustrate RU 486/PG abortions by either its chemical name, RU 486/PG, or by the term chemical abortion. Similarly, I have chosen to use the term conventional abortion rather than surgical abortion, in an effort to reduce any discomfort the surgical concept may bring up for women.

2. Although there has been a great deal of debate as to how to refer to this procedure and these pharmaceuticals, I have chosen to use the term RU 486, the manufacturers designated code for the drug, as opposed to its brand name mifepristone. In an interview with Bonnie Johnson, on 16 February 1995 (Ottawa), she indicated to me that she felt that discussions on this issue should use the term mifepristone in an attempt to get the drug out of the hands of the manufacturer. However, I think that within the discussion there are too many different terms for the drugs themselves and the procedure itself, so I have chosen to use RU 486 because it has been the more commonly used term and more people are familiar with it. I am attempting to present the debate in the most accessible terms when possible.

3. Strictly for the record the chemical composition of RU 486 is 17β -hydroxy- 11β -(4-dimethylamino-phenyl)- 17α -(1-propynyl)-estra-4,9-diene-3-one.

4. Janice Raymond, Renate Klein, and Lynette Dumble, *RU 486: Misconceptions, Myths and Morals* (Massachusetts: Institute on Women and Technology, 1991), 80. **Contraception is the shortened form of contra-gestation.

5. Benjamin F. Miller and Claire Brackman Keane, *Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health* (Philadelphia: W.B. Saunders Company, 1987), 1018.

6. Ibid.

7. References to RU 486/PG are references to the dual abortion procedure. Reference to RU 486 indicates that single component of the procedure.

8. I will address what the specifications for use are further on in the section on contraindications.

9. Rebecca Chalker and Carol Downer, *A Woman's Book of Choices* (New York: Four Walls Eight Windows, 1992), 208.

- 10.M. Heard and J. Guillebaud, "Medical abortion. Safe, effective and legal in Britain," *British Medical Journal* 304 (1992): 195-6.
- 11."Public outcry forces firm to postpone abortion pill," *Montreal Gazette*, 27 October 1988, A13.
- 12."Scientists rally against abortion pill ban," *Toronto Star*, 28 October 1988, A1.
- 13.Beth Ryan, "Canadian Women wait for revolutionary drug: RU 486 -the abortion pill," *The Womanist*, December 1988, 10.
- 14.L. Silvestre et al., "Voluntary Interruption of Pregnancy with Mifepristone (RU 486) and a Prostaglandin Analogue. A large scale French experience," *New England Journal of Medicine* 322(10) (1990): 645-8.
- 15.Michael Klitsch, "Antiprogestins and the Abortion Controversy: A Progress Report," *Family Planning Perspectives* 23(6) (1991): 275.
- 16.Ibid., 277.
- 17.The UK Multicentre Trial Group, "The efficacy and tolerance of mifepristone and prostaglandin in first trimester termination of pregnancy," *British Journal of Obstetrics and Gynaecology* 97 (1990): 480-6.
- 18.Raymond, Klein, and Dumble, 34.
- 19.Canadian Pharmaceutical Association (CPA), *Drug Brief: Mifepristone (RU 486) "A Politically Offensive Drug"* (Ottawa:CPA, 1992), 6.
- 20.This list has been compiled from two sources: the CPA's drug brief and from Raymond, Klein, and Dumble, 34-37.
- 21.Janice Raymond, "Side-effects," *Montreal Gazette*, 17 April 1993, B6.
- 22."France confirms death from abortion pill," *Montreal Gazette*, 9 April 1991, F7.
Annette MacDonald, "RU-486: a dangerous drug," *The Vancouver Sun*, 18 September 1992, A23.
23. Worthy of note is the fact that many of the reports of this death have included the information that the woman who died was in her thirteenth pregnancy and was a heavy smoker. This raises the issue of how one of the first RU 486 related deaths has perhaps been framed by medical and non-medical discourse to be more a fault of the woman herself than of the chemical procedure.
- 24.CPA, 6.
- 25.Anne McIlroy, "Women find 'in control' aspect a big plus for abortion pill," *Vancouver Sun*, 20 November 1992, C2.

26. Virginia Byfield, "Checking on France's 'killer pill'," *Alberta Report*, 9 October 1989, 35.
27. Tamar Lewin, "British Offering Abortion Drug to U.S. Women," *The New York Times* (National) 18 February 1994, A1.
28. "Abortion pill offered," *Maclean's*, 28 February 1994, 33.
29. Barb Livingstone, "Abortion drug sale forseen," *Calgary Herald*, 23 July 1988, A1.
30. *Ibid.*, A2.
31. Neither the manufacturer or the Federal government seem prepared to move on RU 486 at this time. Donald Bryton, President of Roussel-Canada is waiting for an invitation to apply, and Diane Marleau, Minister of Health, is waiting for an application. Authors Mullen, Slater and Deber argue that Canada does meet Roussel-Uclaf's pre-application requirements. For more on this and the Canadian stalemate see: Michelle A. Mullen, Barbara Slater and Raisa Deber, "Politics, Principles and a Pill: Public Policy, Ethics and RU 486," *Health Law in Canada*, Fall 1994, 63-68.
32. Katharine Q. Seelye, "Accord Opens Way for Abortion Pill in US in 2 Years," *The New York Times* (National), 17 May 1994, A1.
33. Bonnie Johnson (Director of Planned Parenthood Canada), interview by author, Tape recording, Ottawa, Ontario, 16 February 1995.
34. Seelye, A1.
35. Joannie M. Schrof, "Reproduction Showdown," *U.S. News & World Report*, 22 March 1993, 32.
36. Janine DeFao, "Feminist Foundation gets \$10 million gift," *The Vancouver Sun*, 4 October 1991, A22.
37. Lewin, A1.
38. Marge Berer, "Inducing a Miscarriage: RU 486 and Prostaglandin for Early Abortion," in Helen Bequaert Holmes, ed., *Issues in Reproductive Technology I. an anthology* (New York: Garland Publishing, 1992), 138.
39. Childbirth by Choice Trust, *RU 486: the "abortion pill"* (Toronto: Childbirth by Choice Trust, 1993), 5.
40. Livingstone, F10.
41. "Cushing's Syndrome: a group of symptoms produced by an excess of free circulating cortisol from the adrenal cortex. Circumstances that can bring about the manifestations typical of

Cushing's Syndrome are: (1) excessive secretion of adrenocorticotrophic hormone (ACTH) from the pituitary gland, which may actually result from faulty release of corticotropin - releasing factor (CRF) from the hypothalamus; (2) tumour of the adrenal cortex...; (3) ectopic production ACTH by estrapituitary tumours...;(4) iatrogenic Cushing's Syndrome resulting from overzealous administration of exogenous glucocorticoids." (Benjamin F. Miller and Claire Brackman Keane, *Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health* (Philadelphia: WB Saunders, 1987), 314.)

42.M. Coucherne, "RU 486: The new abortion pill," *The Optimist*, September 1992, 10.

43.Rebecca Cook, "The Moral Property of Women?" (Commentary), *People* 17(3) (1990):12.

41.Ibid.

45.Miller and Keane, 314.

46.Raymond, Klein, and Dumble, 84.

47.X. Bertagna et al., "Pituitary-adrenal response to the antiglucocorticoid action of RU 486 in Cushing's Syndrome," *Journal of Clinical Endocrinology and Metabolism* 63 (1986): 642.

48.Raymond, Klein, and Dumble, 69.

49.R. Sitruk-Ware R et al., "The use of RU 486 as an abortifacient in early pregnancy," in *The Antiprogesterin Steroid RU 486 and Human Fertility Control*, ed. E.E. Baulieu and S. Segal (Plenum Press: New York, 1985), 247.

50.T. Luukkainen et al., "Inhibition of Folliculogenesis and Ovulation by the Antiprogesterone RU 486," *Fertility and Sterility* 49 (1988): 961.

51.Ibid.

52.Population Action International, *RU 486: A Non-Surgical method of Abortion. Questions and Answers* (Population Action International, 1993), 2.

53.R. Kekkonen et al., "Interference with Ovulation by Sequential Treatment with the Antiprogesterone RU 486 and Synthetic Progestin," *Fertility and Sterility* 53 (1990): 747.

54.Klitsch, 278.

55.M. Permezel, "The antiprogesterone steroid, RU 486 (Mifepristone)," *Australian and New Zealand Journal of Obstetrics and Gynaecology* 30 (1990):78.

56."Abortion Pill might lead to male contraceptive," *Montreal Gazette*, 14 December 1993, A2.

- 57.M.R. Van Stanten and A.A. Haspels, "Interception IV: Failure of mifepristone (RU 486) as a monthly contraceptives, 'Lunarett', " *Contraception* 35 (1987): 433-439.
- 58.B. Couzin et al., "Late luteal administration of the antiprogesterone RU 486* in normal women: effects on the menstrual cycle events and fertility control in a long-term study," *Fertility and Sterility* 54(6) (1990):1039.
- 59.David Grimes and Rebecca Cook, "Mifepristone (RU 486) - An Abortifacient To Prevent Abortion?" *The New England Journal of Medicine* 327(17) (October 8, 1992): 1088-1089.
- 60.Ibid.
- 61.A. Glasier et al., "Mifepristone (RU 486) compared with high dose estrogen and progestogen for emergency postcoital contraception," *New England Journal of Medicine* 327(15) (1992): 1044.
- 62."Abortion pill research hindered, expert says," *The Globe and Mail*, 29 September 1994, A11.
***It remains to be seen how a sample of only 2000 women can be considered multinational - that it would only take 2000 women to form such a representative sample is worth looking into...
- 63."For the Morning After," *Cosmopolitan*, August 1995, 46.
- 64.Boston Women's Health Collective, *The New Our Bodies Ourselves* (New York: Simon & Schuster Inc., 1992), 294.
- 65.Alexandra Paul, "Group fears Canada next as market for abortion pills," *Winnipeg Free Press*, 27 April 1992, B17.
- 66."Abortion Drug and HIV," *The Globe and Mail*, 15 April 1995, D8.
- 67.M.A. Blankenstein, J.W. Va't Verlaat, and R.J.M. Croughsm, "Hormone dependency of meningiomas," *The Lancet* i (1989): 1381-1382. Referred to in Raymond, Klein, and Dumble, 79.
- 68.Raymond, Klein, and Dumble, 70-71.
- 69."Abortion pill research hindered, expert says," *The Globe and Mail*, 29 September 1994, A1.
- 70."Abortion pill trial gets 'extremely favorable' rating," *The Medical Post*, 12 March 1991, 44, (emphasis added).
- 71.Dr. Paul Ranalli, "The appalling ordeal of abortion by pill," *The Globe and Mail*, 28 August 1992, A17.
- 72.Klitsch, 276.

73. Childbirth by Choice Trust, 3. It is interesting to note here that in 1993 when the revised pamphlet was put out by Childbirth by Choice they had omitted this claim about blood loss, but have never written publicly to explain how or why this has changed in their information.

74. Raymond, B6.

75. "RU 486 and Blood Loss," *OUTLOOK*, December 1989, 7-8.

76. L. Silvestre et al., "Voluntary Interruption of Pregnancy with Mifepristone (RU 486) and a Prostaglandin Analogue: A Large-Scale French Experience," *New England Journal of Medicine* 322 (1990):645.

77. M.W. Rodger and D.T. Baird, "Induction of therapeutic abortion in early pregnancy with mifepristone in combination with prostaglandin pessary," *Lancet* 2 (1987):1415-8, and The UK Multicentre Trial Group, 480-486.

78. M.W. Rodger, A.F. Logan and D.T. Baird, "Induction of early abortion with mifepristone (RU 486) and two different doses of prostaglandin pessary (gemeprost)," *Contraception* 39(5) (1989): 497-502, (emphasis added).

79. Silvestre, 645.

Nulliparous refers to women who have never experienced a live birth.

80. CPA, 5.

81. Rodger, 497-502.

82. Klitsch, 276.

83. Child Birth By Choice, 4.

84. Berer, 129.

85. Silvestre, 645-648.

86. Klitsch, 277.

87. Special Programme of Research, Development and Research Training in Human Reproduction, *Annual Technical Report 1990* (Geneva: WHO, 1991), 5.

88. Amanda Le Rougetel, "RU486 Or Are You Against It?" *Horizons*, Spring 1992, 23.

89. Janice Raymond, Renate Klein, and Lynette Dumble, "RU 486," *MS.*, March/April 1993, 35.

90. E-E. Baulieu, "RU 486 as an Antiprogestosterone Steroid. From Receptor to Contragestion and Beyond," *Journal of the American Medical Association* 262(13) (1989):1808-14.

91.Ibid.

92.Rosanna Baraldi argues that even if RU 486 does come to Canada the manufacturers face only a vague obligation to do long-term testing in Canada. For more on this see: Rosanna Baraldi, "The Evaluation of Pharmaceutical Products: Problems of Phase IV," in Gwynne Basen, Margrit Eichler, and Abby Lippman, eds., *Misconceptions* (Volume 2) (Prescott, Ontario: Voyageur, 1994), 71-81.

93.I.E. Messinis and A. Templeton, "The effect of the antiprogestin mifepristone (RU 486) on maturation and in-vitro fertilization of human oocytes," *British Journal of Obstetrics and Gynaecology* 95 (June 1988): 592-595.

94.Ibid., 592.

95.Ibid., 594.

96.Raymond, Klein and Dumble (1991), 75.

97.Ibid., 77.

98.Ibid., 78.

99.Klitsch, 277.

100.J.-C. Pons et al., "Development After Exposure to Mifepristone in Early Pregnancy," *Lancet* 338 (1991):763.

*** I am aware that the language in this paragraph is ableist, and I find myself in somewhat of a dilemma. This is the language that is used to describe and explain the circumstances of these situations, this is, in fact, similar to the dilemma of abortion and ability dialogue. It is not my intention to be ableist, however I do not want to disguise the seriousness of the issue with relative euphemisms.

101.B.H. Lim et al., "Normal Development After Exposure to Mifepristone in Early Pregnancy," *Lancet* 336 (1990):257.

102.Ibid.

103.Myriam Kami, "RU 486: la tolérance, nouveau sujet de controverse," *Le Quotidien du Médecin* No. 4512 (1990):9.

104.Norma Scarborough (Toronto), Letter to the Editor of *The Globe and Mail* (Toronto), 14 September 1993, TSL.

105.E.E. Baulieu, "Contraception with RU 486: A new approach to postovulatory fertility control," *Acta Obstetrica et Gynecologica Scandinavica Supplement* 149:5-8. Referred to in Raymond, Klein and Dumble (1991), 73.

106. Generally these women are candidates for sterilization procedures, but "agree" to participate in these trials prior to their surgery. To my knowledge no one has studied who the participants are, or why they choose to participate in such trials. Would be an interesting topic to pursue. The question should be raised as to whether these women are in any way coerced into RU 486 PG trials, or if they can have a free sterilization if they do participate.

107. Gary M. Samuelson, "DES, RU-486, and Deja Vu," *Journal of Pharmacy & Law* 2 (1993): 69.

CHAPTER THREE ENDNOTES

1 "The abortion pill," *Toronto Star*, 20 January 1992, A16.

2 See appendix for list of groups and individuals I attempted to contact

3 Women's Health Interaction, *Uncommon Ground*, publication pending.

4 Wendy Masui, Information Centre Co-ordinator (Vancouver), Letter to Julie Johnstone (Ottawa), 31 October 1994, TSL. (TSL indicates Typed Signed Letter)

5 The Saskatoon Abortion Rights Association (SARA), is no longer functioning under that name. It would appear that it closed around 1993/1994. What remains is the Emergency Health Fund (EHF), which is using SARA's remaining funds to help finance out of province abortions. Saskatoon has a limit of abortion services only up to the 12th week, and Margaret Smith of the EHF wrote me that their need for funds and services was increasing as Social Services now refuses to pay for Native women to go out of province.

Margaret Smith, EHF (Saskatoon), Letter to Julie Johnstone (Ottawa), no date, letter postmarked 17 December 1994, SL. (SL indicates Signed Letter)

Sue Cook, Women's Health Action Committee (Regina), Letter to Julie Johnstone (Ottawa), no date, date of post mark unavailable, SL.

6 Pat Israel, Executive Director, DAWN Ontario (Toronto), Letter to Julie Johnstone (Ottawa), 4 August 1994, TSL. In her correspondence Ms. Israel included a 1993 pamphlet produced by her organization, *"I want to be a mother. I have a disability: What are my Choices?"*.

7 Monica B. McCunn, Canadian Women's Health Network (Westville, NS), Letter to Julie Johnstone (Ottawa), 10 October 1994, TSL.

Julie Schofield, Women's Health Promotion Network (Victoria), Letter to Julie Johnstone (Ottawa), 7 October 1994, SL.

**Women's Health Promotion Network was only recently organized in late 1992 and they are still working to establish their goals and focus. The Canadian Women's Health Network has only met a few times over the past ten years and have only recently begun to solidify as a working organization in the last few years. For more information on the Canadian Women's Health Network see *The Strength of Links. Building the Canadian Women's Health Network*, Report on the Canada-Wide Consultation Meeting Held in Winnipeg, Manitoba May 21-24, 1993 and Including a 1994 network Update (Winnipeg: December, 1994). Copies in English or French can be purchased c/o Women's Health Clinic, 3rd Floor, 419 Graham Ave., Winnipeg MB, R3C 0M3 Canada (204) 947-1517 TEL (204) 943-3844 FAX. (204) 956-0385 TTY.

8 Catherine Martell, Vancouver Women's NRT Coalition (Vancouver), Letter to Julie Johnstone (Ottawa), 16 December 1994, TSL.

- 9.Canadian Advisory Council on the Status of Women (Ottawa), Letter to the Honourable Benoit Bouchard, Minister of National Health and Welfare (Ottawa), 6 November 1992, TSL.
 - 10.The Society of Obstetricians and Gynaecologists of Canada (SOGC), *Policy Statement on RU-486*, 10 November 1992. The Federation of Medical Women of Canada, Press Release "The Federation of Medical Women of Canada Supports the Legal Availability of RU 486 in Canada," 11 March 1993.
 - 11.Toronto Women's Health Network, Newsletter, October 1994, 3.
- Worthy of note, this policy was established as a result of my writing to inquire about their policy Lyba Spring told me that it was my request that prompted them to establish a position. Every now and then it's nice to realize that there is a point to writing your Master's Thesis
- 12.Ibid.
 - 13.Ibid.
 - 14.Ibid.
 - 15.National Action Committee, Resolutions, 500.40 1/91, 1991.
 - 16.Women's Health Clinic, General Manual Policy RU-486, 3 June 1991
 - 17.Ibid
 - 18.The Canadian Abortion Rights Action League (CARAL), *Brief Presented To The Royal Commission on Reproductive Technologies*, Halifax, Nova Scotia, October 17, 1990. Ontario Coalition for Abortion Clinics (OCAC), *Brief to the Royal Commission on The New Reproductive Technologies*, Toronto, May 1991.
 - 19.OCAC, 7.
 - 20.Ibid., 8
 - 21 Ibid.
 - 22.Ibid., 11.
 - 23.CARAL, 10.
 - 24.Darlah Purdy, Women's Health Education Network (Dearborn, NS), Letter to Julie Johnstone (Ottawa), 17 October 1994, TSL.
 - 25 Deborah Morrissey, "Canadians behind in birth control options", *Hospital News*, August 1993, 5.

- 26 Barb Livingstone, "Abortion drug sale forseen," *Calgary Herald*, 23 July 1988, A1.
- 27 Clayton Ruby, "Clayton Ruby explains why the abortion pill won't be coming to Canada" (Fifth Column), *The Globe and Mail*, 28 August 1992, np
- 28 Arlington Virginia, December 6-7, 1991.
- 29 Debra Black, "Supporters demand abortion pill in Canada," *The Globe and Mail*, 24 July 1992, np
- 30 Richard Mackie, "Public-opinion poll results fuel fight for abortion pill," *The Globe and Mail*, 22 July 1992, np
- 31 Ruby, np
- 32 Amanda LeRougetel, President of CARAL (Winnipeg), phone interview by author, Tape recording, Ottawa, Ontario, 16 March 1995.
- 33 FQPN, *RU-486/prostaglandine - mise à jour*, 14 juillet 1993.
- 34 Ibid Translation: "Because the secondary effects are very dangerous to women's health."
- 35 No specific date is indicated in any of their literature or correspondence.
- 36 Le Regroupment des centre de santé des femmes du Quebec (RCSFQ), *Le RU 486 et Prostaglandines: On l'appelle 'Pilule Abortive', On la qualifie de 'Propriete des Femmes', On la nomme 'Cocktail Chinoise'*, Montréal, nd.
- 37 Ibid
- 38 Connie Clement, interview by author, Tape recording, Toronto, Ontario, 20 February 1995.
- 39 Women's Health Clinic, 4
- 40 Madeline Boscoe (Women's Health Clinic), interview by author, Tape recording, Ottawa, Ontario, 18 February 1995
- 41 Clement Interview.
- 42 Boscoe Interview.
- 43 LeRougetel Interview
- 44 Clement Interview.
- 45 Women's Health Clinic, 4.

46.OCAC, 10-11.

47.Ibid.

48.Art Hister, "Abortion In A Bottle," *Alberta Living*, April 1993, 2

49.Daniel Sanger, "Abortion pill being secretly used," *Kingston Whig-Standard*, 30 May 1994, np.

50.Personal communication with Caroline Kidd (OMA - Toronto), unrecorded, Ottawa, Ontario, 25 May 1994.

51.Leonora Lloyd, "What is happening about RU 486?" *Women's Choice*, Spring 1993, 2-6

52.Ibid.

53.Ibid.

54.Anne St.Cerny, interview by author, Tape Recording, Montréal, Québec, 17 March 1995

55.Ibid.

56.Morrissey, 5.

57.Ibid.

58.LeRougetel Interview.

59.Clement Interview.

60.Amy Gottlieb, interview by author, Tape Recording, Toronto, Ontario, 20 February 1995

61.Etienne-Emile Baulieu, "Contragestation and other Clinical applications of RU 486, an antiprogesterone at the receptor," *Science* (1988) 245, 128.

62.Ginette Bastien, interview by author, Tape recording, Montréal, Québec, 17 March 1995

63.Bonnie Johnson, Interview by Julie Johnstone, 16 February 1995, Ottawa

64.Ibid.

65.Judy Norsigian, "RU 486", in Marlene Gerber Fried, ed , *From Abortion to Reproductive Freedom - Transforming A Movement* (Boston: South End Press, 1990), 197

66 Angela Davis, "Racism, Birth Control and Reproductive Rights", in Marlene Gerber Fried, ed , *From Abortion to Reproductive Freedom - Transforming A Movement* (Boston South End Press, 1990), 15-26.

67 Makeda Silvera, "Black Women and Health", in Kathleen McDonnell and Mariana Valverde, eds., *The Healthsharing Book* (Toronto: The Women's Press, 1985), 161.

68 Lawrence I.ader, *RU 486 - The Pill That Could End the Abortion Wars and Why American Women Don't Have It* (New York: Addison Wesley, 1991), 111.

69 Gottlieb Interview

70 I have attempted numerous times to reach DAWN Canada, and the Canadian Disability Rights Council, but remain unsuccessful.

71 Anne Finger, "Claiming All of Our bodies: Reproductive Rights and Disability," in Renate Klein, Rita Arditti, and Shelley Minden, eds., *Test Tube Women: What Future for Motherhood* (Pandora Press, 1984), 281.

72 Gottlieb Interview.

73 Clement Interview

74 Ibid

75 Boscoe Interview.

76 LeRougetel Interview.

77 Ibid

78 OCAC, 7-8.

79 Ruby, np

80 Gottlieb Interview.

81 Johnson Interview

82 Ibid

83 Ibid

84 "RU 486, The New French Pill: New technologies/new choices." Reproductive Health Technologies Project, Washington D.C., unpublished report, not dated. "Mifepristone: widening the choice for women", *Lancet*, 4 November 1989, 1113. W. Burger and R. Marshall, "Battle of the abortion pill An international outcry blocks a new French drug - but only temporarily," *Newsweek*, 7 November 1989, 8-9.

85 Childbirth By Choice Trust, *RU 486: the "abortion pill"* (Toronto: CBCT, 1993), 5.

- 86.Amanda LeGrand, "The Abortion Pill: A Solution For Unsafe Abortions in Developing Countries," *Soc. Sci. Med.* 1992 35(6) 767-776.
- 87.Ibid.
- 88.TWHN, 2.
- 89.WHI, 7.
- 90.Ibid.
- 91.Rebecca Chalker and Carol Downer, *A Woman's Book of Choices* (New York: Four Walls Eight Windows, 1992), 219-220.
- 92.Donna Alvarado, "Abortion pill now a legal issue," *Calgary Herald*, 17 July 1992, B9
- 93.Sanger, np.
- 94.LeRougetel Interview.
- 95.Ibid.
- 96.Johnson Interview.
- 97.Clement Interview.
- 98.LeRougetel Interview.
- 99.Ibid.
- 100.Gottlieb Interview.
- 101.Ibid.
- 102.Boscoe Interview.
- 103.Chalker and Downer, 220.
- 104.Ginette Bastien, "L'avortement chimique: reflexions d'une resistente," *Canadian Woman Studies*, Summer 1994, 102.
- 105.Bastien, 103. Translation: "The women do not like aborting at home. There is work to do on this because we can't keep them at the hospital clinic for long periods of time. The experience is hard to live through, but we will just have to educate women about this."
- 106.Bastien Interview.

107 Ibid

108 Ibid

109 Bastien, 102 Translation "I asked for an abortion, but what I lived through during three days, was labour. The waiting, the contractions, the expulsion. That was emotionally difficult to live through. Having been in some sort of labour on day 1, day 2, and day 3."

CHAPTER FOUR ENDNOTES

1. The TWHN policy provides a clear example of the "choice" basis for RU 486/PG. "We believe that women must have increased choices concerning abortion. It is with this same note of caution that we advocate for clinical trials of RU 486, "the abortion pill". We will support the approval of RU 486 as an abortifacient to be made available to Canadian women only after careful scrutiny of the experimental data. As well, women must be offered comprehensive counselling about their abortion options so that the choices they make are truly informed choices." Toronto Women's Health Network, Newsletter, October 1994, 3.
2. Women's Health Clinic, General Manual Policy - RU 486, June 3, 1991
3. The Society of Obstetricians and Gynaecologists of Canada, Policy Statement on RU 486, 10 November 1992. The Federation of Medical Women of Canada, Press Release "The Federation of Medical Women of Canada Supports the Legal Availability of RU-486 in Canada," 11 March 1993.
4. "RU-486: We need this choice now!", *Pro-Choice News*, Summer 1991, 1 and 3
5. Norma Scarborough (Toronto), Letter to the Editor of *The Globe and Mail* (Toronto), 22 August 1992, TSL.
6. Clement Interview.
7. Johnson Interview.
8. Ibid.
9. Ibid.
10. Rebecca Chalker and Carol Downer, *A Woman's Book of Choices* (New York: Four Walls Eight Windows, 1992), 197.
11. Susan Ince, "The Trouble With RU 486," *Vogue*, July 1991, 88-90
12. Heidi Walsh, "RU 486 - "the abortion pill": Stops, starts and uncertainties," *Kinesis*, May 1991, 12-13. In fact, local anesthetic or tranquilizers are the norm throughout Canada
13. The Canadian Abortion Rights Action League (CARAL), *Brief Presented to the Royal Commission on Reproductive Technologies*, Halifax, Nova Scotia, 17 October 1990, 12
14. Norma Scarborough (Toronto), Letter to the Editor of *The Globe and Mail* (Toronto), 14 September 1993, TSL.
15. Kit Holmwood, "The Broader Ramifications of Choice," *Pro-Choice News*, Spring 1991, 3

16 Ibid

17 This view is problematic, in that not all women are in equal positions to negotiate with each other, let alone against such a respected and authoritative institution.

18. Amanda Le Rougetel, "RU486 Or Are You Against It?" *Herizons*, Spring 1992, 21-23.

19 Ontario Coalition for Abortion Clinics (OCAC), *Brief to the Royal Commission on the New Reproductive Technologies*, Toronto, May 1991, 4, (emphasis added).

20 Bastien Interview.

21. For more information on prostaglandin abortions see The Boston Women's Health Collective, *The New Our Bodies Ourselves* (New York: Touchstone, 1992). For a critique of the dangers of prostaglandin abortions, and a discussion of the European experience and feminist response, see Janice Raymond, Renate Klein, and Lynette Dumble, *RU 486: Misconceptions, Myths and Morals* (Cambridge: IWT, 1991). For more on the current medical use of prostaglandin abortions see Antonio Bugalho et als., "The Effectiveness of Intravaginal Misoprostol (Cytotec) in Inducing Abortion after Eleven Weeks of Pregnancy," *Studies in Family Planning* (September/October 1993) 24(5):319-323.

22. Shelley Gavigan discusses how the Morgentaler case ensured that abortion would be considered a medical issue. Shelley Gavigan, "Morgentaler and Beyond: Abortion, Reproduction, and the Courts," in Janine Brodie, Shelley Gavigan, and Jane Jenson, eds., *The Politics of Abortion* (Toronto: Oxford University Press, 1992), 117-146. Recently the province of British Columbia announced new legislation to curtail protestors at clinics, hospitals and homes. Health Minister Paul Ramsey justified the legislation as follows: "Abortion is a legal, medical service and access to medical services is one of the foundations of medicare." (Craig McInnes, "B.C. to curb abortion foes," *The Globe and Mail*, 20 June 1995, A1.)

23. St. Cerny Interview.

24 "A Different Approach to Women's Health: Montreal Women's Health Centre," *Communiqu'ELLES*, January 1989, 5-8.

25 FQPN, *RU-486/prostaglandine - mise à jour*, 14 juillet 1993. Translation: "From this point of view, accepting the entry of RU 486/PG constitutes the accepting the hormonization of women's bodies, a larger bio-medical control of women's bodies and increased dependence on medicines and hormones."

26 B. Singh Bolaria and Rosemary Bolaria, eds., *Women, Medicine and Health* (Halifax: Fernwood, 1994), 1. There are currently three medically accepted models of health care: the treatment model, which "emphasizes that normal, or healthy functioning can be restored through mechanical procedures, and technological and pharmaceutical fixes"; the clinical model, which "attributes disease to physiological malfunctioning"; and a related "reductionist perspective",

which "attributes illness to individual lifestyles, behaviour and consumption patterns " None of these models is particularly conducive to feminist based, women-centred health care

27.Ibid.

28.Joel Lexchin, *The Real Pushers: A Critical Analysis of the Canadian Drug Industry* (Vancouver: New Star Books, 1984), 207

29.Joel Lexchin, "Public Good or Private Profits: Focus on Pharmaceutical Issues," in B Singh Bolaria and Rosemary Bolaria, eds., *Women, Medicine and Health* (Halifax: Fernwood, 1994), 39.

30.The medical-industrial complex is defined as: "a large and growing network of private and public corporations engaged in the business of supplying medical care for a profit Included in the medical-industrial complex are proprietary hospitals and nursing homes, home care services, diagnostic services, including the tremendously expensive CAT scanners, haemodialysis, the pharmaceutical companies, and the medical tools and technology supply companies." Juaane Nancarrow Clarke, *Health, Illness, and Medicine in Canada* (Toronto: McClelland & Stewart, 1990), 280. This definition does not include medical staff, but because Canadian physicians are generally paid on a fee-for-service basis, they too are in the "business of supplying medical care for profit".

31.Deborah A. Findlay and Leslie J. Miller, "Medical Power and Women's Bodies," in B Singh Bolaria and Rosemary Bolaria, eds., *Women, Medicine and Health* (Halifax: Fernwood, 1994), 133. For further information on the topic of how the male dominated medical system effects women see: Diana Scully, *Men who Control Women's Health: The Miseducation of Obstetricians-Gynecologists* (Boston: Houghton Mifflin, 1980), and John M. Smith, *Women and Doctors* (New York: The Atlantic Monthly Press, 1992).

32.Impossible pregnancy is my attempt to find a term to illustrate pregnancies that are wanted but for various reasons, be they financial, familial, emotional etc., are not feasible for women at that time. Pregnancy can be intended, but be unrealistic for many women What I am trying to do is find a way around using "unwanted" pregnancy, and think that "unplanned" does not reflect the reason many women are forced to abort.

33."Medicalization refers to the process whereby an object or a condition becomes defined by society at large as an illness (Either physical or psychological) and is thereby moved into the sphere of control of the medical profession." (Findlay and Miller, 115)

34.For further reading on the medicalization of women's bodies see: *Women, Medicine and Health*, eds. Bolaria and Bolaria (Halifax: Fernwood Publishing, 1994), Juaane Clarke, *Health, Illness, and Medicine in Canada* (Toronto: McClelland & Stewart, 1990), Catherine Kohler Reissman, "Women and Medicalization: A New Perspective," in Howard D Schwartz, ed, *Dominant Issues in Medical Sociology* (New York: Random House, 1983), 101-121

35 Marge Berer, "Inducing A Miscarriage: RU 486 and Prostaglandin for Early Abortion," in Helen Bequart Holmes, ed., *Issues in Reproductive Technology* (New York: Garland Publishing Inc., 1992), 130, (emphasis added).

36 Ibid., 139

37 Ibid., 140

38 Janice Raymond, *Women as Wombs* (New York: Harper Collins, 1993), 116.

39 Kathryn Strother Ratcliff, "Health Technologies for Women: Whose Health? Whose Technology?" in Kathryn Strother Ratcliff, ed., *Healing Technology: Feminist Perspectives* (Michigan: University of Michigan Press, 1989), 182.

40 Johnson Interview. Emphasis added.

41 Ibid.

42 Norma Scarborough, 22 August 1992.

43 Author Suzanne Staggenborg argues that "the term 'pro-choice' was not used until after the legalization of abortion in 1973 [Roe v. Wade], in response to the 'pro-life' rhetoric of the anti-abortion movement. Before 1973, the single-issue component of the movement was referred to by participants as 'the abortion movement'". Suzanne Staggenborg, *The Pro-Choice Movement* (New York: Oxford University Press, 1991), note 2, chapter 1, 188. Although the right to choose was a prominent slogan in Canada, it would appear that the pro-choice movement did not take off in Canada until a few years after the US. In the summer of 1978 the Vancouver Status of Women established a pro-choice position at their AGM, where they affirmed their support of a newly developed organization called Concerned Citizen's for Choice. It was not until the early 1980's that choice as a strategy was more widely used, and it was around the same time that criticisms did start to develop regarding the strategy of choice.

44 This is not meant to say that collective organizing was not problematic, or that there were no other factors that prevented women from working towards a more collective strategy.

45 Raymond, *Women as Wombs*, 77.

46 Ibid., 85.

47 Other feminists had raised the issue prior to Rebick. In 1976 Toronto's feminist paper, *The Other Woman*, reprinted an article from the Vancouver-based *Pedestal*, which criticized the decision to address abortion outside of the women's movement as a single issue. "Energy was dissipated and women turned to day care and union organizing, leaving the abortion movement to liberals and trotskyists... 'Free Abortion on Demand' was entirely dropped from all further mention to be replaced by 'Repeal the Abortion Law -- Freedom to Choose'". The author of this article argued that the choice argument was developed so that the more "bourgeois" population

would think the movement respectable enough to get involved. "Abortion Cavalcade," *Pedestal* 11(4):np. In 1983, after the publication of Kathleen McDonnell's article in *Still Ain't Satisfied*, Vivian Harrower also raised questions about the choice strategy. "The radicalization of the pro-choice side appears to me to be its reduction of the abortion issue to a woman's decision to abort or carry a fetus to term...I do not favour outlawing access to abortion in Canada, but I would like to hear more from the 'pro-choice' side about choices other than abortion." Vivian Harrower, "More Choices for Pro-Choicers," *Broadside*, October 1983, 14.

48. Judy Rebick, "Is the Issue Choice?" in Gwynne Basen, Margrit Eichler, and Abby Lippman, eds., *Misconceptions* (Volume 1) (Hull, Quebec: Voyageur, 1993), 88

49. Ibid.

50. Ibid.

51. Ibid., 89.

52. Elisabeth Beck-Gernsheim, "From the Pill to Test-Tube Babies: New Options, New Pressures in Reproductive Behaviour," in Kathryn Strother Ratcliff, ed., *Healing Technology* (Michigan: University of Michigan, 1989), 29.

53. For more on this see: Robin J.R. Blatt's *Prenatal Tests: What They Are, Their Benefits and Their Risks, and How to Decide Whether to Have Them or Not* (New York: Vintage, 1988), Ann Oakley, *Telling the Truth About Jerusalem* (New York: Basil Blackwell, 1986), and The Boston Women's Health Collective, *The New Our Bodies, Ourselves* (New York: Touchstone, 1992)

54. Kim Yanoshik and Judy Norsigian, "Contraception, Control, and Choice. International Perspectives," in Kathryn Strother Ratcliff, ed., *Healing Technology* (Michigan: University of Michigan Press, 1989), 84. Yanoshik and Norsigian provide a good discussion on how choice is constructed, and how women are not informed well enough to make unbiased choices

55. FQPN, 14 juillet 1993.

56. I am thinking here of the concern feminists expressed over Depo Provera, and the national coalition that was developed to prevent its entry into Canada. Yet while we were not looking in the past few years Depo Provera did come, and has been offered at the Bay Centre for Birth Control for the last year. Women's health activists expressed concerns over NORPLANT, and it too is now available.

57. Ashok Sharma, "India works on reversible sterilization for men," *The Ottawa Citizen*, 13 June 1995, A14. The injections inhibit the sperms ability to fertilize the ova. "Membranes covering the head of the sperm fracture on contact with the compound, leaking enzymes that are needed to successfully penetrate the egg." To date only 60 men have participated in clinical trials

58. Health Action International (Europe) and Women's Health Action Foundation. *Immunological Contraceptives, Designed For Populations Not People*. May 1994. "The most advanced research is on methods which attack the hormone human chorionic gonadotrophin (HCG) produced by the fertilised egg just after conception. They are formed by combining part of the hormone HCG with parts of substances produced by a germ, usually tetanus or diphtheria toxoids. When the body defends itself against this combined molecule, it also attacks the hormone HCG. If the attack is successful, pregnancy is prevented."

59. The main health risks are a sevenfold increase in blood clots, and increased risk of endometrial cancer, by almost five times.

60. Susan Rennie, "Breast Cancer Prevention: Diet vs. Drugs," *Ms. Magazine*, May/June 1993, 3(6). 38-46.

Another controversial "therapy" for breast cancer prevention is the GnRH agonist, which interrupts ovulation by influencing the pituitary gland to inhibit production of progesterone and estrogen. Women receive monthly injections, and then to counter the GnRH induced side effects (menopause) they are given estrogen replacement for 24 days of the 28 day cycle. "Finally, to ensure continuing fertility, the women, who are in their twenties and thirties, are given a synthetic progesterone for 13 days every fourth month to induce a menstrual period three times a year." The epidemiologist on this experiment, points out that breast cancer can be blamed on modern women's "incessant ovulation".(43)

61 Ibid , 40.

62. Ibid., 42.

63. Currently the CSF uses local anaesthesia and over the counter pain killers when required. They do, however, offer an extremely demedicalized environment. There is a large room for women to recover by themselves or with their friends or partners, that is decorated in relaxing tones, where women can use the kitchen to make themselves something to eat or drink. Women are free to move around. There are other touches which make it a less medicalized environment, such as the posters over the table and the pink quilted covers for the stirrups.

64 Findlay and Miller, 135

65. Bette Vanderwater, "Meanings and Strategies of Reproductive Control: Current Feminist Approaches to Reproductive Technology," *Issues in Reproductive and Genetic Engineering*, (1992) 5(3):229.

66. Raymond, *Women as Wombs*, 91.

67 Ibid

68 Former editor Amy Gottlieb said that at the time the issue came to prominence *Healthsharing* was in the process of compiling their regional issues, and that they "just didn't sort of catch this

one". *Healthsharing* was also working to maintain a greater balance of health issues, with not so much focus on reproductive health issues.

69.St.Cerny Interview.

70.Clement Interview.

71.Ibid.

72.Ibid.

73 Johnson Interview.

74.Gottlieb Interview.

75.Ibid.

76.Ginette Bastien, "L'avortement chimique: réflexions d'une résistante," *Canadian Woman Studies*, (Summer 1994) 14(3).101. Translation: "What a troubling paradox no? Trapped in a concept (free choice) that we created!"

77.The issue of women's capacity to make decisions has been raised previously by CARAL in a clash with more medically critical feminists. In their Winter 1988/89 edition of the Pro-Choice News, CARAL included an article about prenatal diagnosis, as an avenue for "women [to] exercise their choices". Abby Lippman and Karen Messing wrote in response how these "choices" are controlled by medical and social constructs. They argued that some pro-choice feminists "want to be certain that prenatal diagnosis and all other reproductive technologies, give women real choices and real control, not hypothetical alternatives as is now the case, since these technologies are controlled by health professionals and other scientists who set the criteria for access to them individual women do not decide independently". CARAL's response in the ensuing edition to this critique of their position on prenatal diagnosis was the following: "We trust women to decide as to the complex issues implicit in prenatal diagnosis we ought not to fall into the trap of investing these issues with so much complexity that people think they cannot think for themselves "

78.FQPN, 14 juillet 1993. Translation: "It's the individual choice argument: 'leave each women to decide; if she has the information on the known side effects and on the state of the research, she is intelligent enough to decide'."

79.TWHN, Newsletter, October 1994.

80.FQPN, 14 juillet 1993. Translation: "We have no doubts about women's intelligence. What we doubt is the quality of the information that women are given "

81.LeRougetel Interview.

82.Ibid.

83 Rebecca Wigod, "Doctor seeks women to test abortion drug," *Vancouver Sun*, 9 June 1994, A2

84 RU-486 - Questions Asked About RU-486 Prepared by Alliance NonProfit ProLife Action Inc., nd

85 REAL Women "Abortion and The Abortion Pill RU 486," *REAL Women of Canada Position Papers* (Ottawa, nd), 57-62

**For the record, REAL women had the fastest response time for providing me with a policy statement, faxing it to me in ten minutes from the time that I phoned to request it. I think it's note worthy that their policy is ready to go in advance, because while Canadian feminists are not really dealing with the issue to any great extent, groups such as this and the pro-life/anti-choice groups are already prepared and organized

86 Childbirth By Choice Trust, *RU 486: the "abortion pill,"* (Toronto: CBCT, 1993), 6

87 Women's Health Interaction, *Uncommon Ground*, publication pending, 7. The letter I received from Women's Health Education Network (WHEN) indicated that they would be supporting RU46 because they were a member group of CARAL. At first I thought the "RU46" was a typing error, but it was used consistently throughout the letter. This is arguably a clear example of groups taking supportive positions based on insufficient information.

88 "For" by Janet Callum, "Against" by Renate Klein, Lynette Dumble, and Janice Raymond, "RU-486: A Dialogue," *The Network News*, September/October 1992, 1-8.

89 "RU 486: Yes/No," *Ms Magazine*, March/April 1993 41-46

90 This interview participant chose to remain anonymous regarding this particular comment

91 St Cerny Interview.

92 Scott Feschuk, "Alberta may stop funding abortions," *The Globe and Mail*, 20 July 1995, A1/A2. British Columbia attempted to drop abortion funding in 1988, and in 1991 Saskatchewan residents voted in a non-binding plebiscite against abortion funding from medicare. More recently Alberta has taken steps towards stopping provincial funding for abortions. Premier Ralph Klein will be holding a free caucus vote on the issue during July 1995.

93 Helen Bequaert Holmes, ed., "Preface," in *Issues in Reproductive Technology* (New York: New York University Press, 1992), X

94 Anne Pappert, "A voice for infertile women," in Renate Klein, ed., *Infertility* (Sydney: Pandora, 1989), 199

95 St Cerny Interview

96.Canadian Advisory Council on the Status of Women (CACSW), *Brief to the Royal Commission on New Reproductive Technologies*, Ottawa, March 1991, 31

97 Ibid.

98.Ibid

99.It has not been possible to discuss this finding with any of the staff of the Advisory Council, in light of its recent government closure.

100 National Action Committee on the Status of Women (NAC), "The New Reproductive Technologies: A Technological Handmaid's Tale - a Brief submitted to the Royal Commission on New Reproductive Technologies", reproduced in *Issues in Reproductive and Genetic Engineering* (1991) 4(3):288.

101.At this time, NAC's Health Committee is not functioning, and NAC itself has not taken any steps to publicly explain this apparent contradiction. Perhaps this is a further indication of the feminist reluctance to critique RU 486/PG

CONCLUSION ENDNOTES

1. Rebecca Wigod, "No-surgery abortions soon to be available," *Vancouver Sun*, 18 February 1994, B4.
2. Toronto Women's Health Network, *Newsletter*, June 1995, 5.
3. Janice Raymond, *Women as Wombs*, 103.

BIBLIOGRAPHY

PRIMARY SOURCES

(1) INTERVIEWS

Bastien, Ginnette and Karol O'Brien, CSF. Interview by author, 17 March 1995, Montréal. Tape Recording.

Boscoe, Madeline, WHC. Interview by author, 18 February 1995, Ottawa. Tape Recording.

Clement, Connie. Interview by author, 20 February 1995, Toronto. Tape Recording.

Gottlieb, Amy, Editor of the *Pro-Choice News*. Interview by author, 20 February 1995, Toronto. Tape Recording.

Johnson, Bonnie, President of PPFC. Interview by author, 16 February 1995, Ottawa. Tape Recording.

Kidd, Caroline, Ontario Medical Association (Toronto). Personal communication with author, 25 May 1994, Ottawa.

LeRougetel, Amanda, President of CARAL (Winnipeg). Interview by author, 16 March 1995, Ottawa. Tape Recording.

St.Cerny, Anne, FQPN. Interview by author, 17 March 1995, Montréal. Tape Recording.

(2) LETTERS

Canadian Advisory Council on the Status of Women, Ottawa, Letter to Benoit Bouchard, Minister of Health and Welfare, Ottawa, 6 November 1992.

Catholic Health Association of Canada, Ottawa, Letter to Donald Buxton of Roussel Canada Inc., 4 May 1994.

Cook, Sue, WHAC, Regina, Letter to the author, Ottawa, no date.

DeMarco, Carolyn, M.D., Winlaw, BC, Letter to the author, Ottawa, 18 December 1994.

Israel, Pat, DAWN (Ontario), Toronto, Letter to the author, Ottawa, 4 August 1994.

Martell, Catherine, Vancouver Women's NRT Coalition, Vancouver, Letter to the author,

Ottawa, 16 December 1994.

Masui, Wendy, Information Centre Co-ordinator, VWHC, Letter to the author, Ottawa, 31 October 1994.

McCunn, Monica, CWHN, Westville, Nova Scotia, Letter to the author, Ottawa, 10 October 1994.

Purdy, Darla, WHEN, Dearborn, Nova Scotia, Letter to the author, Ottawa, 10 October 1994.

Scarborough, Norma, CARAL, Letter to the Editor of *The Globe and Mail*, Toronto, 22 August 1992. Unpublished.

Scarborough, Norma, CARAL, Letter to the Editor of *The Globe and Mail*, Toronto, 14 September 1993. Unpublished.

Schofield, WHPN, Victoria, Letter to the author, Ottawa, 7 October 1994.

Smith, Margaret, EHF, Saskatoon, Letter to the author, Ottawa, 17 December 1994.

(3) BRIEFS, POLICIES, POSITIONS, PAPERS

Alliance For Life. *RU 486 - Questions Asked About RU-486*. No date.

Canadian Abortion Rights Action League. *Brief Presented to The Royal Commission on New Reproductive Technologies*, 17 October 1990.

Canadian Abortion Rights Action League. *Brief to the Standing Committee on Legal and Constitutional Affairs*, December 1990.

Canadian Advisory Council on the Status of Women. *Brief to The Royal Commission on New Reproductive Technologies*, March 1991.

Canadian Advisory Council on the Status of Women. *Ten Years Later*, Ottawa 1979.

Canadian Pharmaceutical Association. *Drug Brief - Mifepristone (RU 486) "A Politically Offensive Drug."* 18 November 1992.

Catholic Women's League of Canada. *Submission Made to the Legislative Committee on Bill C-43, "An Act Respecting Abortion,"* 13 March 1990.

Childbirth by Choice Trust. *"RU 486: the "abortion pill,"* CBCT, 1992.

Childbirth by Choice Trust. *"RU 486: the "abortion pill,"* CBCT, 1993.

Fédération des Planning des Naissances du Québec. *RU-486/prostaglandine - mise à jour*, 14 juillet 1993.

Feminist Majority Foundation. *Reports on RU 486: Highlights*, (No publication information available).

Health Action International (Europe) and Women's Health Action Foundation. *Immunological Contraceptives, Designed for Populations Not People*, May 1994.

Le Regroupement des centre de santé des femmes du Québec. *Le RU 486 et Prostaglandines: On l'appelle 'Pilule Abortive', On la qualifie de 'Propriete Morale des Femmes', On la nomme 'Cocktail Chimique'*, nd.

National Action Committee on the Status of Women. 1991 Resolution, Number 500.40.1/91.

Ontario Coalition for Abortion Clinics. *Brief to The Royal Commission on the New Reproductive Technologies*, May 1991.

Ontario Coalition for Abortion Clinics. *Guiding Principles of Reproductive Health Care*, nd.

Ontario Coalition for Abortion Clinics. *The Way Forward for Abortion and Reproductive Health Care: OCAC Response to the Proposed Women's Health Centres*, January 1988.

Papers of the Toronto Women's Caucus, Records in the Canadian Women's Movement Archives Collection, Morisset Library Special Collections, University of Ottawa. Collection Name: Toronto Women's Caucus.

Papers of the Vancouver Women's Health Collective, Records in the Canadian Women's Movement Archives Collection, Morisset Library Special Collections, University of Ottawa. Collection Name: Vancouver Women's Health Collective.

REAL Women of Canada. "Abortion and the Abortion Pill RU 486." *REAL Women of Canada Position Papers*, Ottawa, nd, 57-62.

Royal Commission on the Status of Women, Ottawa, 1970.

"RU-486 Action Appeal," CARAL, nd.

RU 486. The New French Pill. New technologies/new choices. Reproductive Health

Technologies Project, Washington D.C., unpublished report, nd.

SERENA. *SERENA Canada - Historical Highlights*. Ottawa, 1994.

The Federation of Medical Women of Canada. Press Release: "The Federation of Medical Women of Canada Supports the Legal Availability of RU-486 in Canada," 11 March 1993.

The Population Council. Press Release: "The Population Council Announces Receipt of Mifepristone (RU 486) Rights from Roussel Uclaf for the United States," 16 May 1994.

The Society of Obstetricians and Gynaecologists of Canada. Policy Statement: SOGC RESOLUTION REGARDING RU-486, 10 November 1992.

Toronto Women's Health Network. *Newsletter*, October 1994.

Winnipeg Consultation Organizing Committee. *The Strength of Links: Building the Canadian Women's Health Network*. Winnipeg, 1994.

Women's Health Clinic. General Manual Policy: RU-486, 3 June 1991.

(4) LEGAL CITATIONS

Criminal Code, R.S.C. 1979, c. C-34.

R v. Morgentaler, [1988], 1 S.C.R. 30.

Roe v. Wade, 410 U.S. 113 (1973).

(5) NEWSPAPERS AND PERIODICALS

"Abortion Drug and HIV." *The Globe and Mail*, 15 April 1995, D8.

"Abortion pill also effective morning-after contraceptive." *The Globe and Mail*, 8 October 1992, A7.

"Abortion pill curbs male fertility." *Vancouver Sun*, 20 January 1994, A14.

"Abortion pill may battle brain tumors." *Science News*, 143(16) (April 1993), 255.

"Abortion pill might lead to male contraceptive." *Montreal Gazette*, 14 December 1993, A2.

"Abortion pill offered." *Maclean's*, 28 February 1994, 33.

- "Abortion pill research hindered, expert says." *The Globe and Mail*, 29 September 1994, A1.
- "Abortion pill trial gets 'extremely favorable' rating." *The Medical Post*, 12 March 1991, 44.
- Adamson, Nancy, and Susan Prentice. "Toward a Broader Strategy for Choice." *Cayenne*, May/June 1985, 3-8.
- "A Different Approach to Women's Health: Montreal Women's Health Centre." *Communiqu'ELLES*, January 1989, 5-8.
- Alvarado, Donna. "Abortion pill now a legal issue." *Calgary Herald*, 17 July 1992, B9.
- Baulieu, Etienne-Emile. "Contragestion and other clinical applications of RU 486, an antiprogesterone at the receptor." *Science* 245 (1988), 128.
- "B.C. doctor tests new abortion method." *Calgary Herald*, 18 February 1994, A13.
- Black, Dawn. "Withholding the abortion pill makes no sense." *The Globe and Mail*, August 18, 1992, np.
- Black, Debra. "Supporters demand abortion pill in Canada." *Toronto Star*, 24 July 1992, np.
- Black, Debra. "The abortion pill." *Toronto Star*, 6 November 1988, B1.
- Blankenstein, M.A., J.W. Va't Verlaat, and R.J.M. Croughsm. "Hormone dependency of meningiomas." *The Lancet*, (1989), 1381-1382.
- Brand, Johanna. "Health Carelessness and the Plight of Immigrant Women." *Healthsharing*, 14(1) (Spring/Summer 1993), 14-16.
- "Breast-cancer test called way to open door for abortion pill." *Vancouver Sun*, 28 April 1992, A7.
- Brown, Beverly. "International Congress Studies Women's Health." *Communiqu'ELLES*, 16(1) (January 1989), 13-14.
- Burger, W. and R. Marshall. "Battle of the abortion pill. An international outcry blocks a new French drug - but only temporarily." *Newsweek*, 7 November 1989, 8-9.
- Burnet, Anne. "Why not here? The Abortion Pill RU 486." *The Womanist*, 3(2) (Fall 1992), 21.

- Byfield, Virginia. "Checking on France's 'killer pill'." *Alberta Report*, 9 October 1989, 35.
- Callum, Janet. "RU-486 and Early Termination Abortion." *Pro-Choice News*, Spring 1992, 1/2.
- "Canada touted as test ground for abortion-inducing drug." *Winnipeg Free Press*, 24 July 1988, 5.
- "Canadian testing of RU-486 urged." *Pandora*, 5(2) (January 1990), 10.
- "Canadian Women Await RU-486 Revolutionary Abortion Pill." *Humanist in Canada*, Fall 1989, 9.
- Chow, Wyng. "30 abortion foes demonstrate against controversial French pill." *Vancouver Sun*, 22 June 1993, B3.
- Clement, Connic. "The Case for Lay Abortion." *Healthsharing*, 5(1) (Winter 1983), 9-14.
- Cole, Susan. "The Real Abortion Issue." *This Magazine*, 17(2) (June 1983), 4-8.
- Conn, Melanie, and Rebecca Fox. "Undoing Medical Conditioning." *Healthsharing*, 1(4) (Fall 1980), 10-12.
- "Controversial abortion drug to be tested in United States." *The Globe and Mail*, 17 May 1994, A10.
- Cook, Rebecca. Commentary: 'The moral property of women'?" *People*, 17(3) (1990), 12.
- Corbett, Patricia. "Pill Talk: Voices from a French Abortion Clinic." *LEAR'S*, January 1993, 82-83.
- Cottingham, Jane, and Paul Van Look. "RU 486: Misconceptions, Myths and Morals: A Critique." *Pro-Choice News*, Winter 1992, 8/3.
- Coucherne, M. "RU 486: The New Abortion Pill." *The Optimist*, 18(3) (September 1992), 18.
- Crawford, Kelly. "Women Must Control Their Own Bodies." *Common Ground*, 11(4) (August 1992), 5-6.
- Crenson, Matt. "RU 486 'far more' than abortion pill." *Calgary Herald*, 4 September 1993, B6.

- "Dealing With Liberated Female Patients." *The Other Woman*, 2(2) (Nov/Dec. 1973), 4.
- DeFao, Janine. "Feminist Foundation gets \$10 million gift." *Vancouver Sun*, 14 October 1991, A22.
- "Doctors endorse 'safe' abortion pill." *Calgary Herald*, 25 November 1989, K3.
- Dunn, Kate. "Make abortion pill available in Canada: counsellors." *Montreal Gazette*, 8 November 1989, B4.
- Egan, Carolyn. "The Right To Choose." *Our Times*, June 1985, 30-32.
- Emson M.D., Harry. "Ru-486 shouted down by the loud voice of the minority." *The Medical Post*, 25 January 1994, 8.
- Ferguson, Derek. "Ontario endorses abortion pill tests." *Toronto Star*, 21 July 1992, A3.
- Feschuk, Scott. "Alberta may stop funding abortions." *The Globe and Mail*, 20 July 1995, A1/A2.
- "For the Morning After." *Cosmopolitan*, August 1995, 46.
- "France confirms death from abortion pill." *Montreal Gazette*, 9 April 1991, F7.
- Gilbert, Terry. "Pill induces abortion hangover." *Calgary Herald*, 14 October 1990, F1.
- Goodman, Ellen. "RU-486 will transform abortion - and the abortion debate." *Vancouver Sun*, 4 November 1988, np.
- Gottlieb, Amy. "An Interview with Henry Morgentaler." *Pro-Choice News*, Spring 1992, 6-7.
- Gottlieb, Amy. "Saying Good-bye to Healthsharing." *Canadian Woman Studies*, Summer 1994, 117-118
- "Greater use of abortion pill urged." *Halifax Chronicle Herald*, 11 November 1989, A5.
- Hamazaki, Terrie. "Abortion Pill" now on the scene." *Kinesis*, December/January 1989, 7.
- Harper, Tim. "Ottawa won't ease way for French abortion pill." *Toronto Star*, 22 July 1992, A1/A22.
- Harrower, Vivian. "More Choices for Pro-Choicers." *Broadside*, October 1983, 14.

- Healthsharing Collective. "Notes from the Collective." *Healthsharing*, 1(1) (Fall 1979), 2-3.
- Hilts, Philip. "When Medical Reliability Adds Political Sensitivity." *The New York Times*, 17 May 1994, A16.
- Hister, Art, M.D. "Abortion In A Bottle." *Alberta Living*, April 1993, 1-3.
- Hobel, John. "Abortion pill stirs up controversy." *Hospital News* (Toronto and Region), September 1992, 5.
- Holmwood, Kit. "The Broader Ramifications of Choice." *Pro-Choice News*, Spring 1991, 3.
- Holmwood, Kit. "Will Canada be Next for RU-486." *Pro-Choice News*, Spring 1992, 3.
- Hustak, Alan. "Legal Vacuum could ease the way for abortion pill in Canada." *The Montreal Gazette*, 30 September 1988, A1.
- Ince, Susan. "The Trouble with RU 486." *Vogue*, July 1991, 88-90.
- Krieger, Lisa. "Inexpensive drugs already available can end pregnancy." *The Globe and Mail*, 20 October 1993, A12.
- Krier, Beth Ann. "RU-486: the 'dream' pill." *Vancouver Sun*, 26 May 1990, A14.
- Labris, Ellen. "Women & Medicine: The Problem and The Alternative." *The Other Woman*, 2(6) (July 1974), 16-17.
- Landsberg, Michele. "Ottawa's hypocrisy is delaying abortion pill." *Toronto Star*, 28 July 1992, np.
- Lafave, Bonnie. "Who's In Control?" *Healthsharing*, 9(4) (Fall 1988), 29-31.
- "Law may permit abortion pill to be sold here." *Toronto Star*, 30 September 1988, A1.
- LeRougetel, Amanda. "RU486 Or Are You Against It?" *Herizons*, Spring 1992, 21-23.
- Lewin, Tamara. "British Offering Abortion Drug to U.S. Women." *The New York Times* (National), 18 February 1994, A1.
- Lim, B.H. et al. "Development After Exposure to Mifepristone in Early Pregnancy." *Lancet*, 338, (1991), 257-258.

- Livingstone, Barb. "Abortion pill on horizon." *Calgary Herald*, 23 July 1988, F10.
- Livingstone, Barb. "Abortion drug sale forseen." *Calgary Herald*, 23 July 1988, A1/A2.
- Lloyd, Leonora. "What is happening about RU 486?" *Women's Choice* (UK), Spring 1993, 2-6.
- Love, Rhonda. "The Power of Science and Medicine." *Healthsharing*, 2(1) (Spring 1981), 9-12.
- MacDonald, Annette. "RU-486: a dangerous drug." *Vancouver Sun*, 18 September 1992, A23.
- Mackie, Richard. "Lankin wants abortion pill in Canada." *The Globe and Mail*, 21 July 1992, np.
- Mackie, Richard. "Public-opinion poll results fuel fight for abortion pill." *The Globe and Mail*, 22 July 1992, np.
- Majury, Diana and Connie Clement. "Interview: Visions for Women's Reproductive Care." *Healthsharing*, 9(2) (Spring 1988), 18-22.
- Mathorne, Jacquie. "The Medicalization of Women's Lives." *Communiqu'ELLES*, 13(4) (1987), 4-7.
- McDonnell, Kathleen. "The Women's Health Movement in Canada: New Directions." *Canadian Dimension*, 13(7) (May 1979), 30-32.
- McGovern, Celeste. "Canadians raise a clamour for France's abortion pill." *Alberta Report*, 19(34) (August 1992), 37.
- McIlroy, Anne. "Women find 'in control' aspect a big plus for abortion pill." *Vancouver Sun*, 20 November 1992, C2.
- McInnes, Craig. "B.C. to curb abortion focs." *The Globe and Mail*, 20 June 1995, A1.
- McKenzie, Robyn. "Why Do Women Need Medical Knowledge and Health Advocates?" *Vitality*, 11(3) (Fall 1989), 8-9.
- "Mds urge pressure for abortion pill." *Winnipeg Free Press*, 6 June 1993, A3.
- Mellor, Clare. "Moody not lobbying for abortion pill." *Halifax Chronicle Herald*, 23 July 1992, A7.

- "Mifepristone: widening the choice for women." *Lancet*, 4 November 1989, 1113.
- Mills, Chris. "Strategy for Choice: An Interview with Judy Rebick." *Cayenne*, February 1985, 22-28.
- Mintzes, Barbara. "Through the Medical Maze." *Healthsharing*, 8(4) (Fall 1987), 17-20.
- Montreal Women's Health Clinic. "A Different Approach To Women's Health." *Communiqu'ELLES*, 16(1) (January 1989), 5-8.
- "Morgentaler Decision: Who Controls What?" *Broadside*, 6(3) (December 1984/January 1985), 2.
- Morrissey, Deborah. "Canadians behind in birth control options." *Hospital News*, August 1993, 5.
- Moysa, Marilyn. "Male contraceptive vaccine 'on the way'." *Ottawa Citizen*, 1 October 1994, A2.
- "Most Canadians support sale of abortion pill, drug firm claims." *Montreal Gazette*, 3 November 1988, B1.
- National Women's Health Network. "RU 486: A Dialogue: with Janet Callum, Renate Klein, Lynette Dumble and Janice Raymond." *The Network News*, September/October 1992, 1-8.
- National Women's Health Resource Center. *Contraception: Issues and Options. National Women's Health Report*, 16(5) (July/August 1994).
- Nolen, Stephanie. "RU-486 stirs up abortion debate." *The Globe and Mail*, 13 September 1993, A7.
- Palmer, Hazelle. "Byllye Avery speaks about black women's health." *Healthsharing*, 12(3) (Fall 1991), 7.
- Paul, Alexandra. "Abortion pill no cancer drug, group says." *Winnipeg Free Press*, 15 December 1991, B13.
- Paul, Alexandra. "Group fears Canada next as market for abortion pills." *Winnipeg Free Press*, 27 April 1992, B17.
- "Politics and pills." *Toronto Star*, 19 October 1992, np.
- Pons, J.C. et al. "Development After Exposure to Mifepristone in Early Pregnancy."

Lancet, 338 (1991), 763.

"Pressure Mounting for RU 486." *Pro-Choice News*, Winter 1992, 1.

"Public outcry forces firm to postpone abortion pill." *Montreal Gazette*, 27 October 1988, A13.

Ranalli, Paul. "The appalling ordeal of abortion by pill." *The Globe and Mail*, 28 August 1992, A17.

Raymond, Janice, et al. "RU 486: Yes/No." *Ms. Magazine*, March/April 1993, 34-37.

Raymond, Janice. "Side-effects." *Montreal Gazette*, 17 April 1993, B6.

Regush, Nicholas. "Abortion pill won't be sold in Canada until fetus issue settled: drug firm." *Montreal Gazette*, 29 October 1988, A4.

Rennie, Susan. "Breast Cancer Prevention: Diet vs. Drugs." *Ms. Magazine*, 3(6) (1993), 38-46.

Rex, Kathleen. "Group formed to support legal abortion." *The Other Woman* 1(6) (July/August 1973), 22.

Ruby, Clayton. "Clayton Ruby explains why the abortion pill won't be coming to Canada." *The Globe and Mail*, 28 August 1992, np.

"RU 486 and Blood Loss." *OUTLOOK*, December 1989, 7-8.

"RU 486 could abort brain tumor growth." *The Medical Post*, 20 April 1993, np.

"RU-486 shouted down by the loud voice of the minority." *The Medical Post*, 25 January 1994, 8.

"RU-486: We need this choice now!" *Pro-Choice News*, Summer 1991, 1 & 3.

Ryan, Beth. "Canadian women wait for revolutionary drug: RU486 - the abortion pill." *The Womanist*, December 1988, 10.

"Safety wins abortion pill Mds' favor." *Montreal Gazette*, 29 November 1989, D11

Sanger, Daniel. "Abortion pill being secretly used." *Kingston Whig-Standard*, 30 May 1994, np.

Schrof, Joannie. "Reproduction showdown." *U.S. News & World Report*, 114(11) (March

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PM-1 3 1/2" x 4" PHOTOGRAPHIC MICROCOPY TARGET
NBS 1010a ANSI/ISO #2 EQUIVALENT

PRECISIONSM RESOLUTION TARGETS

1993), 32-33.

Schrof, Joannie. "Will The Abortion Pill Remain Banned?" *U.S. News & World Report*, 115(25) (December January 1994), 78-79.

"Scientists rally against abortion pill ban." *Toronto Star*, 28 October 1988, A1.

Seelye, Katherine Q. "Accord Opens Way For Abortion Pill in U.S. in 2 Years." *The New York Times*, 17 May 1994, A1/A16.

Seiden, Dr. Howard. "Morning-after pill RU 486 should not be blocked." *Montreal Gazette*, 31 October 1992, L5.

Seligmann, Jean, et als. "The Long Tug of War Over RU 486." *Newsweek*, 122(21) (November 1993), 53.

Scott, Grace. "The Real History". *The Pedestal* reprinted in *The Other Woman*, 4(1), pull-out.

Sharma, Ashok. "India works on reversible sterilization for men." *The Ottawa Citizen*, 13 June 1995, A14.

Sheppard, Robert. "Abortion pill: too late to turn back clock." *The Globe and Mail*, 22 July 1992, A13.

Silvera, Makeda. "Black Women Organize for Health." *Healthsharing*, 5(2) (Spring 1984), 19-22.

Spears, Tom. "Scientist says chemicals block human reproduction." *Ottawa Citizen*, 22 June 1994, 22.

Stockwood, Krishna. "Practical Pill: RU 486 as a morning-after pill." *Montreal Mirror*, 29 October 1992, 8.

"Sweden to start tests on pill." *Calgary Herald*, 13 August 1990, A7.

Taylor, Paul. "Abortion pill may be tried on cancer." *The Globe and Mail*, 6 December 1991, A8.

Taylor, Paul. "'Abortion pill' safe, French study shows." *The Globe and Mail*, 9 March 1990, np.

Taylor, Paul. "Breakthrough that can't get started." *The Globe and Mail*, 2 February 1991, D10.

- Tempest, Rone. "50 000 French women choose drug." *Vancouver Sun*, 13 August 1990, A1/A8.
- "The Abortion pill: a question of choice." *The Globe and Mail*, 9 October 1992, A28.
- "The Abortion Pill." *Toronto Star*, 20 January 1992, A16.
- The Boston Women's Health Book Collective. "When Yogurt Was Illegal." *Ms. Magazine*, July/August 1992, 38-40.
- "The Day after: Rethinking RU 486." *Time*, 141(10) (March 1993), 20.
- Ihobani, Sunera. "In Whose Interest." *Healthsharing*, 12(3) (Fall 1991), 15-18.
- Ihompson, Allan. "Apotex seeks right to copy French abortion pill." *Toronto Star*, 29 July 1992, F3.
- Lien, Homer. "Abortion: bitter pill for a physician." *The Globe and Mail*, 10 September 1992, A24.
- Toufexis, Anastasia. "Battle over the Abortion Pill." *Time*, 136(6) August 1990), 40.
- Toufexis, Anastasia. "Abortions Without Doctors." *Time*, 134(9) (August 1989), 50.
- Tudiver, Sari. "Norplant, Why the rush to approve?" *Womanly Times*, Winter 1994, 1-5.
- "UK clears abortion drug RU 486." *Vancouver Sun*, 4 July 1991, A3.
- Ulmann, Andre, George Teutsch, and Daniel Philibert. "RU 486." *Scientific American: Medicine - Special Issue*, 1993, 38-44.
- "Unapproved abortion pill used here." *The Ottawa Sun*, 30 May 1994, 4.
- Valverde, Clara, and Connie Clement. "Nurturing Politics and Health: Centre de Sante des Femmes du Quartier." *Healthsharing*, 1(1) (Fall 1979), 15-17.
- Walsh, Heidi. "RU 486: stops, starts and uncertainties." *Kinesis*, May 1991, 12-13.
- "Women as Healers." *The Other Woman*, 1(4), 12.
- Women Healthsharing. "Visions For Reproductive Care: Interview with Two Health Activists." *Healthsharing*, 9(2) (Spring 1988), 30-32.
- "Women's Health Centre: Our Bodies And Our Creative Potential." *The Other Woman*,

3(2) (Fall 1974). 18-20.

Wigod, Rebecca. "Doctor seeks women to test abortion drug." *Vancouver Sun*, 9 June 1994, A1/A2.

Wigod, Rebecca. "No-surgery abortions soon to be available." *Vancouver Sun*, 18 February 1994, B3.

Wigod, Rebecca. "Pro-lifers object to drug being used for abortions." *Vancouver Sun*, 13 June 1994, B4.

Wright, Karen. "Hard to Swallow." *Discover*, 12(1) (January 1991), 86-87.

Zaremba, Eve. "Choice Is Not Enough." *Broadside*, 6(4) (February 1985), 11.

SECONDARY SOURCES

Adamson, Nancy, Linda Briskin, Margaret McPhail. *Feminist Organizing for Change*. Toronto: Oxford University Press, 1988.

Backhouse, Constance. "Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada." *The Windsor Yearbook Access to Justice*, 3 (1983), 61-130.

Backhouse, Constance. *Petticoats & Prejudice*. Toronto: Women's Press, 1991.

Baraldi, Rosanna. "The Evaluation of Pharmaceutical Products: Problems of Phase IV." In Gwynne Basen, Margrit Eichler and Abby Lippman, eds., *Misconceptions* (Volume 2). Prescott, Ontario: Voyageur, 1994, 71-78.

Bart, Pauline. "Seizing the Means of Reproduction: An Illegal Feminist Abortion Collective - How and Why it Worked." *Qualitative Sociology*, 10(4), 339-357.

Bastien, Ginette. "L'avortement chimique: réflexions d'une résistante." *Canadian Woman Studies*, 14(3) (1994), 101-104.

Baulieu, E.E. "Contraception with RU 486: A new approach to postovulatory fertility control." *Acta Obstetrica et Gynecologica Scandinavica Supplement*, 149, 5-8.

Baulieu, E.E. "RU 486 as an Antiprogesterone Steroid. From Receptor to Contraception and Beyond." *Journal of the American Medical Association*, 262(13), 1989, 1808-14.

Beck-Gernsheim, Elisabeth. "From the Pill to Test-Tube Babies: New Options. New

- Pressures in Reproductive Behaviour." In Kathryn Strother Ratcliff, ed., *Healing Technology*. Michigan: University of Michigan, 1989, 23-40.
- Berer, Marge. "Inducing a Miscarriage: RU 486 and Prostaglandin for Early Abortion." In Helen Bequaert Holmes, ed., *Issues in Reproductive Technology*. New York: Garland Publishing, 1992, 123-143.
- Bertagna X, et al. "Pituitary-adrenal response to the antiglucocorticoid action of RU 486 in Cushing's Syndrome." *Journal of Clinical Endocrinology and Metabolism*, 63 (1986), 639-643.
- Bequaert Holmes, Helen, ed. *Issues in Reproductive Technology*. New York: New York University Press, 1992.
- Bodeur, Violette et al, eds. *Le Mouvement Des Femmes Au Québec - étude des groupes montréalais et nationaux*. Montréal: Composition Solidaire, 1982.
- Bodnar, Ana. "Immigrant Women's Health." In Kathleen McDonnell and Mariana Valverde, eds., *The Healthsharing Book*. Toronto: The Women's Press, 1985, 144-146.
- Bolaria, B. Singh, and Rosemary Bolaria, eds., *Women, Medicine and Health*. Halifax: Fernwood Publishing, 1994.
- Breen, Mary J. "Poverty and Ill Health." In Kathleen McDonnell and Mariana Valverde, eds., *The Healthsharing Book*. Toronto: The Women's Press, 1985, 150-153.
- Brodie, Janine, Shelley Gavigan, and Jane Jenson. *The Politics of Abortion*. Toronto: Oxford University Press, 1992.
- Bugalho, Antonio, et als. "The Effectiveness of Intravaginal Misoprostol (Cytotec) in Inducing Abortion after Eleven Weeks of Pregnancy." *Studies in Family Planning*, 24(5) (1993), 319-323.
- Chalker, Rebecca and Carol Downer. *A Woman's Book of Choices*. New York: Four Walls Eight Windows, 1992.
- Cherniak, Donna and Allan Feingold. "Birth Control Handbook." In Discussion Collective No. 6 of the Toronto Women's Liberation Movement, eds., *Women Unite*. Toronto: Canadian Women's Educational Press, 1972, 109-113.
- Clarke, Adele, and Theresa Montini. "The Many Faces of RU486: Tales of Situated Knowledge and Technological Contestations". *Science, Technology & Human Values*, 18(1) (Winter 1993), 42-78.

- Clarke, Juanne Nancarrow. *Health, Illness, and Medicine in Canada*. Toronto: McClelland & Stewart, 1990.
- Couzinnet, B. et al. "Late luteal administration of the antiprogestosterone RU 486* in normal women: effects on the menstrual cycle events and fertility control in a long-term study." *Fertility and Sterility*, 54(6) (1990), 1039-1044.
- Davis, Angela. "Racism, Birth Control, and Reproductive Rights." In Marlene Gerber Fried, ed., *From Abortion to Reproductive Freedom*. Boston: South End Press, 1990, 15-26.
- Edwards, Rosalind. "Connecting Method and Epistemology: A White Woman Interviewing Black Women." *Women's Studies Int Forum*, 13(5) (1990), 477-490.
- Ehrenreich, Barbara and Deirdre English. *Witches, Midwives, and Nurses: A History of Women Healers*. New York: Glass Mountain Pamphlets, 1972.
- Femmes en Tête, *de travail et d'espoir*. Montréal: Les Éditions du remue-menage, 1990.
- Findlay, Deborah, and Leslie Miller. "Medical Power and Women's." In B. Singh Bolaria and Rosemary Bolaria, eds., *Women, Medicine and Health*. Halifax: Fernwood, 1994, 115-140.
- Finger, Anne. "Claiming All of Our Bodies: Reproductive Rights and Disability." In Renate Klein, Rita Arditti and Shelley Minden, eds., *Test Tube Women*. Boston: Pandora Press, 1984, 281-297.
- Fulford, Margaret, ed., *1960-1990: A Guide to Archival Resources*. Toronto: ECW Press, 1992.
- Glasier, Anna, et als. "Mifepristone (RU 486) Compared With High-Dose Estrogen and Progesterone For Emergency Postcoital Contraception." *The New England Journal of Medicine*, 327(15) (October 1992), 1041-1044.
- Gossage, Peter. "Absorbing Junior: The Use of Patent Medicines as Abortifacients in Nineteenth Century Montreal." *The Register*, 3(1) (March 1982), 1-13.
- Grimes, David and Rebecca Cook. "Mifepristone (RU 486)-An Abortifacient to Prevent Abortion." *The New England Journal of Medicine*, 327(15) (October 1992), 1088-1089.
- Heard, M. and J. Guillebaud. "Medical abortion. Safe, effective and legal in Britain." *British Medical Journal*, 304 (1992), 195-6.

- Kami, Myriam. "RU 486: la tolerance, nouveau sujet de controverse." *Le Quotidien du Medicin*, 4512 (1990), 9.
- Kekkonen, R. et al. "Interference with Ovulation by Sequential Treatment with the Antiprogesterone RU 486 and Synthetic Progestin." *Fertility and Sterility*, 53 (1990), 747-750.
- Kirby, Sandra, and Kate McKenna. *Experience, Research, and Social Change: Methods From the Margins*. Toronto: Garamond Press, 1989.
- Klitsch, Michael. "Antiprogestins and the Abortion Controversy: A Progress Report." *Family Planning Perspectives*, 23(6) (1991), 275-282.
- Lader, Lawrence. *RU 486 - The Pill That Could End the Abortion Wars and Why American Women Don't Have It*. New York: Addison Wesley, 1991.
- LeGrand, Amanda. "The Abortion Pill: A Solution for Unsafe Abortions in Developing Countries." *Social Science Medicine* 35(6) (1992), 767-776.
- Lévesque, Andrée. *Making and Breaking the Rules*. Toronto: McClelland and Stewart Inc., 1994.
- Lexchin, Joel. "Public Good or Private Profits: Focus on Pharmaceutical Issues." In B. Singh Bolaria and Rosemary Bolaria, eds., *Women, Medicine and Health*. Halifax: Fernwood Publishing, 1994, 39-56.
- Lexchin, Joel. *The Real Pushers: A Critical Analysis of the Canadian Drug Industry*. Vancouver: New Star Books, 1984.
- Luukkainen, T. et al. "Inhibition of Folliculogenesis and Ovulation by the Antiprogesterone RU 486." *Fertility and Sterility*, 49 (1988), 961-963.
- Maillé, Chantal. *The Women's Health Movement in Québec Society: An Analysis for the purpose of the Constitutional Debate*. Alberta: Centre for Constitutional Studies, 1991, 78-80.
- McDonnell, Kathleen. "Claim No Easy Victories: The Fight for Reproductive Rights," in Maureen Fitzgerald, Connie Guberman, Margie Wolfe, eds., *Still Ain't Satisfied*. Toronto: The Women's Press, 1982, 32-42.
- McDonnell, Kathleen. *Not An Easy Choice*. Toronto: The Women's Press, 1984.
- McLaren, Angus. *A History of Contraception*. Oxford: Blackwell, 1990.

- McLaren, Angus. "Birth Control and Abortion in Canada, 1870-1920." *Canadian Historical Review*, 59 (1978), 319-340.
- McLaren, Angus, and Arlene McLaren. *The Bedroom and the State*. Toronto: McClelland and Stewart Inc., 1986.
- Messinis, I.E. and A. Templeton. "The effect of the antiprogesterone mifepristone (RU 486) on maturation and in-vitro fertilization of human oocytes." *British Journal of Obstetrics and Gynaecology*, 95 (June 1988), 592-595.
- Miller, Benjamin F., and Claire Brackmen Keane. *Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health*. Philadelphia: W.B. Saunders Company, 1987.
- Mitchinson, Wendy. "The Medical Treatment of Women." In Sandra Burt, Lorraine Code, Lindsay Dorney, eds., *Changing Patterns*, Second Edition. Toronto: McClelland and Stewart Inc., 1993, 391-421.
- Mitchinson, Wendy. *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada*. Toronto: University of Toronto Press, 1991.
- Mullen, Michelle A., Barbara Slater and Raisa Deber. "Politics, Principles and a Pill: Public Policy, Ethics and RU 486." *Health Law in Canada*, 63-68.
- National Action Committee on the Status of Women. "The New Reproductive Technologies: A Technological Handmaid's Tale - A Brief submitted to The Royal Commission on New Reproductive Technologies." *Issues in Reproductive and Genetic Engineering* 4(3) (1991), 279-296.
- Norsigian, Judy. "RU 486." In Marlene Gerber Fried, ed., *From Abortion to Reproductive Freedom*. Boston: South End Press, 1990, 197-203.
- Pappert, Ann. "A voice for infertile women." In Renate Klein, ed., *Infertility*. Sydney: Pandora Press, 1989, 198-206.
- Pappert, Ann. "The Rise and Fall of the IUD." In Kathleen McDonnell, ed., *Adverse Effects*. Toronto: Women's Press, 1986, 167-172.
- Pelrine, Eleanor Wright. *Abortion In Canada*. Toronto: New Press, 1971.
- Permezel, M. "The antiprogesterone steroid, RU 486 (Mifepristone)." *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 30 (1990), 77-80.
- Peyron, Remi, et als. "Early Termination of Pregnancy with Mifepristone (RU-486) and

- the Orally Active Prostaglandin Misoprostol." *New England Journal of Medicine*, 328(21) (May 1993), 1509-1513.
- Population Action International. *RU 486: A Non-Surgical Method of Abortion*. Questions and Answers. 1993.
- Power, Doris. "Statement to the Abortion Caravan." In Discussion Collective No. 6 of the Toronto Women's Liberation Movement, eds., *Women Unite*. Toronto: Canadian Women's Educational Press, 1972, 121-124.
- Prentice, Alison, et als. *Canadian Women*. Toronto: Harcourt Brace Jovanovich, 1988.
- Ratcliff, Kathryn Strother. "Healing Technologies for Women: Whose Health?" In Kathryn Strother Ratcliff, ed., *Healing Technology: Feminist Perspectives*. Michigan: University of Michigan Press, 1989, 173-198.
- Raymond, Janice, Renate Klein, and Lynette Dumble. *RU 486: Misconceptions, Myths, and Morals*. Massachusetts: Institute on Women and Technology, 1991.
- Raymond, Janice. *Women as Wombs*. New York: Harper Collins, 1993.
- Rebick, Judy. "Is the Issue Choice?" In Gwynne Basen, Margrit Eichler and Abby Lippman, eds., *Misconceptions* (Volume 1). Hull: Voyageur, 1993, 87-89.
- Rodger, M.W., A.F. Logan and D.T. Baird. "Induction of early abortion with mifepristone (RU 486) and two different doses of prostaglandin pessary (gemeprost)." *Contraception*, 39(5)(1989), 497-502.
- Rodger, M.W. and D.T. Baird. "Induction of therapeutic abortion in early pregnancy with mifepristone in combination with prostaglandin pessary." *Lancet* 2 (1987), 1415-8.
- "Round Table on RU 486." *Women's Health Journal*, February 1993, 29-52.
- Ruzek, Sheryl Burt. *The Women's Health Movement*. New York: Praeger, 1978.
- Samuelson, Gary M. "DES, RU-486, and Deja Vu." *Journal of Pharmacy and Law*, 2 (1993), 56-70.
- Silvera, Makeda. "Black Women and Health." In Kathleen McDonnell and Mariana Valverde, eds., *The Healthsharing Book*. Toronto: The Women's Press, 1985, 159-162.
- Silvestre M.D., Louise, et als. "Voluntary Interruption of Pregnancy with Mifepristone (RU 486) And A Prostaglandin Analogue." *The New England Journal of*

- Medicine*, 322(10), 645-648.
- Sitruk-Ware, R. et al. "The use of RU 486 as an abortifacient in early pregnancy." In F.F. Baulieu and S. Segal, eds., *The Antiprogesterin Steroid RU 486 and Human Fertility Control*. New York: Plenum Press, 1985, 247.
- Staggenborg, Suzanne. *The Pro-Choice Movement*. New York: Oxford University Press, 1991.
- The Boston Women's Health Book Collective. *The New Our Bodies, Ourselves*. New York: Touchstone, 1992.
- The UK Multicentre Trial Group. "The efficacy and tolerance of mifepristone and prostaglandin in first trimester termination of pregnancy." *British Journal of Obstetrics and Gynaecology*, 97 (1990), 480-6.
- Vanderwater, Bette. "Meanings and Strategies of Reproductive Control: Current Feminist Approaches to Reproductive Technology." *Issues in Reproductive and Genetic Engineering* 5(3) (1992), 215-230.
- Van Stanten, M.R. and A.A. Haspels. "Interception IV: Failure of mifepristone (RU 486) as a monthly contraceptive, 'Lunarett'." *Contraception*, 35 (1987), 433-439.
- Van Wagner, Vicki, and Bob Lee. "Principles Into Practice: An Activist Vision of Feminist Reproductive Health Care." In Christine Overall, ed., *The Future of Human Reproduction*. Toronto: The Women's Press, 1989, 238-258.
- Weir, Lorna. "Left Popular Politics In Canadian Feminist Abortion Organizing, 1982-1991." *Feminist Studies*, Summer 1994, 249-274.
- Women's Health Interaction. *Ten Years of Caring About Global Justice*. Ottawa: WHI, 1994.
- Women's Health Interaction, *Uncommon Ground*, in publication.
- Yanoshik, Kim and Judy Norsigian. "Contraception, Control, and Choice: International Perspectives." In Kathryn Strother Ratcliff, ed., *Healing Technology*. Michigan: University of Michigan Press, 1989, 61-92.

UNPUBLISHED MATERIALS

- Gavigan, Shelley. *The Abortion Prohibition and the Liability of Women: Historical Development and Future Prospects*. Master of Laws Thesis, York University, Toronto, April 1984.

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