

Beyond Medical Bureaucracy: an Inquiry into Women's Right to Abortion in Italy

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Abstract

Women's right to abortion has been questioned over the past few decades, in tandem with the increasing number of doctors who refuse to perform the procedure in Italian public hospitals. In this paper I argue that even when there is no conscience-based refusal by health professionals, other factors can hinder women's access to legal abortion. My study focuses on three aspects of the medical assistance offered to women who desire or who need to end their pregnancy: (i) the obligation for doctors to provide information and ask for informed consent from patients before the abortion procedure can take place; (ii) the growing presence of men, such as women's partners, during medical consultations related to abortion; and (iii) the growing influence of psychological consultations before and after abortion. Starting from the findings of long-term ethnographic work in Italy, I examine to what extent these elements play a role in therapeutic and non-therapeutic abortion, and according to women's social profile.

Keywords: Abortion; Informed consent; Gender roles; Post-traumatic stress, Italy.

Introduction

Italian law (N. 194/1978) on abortion can be described as a victory for the radical and feminist movements united in the struggle for the deconstruction of the supposed natural connection between being a woman and being a mother (Ortner 1974; Rich 1976; Tabet 1985). The idea promoted by these activists is that sexuality and reproduction have to be understood as separate spheres in women's lives. In pursuit of this goal, they have been trying to build an alliance with doctors as professionals able to provide contraception and ensure safe abortion (Libreria delle donne di Milano 1987). Since the 1970s, the aim of the radical and feminist movements has been

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to overcome the historical antagonism of these specialists, often represented by men, who consider abortion a procedure that goes against the moral principles of the Catholic religion. Like childbirth, until the 1960s abortion mostly occurred outside the hospital setting, and women were generally assisted by midwives (Ehrenreich, English 1973).

Despite political efforts to persuade doctors to give women access to legal abortion, medical trends in Italy show a strong resistance to the normalisation of termination of pregnancy in a hospital setting (De Zordo 2015; De Zordo, Mishtal, Anton 2016). The Council of Europe's Committee of Social Rights denounced this situation in April 2016 after a complaint made in 2013 by the Italian General Confederation of Labour (CGIL, one of the most important Italian leftist trade unions) that underlined how, in some regions, access to legal abortion was nearly impossible for Italian women, as most health providers² refused to carry out this procedure in hospitals. The protection of the right to life for the foetus in voluntary termination of pregnancy and the nexus between therapeutic abortion and eugenic practices are among the discourses promoted by Italian gynaecologists (De Zordo 2015; 2018). As shown by the Italian Ministry of Health, the number of health professionals defending such positions has always been relatively high (59.1% in 1983), but it has particularly increased during the 2000s (70%). Data published by the Italian Ministry of Health in response to European Council criticism show how this phenomenon affects more public hospitals than private clinics, *de facto* restricting women's access to abortion. Furthermore, this trend is not equally distributed in Italian territories: a higher concentration of health professionals object to abortion in the southern regions (over 80%), and a lower concentration of these professionals objects in the northern regions (over 60%).³

In this paper I argue that even when there is no conscience-based refusal by health professionals, other factors can hinder women's access to legal abortion. My study focuses on three aspects of the medical assistance offered to women who desire or who need to end their pregnancy. The first element is the obligation for doctors to provide information and ask for informed consent from patients before the abortion procedure can take place. The

2 This category includes obstetricians-gynaecologists and anaesthesiologists, but also midwives and nurses.

3 According to the statistical data produced by the Italian Ministry of Health, in 2016 13.3% of gynaecologists refused to perform abortions in Valle d'Aosta, 49% in Sardinia, 51.8% in Emilia-Romagna, 56.2% in Tuscany, 58.4% in Friuli Venezia Giulia, 63.6% in Lombardy, 65.4% in Liguria, 65.4% in Umbria, 67.4% in Piedmont, 68.8% in Marche, 72.9% in Calabria, 76.2% in Veneto, 80.7% in Lazio and Abruzzi, 81.8% in Campania, 86.1% in Apulia, 87.6% in Sicily, 90.2% in Basilicata, 92.9% in Trentino Alto Adige, and 93.3% in Molise. See http://www.salute.gov.it/imgs/C_17_pubblicazioni_2686_allegato.pdf

second element is the growing presence of men, such as women's partners, during medical consultations related to abortion. The third element is the growing influence of psychological consultations before and after abortion. The overarching aim is to examine to what extent these elements play a role in therapeutic and non-therapeutic abortion, and according to women's social profile.

Data and methods

The analysis I propose is based on the findings of ethnographic work carried out in 2015 at a maternity hospital in Turin, the capital of Piedmont region, in the north of Italy.⁴ In 2007 this hospital, which has been historically engaged in undertaking abortions, supported 32% of abortion requests in Piedmont. In the last ten years, this trend has increased to 47% (+15%). In 2016, the hospital provided care for 76.4% of abortion requests in Turin province and 87.4% in the city of Turin. This hospital was also one of the first in Italy to introduce alternative abortion methods, such as pharmacological abortion instead of surgery within the second month of pregnancy and the use of local instead of general anaesthesia during abortion surgery after the second month of pregnancy.

The population of women assisted is mixed and strongly stratified. A first population is composed of Italian women who mostly belong to the upper classes. Such a population corresponds to 45% of patients assisted in the maternity hospital. A second population, corresponding to 40%, is composed of Italian patients from the working class. This category refers both to women from Turin and to women from southern regions. Members of this second group often choose a northern Italian hospital for abortion, as they cannot find gynaecologists willing to perform this procedure in the south.⁵ A third population, corresponding to 15% of patients, is composed of migrant women from Maghreb (Morocco and Tunisia), West Africa (Mali and Senegal), Eastern Europe (Romania, Ukraine, Russia) and South America (Mexico and Peru). This population has increased since the 1990s.

In my research I mostly used qualitative methodologies, such as partic-

4 The Fundamental Rights Centre of Turin funded this research, entitled 'Informed Consent, Health Democracy and Social Inequalities'. This anthropological and juridical study was carried out between 2014 and 2016 by the author of this article and the jurist Camilla Fin. For more information on this study, see Quagliariello, C., Fin, C., eds. (2016), *Il consenso informato in ambito medico. Un'indagine antropologica e giuridica*, Bologna, Il Mulino.

5 This is also related to the migratory flows that have occurred since the 1960s from the south to the north of Italy, where people from the south became blue-collar workers in the main production areas of northern Italy, such as Turin.

ipant observation during doctor-patient interactions. Over the course of four months I attended 25 medical consultations and 7 psychological consultations related to both therapeutic and non-therapeutic abortion. My participation in medical and psychological consultations always took place after I received positive consent from the patients and the medical staff. The influence of the researcher's presence on the interactions observed is a methodological matter well known to anthropologists (Althabe, Hernandez 2004; Olivier de Sardan 2008). The attempt to occupy a halfway position (for example choosing to sit at the side of the table during doctor-patient interactions) was not sufficient to allow the researcher to play a simple role as a spectator. The relationship of trust built up with the medical personnel led to a progressive tendency to ask the researcher's opinion on the situations observed. Furthermore, the awareness of being able to influence medical consultations through body language and gestures, such as something as small as a smile or an expression of discomfort during the communication of bad news, requires a particular ability in using the researcher's body in as neutral a manner as possible.

During my research work I conducted 21 semi-structured interviews, 8 with health providers (gynaecologists, anaesthesiologists and psychologists) and 13 with patients. The gynaecologists I interviewed were composed of three men and two women. The anaesthesiologist I met was a man and the two psychologists both women. The patients I interviewed were between 23 and 40 years old. Seven had a high level of education (a university degree). Four of them had a lower level of education (a high school diploma). Two of them were non-Italian: one was from Senegal, with a lower level of education (middle school), and the other from Morocco, with a high level of education (a university degree). Both women were Muslim. Interviews with health professionals took place within the hospital space (medical rooms, meeting rooms, the canteen, or in hospital corridors), while the interviews with the women were undertaken outside the hospital setting (at their houses, in public bars, or at the park). During the interviews with women, partners were not included. This methodological choice aimed to make the women feel more comfortable while collecting their personal point of view on abortion. For reasons related to the privacy law, psychological reports were not included in the research work.

Data collected have been analysed via several anthropological and sociological theories. The bio-political approach (Foucault 1976; Fassin 1996; Memmi 2003, 2014) has been used for reflecting on the characteristics of doctor-patient interactions concerning abortion. Medical anthropology and medical sociology theories (Corrigan 2003; Dixon-Woods *et al.* 2006; Fainzang 2006; Marzano 2004; Mol 2008) have questioned the extent to which informed consent systems increase how informed and autonomous women are when making reproductive choices. Sociological and anthropo-

logical theories on stigmatization of women who ask to end their pregnancy in Catholic countries (De Zordo 2016, 2018; De Zordo, Mishtal, Anton 2016) were used to stress the moral dimension still associated with abortion. Finally, intersectionality theories (Crenshaw 1991; Bridges 2011) have been used for analysing how gender, class and foreign origin of women influence medical consultations related to therapeutic and non-therapeutic abortion.

Informed consent and women's right to choose

As anthropological and sociological theories point out (Corrigan 2003; Edozien 2015; Felt 2009; Mol 2008), the main purpose of informed consent – a procedure introduced in Italy in the early 2000s – is the implementation of the right to choose. Unlike in the past, when doctors decided on the best treatment for patients without consulting them, doctors operating under the informed consent system have to advise patients about the treatment they propose to perform and other medical options. On his/her side the patient has the right to accept, reject or negotiate the models of care suggested by doctors. In other words, he/she becomes the first person entitled to decide how to manage personal health issues according to his/her needs, desires or individual beliefs. Several anthropologists have highlighted, however, how concepts of self-determination of care and patients' freedom of choice are problematic. According to Sylvie Fainzang (2006), patients exist in the gap between the values defended by informed consent and the concrete functioning of the medical system. On her side, Annemarie Mol (2008) underlines how doctors' opinion is still the main element on which health decisions are based. These phenomena concern all medical fields, including reproductive health. In the case of abortion, although women have the right to decide whether or not to interrupt their pregnancy, the manner in which doctors inform them may influence their choice. In the volume *Faire vivre et laisser mourir*, the sociologist Dominique Memmi (2003) highlights the bio-political dimension of medical consultations on reproduction issues. In her opinion, doctors exert a form of control on patients' behaviour via the discourses they promote, the so-called *gouvernement par la parole*. As I observed during my research, this form of control persists even in the era of informed consent.

Doctors' discourses present differently if it is matter of discussing abortion requests due to personal reasons from when the choice to end the pregnancy is medical. In the first case, a greater use of language aimed at underlining the physical problems caused by abortion emerged from the research. The frequent use of specific words and adjectives stressing the negative consequences related to termination of pregnancy, such as the side effects of anaesthesia on a woman's fertility, is an example of this. If patients ask

for abortion within the second month of pregnancy, gynaecologists advise pharmacological abortion as they consider this intervention less traumatic than surgery. Through the same technique, which we can define as a form of governance via specific health narratives, doctors can suggest women end their pregnancy when severe perinatal health problems have been detected. The narrative proposed by doctors this time focuses less on the risks and other negative consequences, while greater emphasis is put on the long-term benefits related to therapeutic abortion (Manai, Burton-Jeangros, Elger 2010).

Most doctors I interviewed are aware that the way they speak with the patients may have an impact on their choice; nevertheless, as they underline, the narrative they choose to employ refers to a sense of responsibility they feel towards the women and the future baby (Boltanski 2004; Garcia 2011; De Zordo 2018). One of the main factors that guides doctor-patient interactions is a woman's life and family situation. Hence, most doctors emphasise more the risks related to non-therapeutic abortion when they speak with married women, or with patients who have a stable romantic relationship. As gynaecologists I interviewed highlight, such a tendency is related to the fact they consider these populations easier to persuade not to abort, unlike women who are not in a stable relationship. Previous maternity experiences also play a role. The information given to women in their first pregnancy, and to women who have already had one or more children, is often not the same. Usually, the more children a woman has already had, the less doctors focus on the risks related to non-therapeutic abortion. In medical consultations related to therapeutic abortion, instead, working conditions contribute to a classification of women into two main categories: those who, as doctors said, "would be better off ending their pregnancy as they could not be good mothers", such as unemployed patients or patients who have not a stable partner; and those about whom the doctors feel, "it is a shame that they ask for abortion[s] as they would be good mothers", such as patients with a stable partner and a good job. The fact that doctors insist more on the negative sides of therapeutic abortion with the second group of patients is representative of the choice to adjust medical information to a woman's profile and personal life elements. Such a choice is generally justified by the assumption that economic means and family background are decisive factors in the quality of care women can provide to children with health problems. Divergent linguistic codes as well as the choice to adjust information according to a woman's family situation underline how *social stigmatisations* and *moral classifications* of patients contribute to doctor-patient interactions even in hospitals where health professionals do not oppose termination of pregnancy.

An additional element that emerged from my study is a non-uniform distribution of the time doctors spent informing the patients. Such time,

which aims to increase patients' awareness of abortion techniques, risks and possible alternatives changes according to women's profiles. According to intersectionality theories (Crenshaw 1991; Bridges 2011), two elements appeared particularly influential in doctor-patient interactions. The first is social class. As scholars have highlighted for other case studies (Charles, Gafni, Whelan 1999), doctors spend more or less time informing patients according to a woman's occupation and level of education. In most cases, the less educated the patients appeared, the less time doctors invested in informing them. One of the doctors I interviewed emphasises this tendency to adapt the length of the conversation interview and the information transmitted to women's capacity to understand the medical language:

The way the patients act and speak allows us to understand immediately whether we are dealing with someone who has studied, or not. It is on the basis of this evaluation that I decide, for instance, how far to go when describing the different techniques for anaesthesia. If I realise that the patient has a level of instruction that allows her to understand little of what I am saying, I cut it short and move on to the next patient.

The same trend was emphasised in a critical manner by another doctor I interviewed:

Often the patients with whom we spend less time explaining are the less well-educated. Unfortunately, not all the doctors spend time making these people understand why a certain intervention is being proposed and in the end, they ask them to sign the consent forms without saying much.

A second influential factor is the foreign origin of women. Only about 5% of termination requests come from migrant women. Among non-Italian women, most of requests concern women who came from Eastern European countries and a few among women coming from South America, West Africa and North Africa. Usually, the average duration of medical consultations with foreign women is about half the time doctors allocate to Italian patients: while medical meetings with the latter last up to 30 minutes, those with non-Italian patients last up to 15 minutes. This differential behaviour concerns all foreign women, beyond their country of origin. As several health professionals underline, such a choice is linked to the idea that even though foreigners have been living in Italy for years, they lack the necessary skills to understand medical language and medical information. This results in the decision to simplify the vocabulary used when informing them, and to reduce the interview to the minimum required for gathering informed consent. Medical interactions present different characteristics if one has to discuss the possibility of therapeutic abortion. Generally, the time doctors spend on informing the patient is much longer than that devoted to ex-

planations concerning voluntary termination of pregnancy. Doctors' interactions with Italian women last up to one hour when perinatal problems are detected. Consultations with non-Italian women, however, again have a shorter duration in this case. Such an attitude is particularly common when patients are Muslim. When questioned about this trend, doctors underline how Muslim women – such as patients who came from North Africa and West Africa countries – always want to keep their babies. Some health professionals emphasise that scientific explanations are not beneficial for these women, as they explain perinatal problems as something related to God's will. One doctor describes the effort he made to inform Muslim patients as a 'waste of time':

I have been working in this hospital for 20 years and, in my career, I have seen two or three Muslim women have abortions if the baby is not fine. For them, all depends on the will of God. Even if we spend our time informing them, they will follow their religion. Honestly, would it not be better to use this time to do other things, for example to inform more the Italian patients who, facing the same problems, really need to understand what to do?

As highlighted by these words, far from being considered a rule applying to all, the time spent informing patients about therapeutic abortion may seem well spent or wasted to health professionals, depending on the cultural characteristics of the patient (Coulter, Entwistle, Gilbert 1999). The result of this attitude is the emergence of *new forms of inequality* in the information process instead of the achievement of women's universal right to be informed about abortion. Fatima, 34, from Morocco, who has been living in Italy since 2011, points out how this behaviour could be perceived as offensive, or even as a form of discrimination towards foreign women:

I am certain some doctors think I don't understand anything they say. When I was younger, I worked as a nurse in Casablanca, so I can perfectly understand! However, doctors don't know that, they just think that I am [a] foreigner so I am not interested in abortion and I cannot understand. In my opinion doctors should assess patients' situations more carefully, as there are people, like me, who would like to say what they think.

So, despite informed consent, which conceives patients as subjects able to decide what to do (or not) with their body and for their health, in cases of abortion, where the right to choose has been recognised since the 1970s, doctors' attitudes in adjusting medical information to women's histories and social profiles may limit patients' awareness and can influence the decision-making process.

The couple dimension and gendered relationships in termination of pregnancy

Social scientists and historians highlight how men have become crucial actors in experiences related to women's reproductive health since the 1980s and (more widely) the 1990s (Charrier, Clavandier 2013). In many Western European and North American contexts, men are increasingly present during antenatal consultations; they attend training courses for childbirth; they are at the side of women during delivery (Quagliariello 2017); and they take part in medical meetings regarding breastfeeding (Gojard 2010). As a consequence, while in the past reproduction was understood as a field that mostly concerned women (Knibiehler 1997), it is now considered a domain in which men are also involved. At the same time, the male presence during medical consultations has become a way for couples to show the solidity of their relationship to medical staff.

As it emerges from situations where abortion requests are not related to medical reasons, these historical trends can challenge women's access to legal abortion. A common request from doctors for *couple consent* to voluntary termination of pregnancy is emblematic in this regard. Only a few doctors prefer to speak just with women in medical consultations. Sometimes health professionals choose to interact first with the woman, and then with the partner. Therefore, despite under Italian law the right to choose whether to continue the pregnancy is allocated to women, abortion has *de facto* become an experience to be shared by both members of a couple. In some situations, a male presence may represent support for women, who describe sharing medical consultations with their partner positively. Several women I interviewed underline, for instance, how they feel less responsible for the choice they make, as they make it together with their partners. Other women have the impression that their partners can protect them against hostility from their own families. Other times, women describe a male presence as a limit on their personal choice. This opinion especially emerged from women who preferred not to explain the reasons for their choice to the doctors, as they feared their partners' reaction. The story of Maria⁶, 34, is representative of the difficulties encountered by some of the women who cannot speak with doctors because of their partner's presence during medical consultations. The first time I met her, Maria was undergoing her first consultation. She arrived at hospital with her partner Pietro. They had been engaged for four years but they were not married. When the doctor called her, Pietro followed Maria down the corridor and he entered the medical room with her. She did not refuse his presence, but her expression showed her discomfort,

⁶ In order to respect the anonymity of the people who participated in the research, the names that appear in the article are pseudonyms.

which the doctor did not seem to notice. During the consultation, Maria underlined that she did not feel ready to become a mother. In her opinion it was not the right time to have a baby. On his side, Pietro highlighted to the doctor that they had not come to a final decision and they were still reflecting on their choice. While Pietro was speaking with the doctor, Maria looked at the ground without speaking. Two weeks later, the couple came back to hospital for a second consultation. On this occasion, they signed the informed consent for surgical abortion to be performed. During the medical meeting, Maria looked worried. She never looked at the doctor and said only a few words. Some days after, I went to visit her at home. It was the first time we had met in a non-institutional context and without her partner. During our meeting, she told me:

In the hospital I could not speak. Did you notice this? I was often silent. There was something secret I could not share. I cannot say I wanted an abortion, as I got pregnant after a relationship with another man. Could I say this in front of Pietro? I don't think so. Could the doctor imagine something like this? I don't know. Actually, my decision would have been the same but it would have been better for me if I could speak to the doctor without lying.

Women can feel ashamed to share their thoughts with the doctors also in other situations. The fear of looking like bad wives or bad mothers was described as a common feeling by women who wanted to pursue individual projects, such as a professional career, instead of investing themselves in the maternity experience (Bajos, Ferrand 2002). Despite women's lack of motivation to have a baby, they may have the impression that their refusal to become a mother might damage their relationship. Some of them even choose not to end their pregnancy after undergoing medical consultations with their partners. Alessandra, 36, describes the alliance she perceived between the doctor and her partner as a *contemporary paradox*. As she highlights, the women's opinion should count the most in abortion decisions:

Sometimes I had the impression the partner's will counts more than the woman's desires in medical consultations. This is really paradoxical. According to the law, it is the woman that has to decide what to do when she is pregnant.

The male presence in medical consultations looks even more problematic when partners have opposite opinions about termination of the pregnancy. As I observed, this situation can lead to conflict that forces doctors to reschedule the expected intervention, which may endanger women's access to legal abortion.⁷

7 With the exception of therapeutic termination of pregnancy, under Italian law

The reactions some of health professionals have to women's choice to undergo medical consultations without their partners also underline the importance placed on the couple. As I observed, some gynaecologists question women if the male partner is absent. Through their inquiries, they try to understand to what extent a partner is aware that the woman is pregnant. Whether gynaecologists understand patients do not want to share their abortion decision, a common reaction is to emphasise to women they might regret such an 'individual choice'. Some gynaecologists may also suggest women come to see them again after they have consulted their partners. In medical consultations I attended, these attitudes especially concern interactions with married women, but can also involve unmarried women. Within this scenario a different approach emerged, however, between male and female gynaecologists. In most cases, in fact, female doctors showed a greater engagement to support patients who did not want to share their abortion decision. Usually, medical interactions with female gynaecologists appeared more focused on the woman's point of view, and the inquiries about partners' thoughts were less numerous compared to consultations with male gynaecologists. This gendered approach opens an inquiry that should be explored in future research, such as to what extent a new female alliance for women's right to abortion is emerging in Italian public hospitals.

The presence of a male partner appeared to be expected and required by both male and female gynaecologists when abortion decisions were linked to medical reasons. In these situations, all doctors I interviewed preferred to inform both individuals in a couple about the detection of a foetus's physical or genetic problems. The need to speak with both parents concerns both married and unmarried couples; hence, the choice of gynaecologists was always to include the father of the coming baby in medical consultations. Unlike voluntary termination of pregnancy, women usually evaluate this attitude of health providers in a positive way. Like the gynaecologists, women promote the idea that male partner involvement is needed for a common evaluation of the capacity – as well as the will – to take care of a child with health problems. In most cases, women I interviewed describe the choice of ending the pregnancy or giving birth as a couple matter, where male partners are considered fundamental actors in the decision-making process.

(194/1978) women can access abortion not later than the third month of pregnancy. Often, however, the 'real time' available for abortion requests is less than three months as a woman may not immediately realise she is pregnant or cannot immediately meet a gynaecologist. For more detailed information about different timeframes established for surgical and therapeutic abortion under the Italian law, see Claudia Mattalucci's article in this volume.

Spaces of support, spaces of control: the role of psychological consultations before and after abortion

Along with gynaecologists, psychologists take part in consultations related to the termination of pregnancy. According to the rules of the maternity hospital where the research took place,⁸ these professionals are entitled to supervise the *psycho-emotional sustainability* of both therapeutic and non-therapeutic abortion, as well as the woman's wellbeing at the different stages of these procedures. In both cases, the first psychological counselling takes place the same day, or the day after, the woman meets the gynaecologist. For voluntary termination of pregnancy, this encounter has one main purpose, which is to assess the reasons for which the woman (or the couple) is asking to end the pregnancy. Despite the fact that the meeting with the psychologists occurs only after the woman has already met other health professionals, the function assigned to psychologists cannot be described as complementary. The two psychologists I interviewed underlined how the acceptability of voluntary termination of pregnancy depends on their professional role. This opinion is based on the fact psychologists – and not doctors – are entitled to write the report that *formally* authorises women to access legal abortion. The fear that psychologists might not take their requests seriously was common among the women I met. Many of them highlighted the need to reflect in advance on the elements of their story to be shared with psychologists. The likelihood of making mistakes in their narrative was prominent in their minds. As I could see, the themes explored during psychological consultation, whose average duration is one hour, mostly focus on women's lives and how they are living their pregnancy. Some of the questions addressed to the patients involve how long they have been in a stable relationship; at what stage of their life they expected to become parents (or whether they have other children); whether they use contraceptive methods to avoid pregnancies, and if so, how long for; to what extent this pregnancy is something that happened by chance; and whether they have already had other abortions. As the two psychologists I interviewed highlighted, these elements, together with general information on women's profiles, are the main elements of the reports they write after the consultations. Such reports are key in women's assistance, as they prove that the abortion request is not related to any *psychiatric problems* but depends on reasonable motivations linked to a woman's personal life.

According to the findings of my research, a woman's need to demonstrate the *rationale* of an abortion request is easier to accomplish when patients are somehow victims of their pregnancy, such as when the latter is the result of

⁸ The role of psychologists is regulated by internal medical protocols and it can change from one hospital to another.

sexual violence.⁹ Other conditions that allow women to give an explanation to a psychologist are the presence of risks for their health, when doctors may suggest a therapeutic abortion. In other situations, women commonly felt the need to look for the right answers in order to justify their abortion request. Eleonora, 31, stressed: "Even if you just do not want the baby, it is better to tell to psychologists you have some problems in your life. Nowadays it seems that if you have no problems, you are less entitled to access abortion." These strategies, however, are not always possible to adopt. The difficulties some of the women have to deal with look greater when the patients have already had a previous abortion. Camilla, 35, explains:

Health providers often define women who ask for abortion more than once as patients who have a 'chronic problem'. During the meeting with the psychologist, he asked me if I were aware of the existence of contraception methods, as I have already had one abortion. His impression was I prefer using abortion as a contraceptive method!

After the first consultation, the number of meetings psychologists propose to women depends on the kind of intervention patients undergo. Usually, psychologists try to meet more often with women requesting a therapeutic abortion, as this intervention is considered more traumatic compared to voluntary termination of pregnancy. In the same way, surgery after the second month of pregnancy is understood as more distressing than pharmacological abortion before this point. The perceived level of uncertainty during the first consultation is another element that counts in psychological assistance: the more women appear doubtful about their choice, the greater the number of meetings psychologists propose to them.

In the hospital where the research took place, meetings with psychologists are proposed to women also after the termination of pregnancy has been performed. In most cases these consultations – the so-called *psychological follow-up* – have a preventive function, such as to combat unsafe behaviour in women who might feel particularly sad or confused after abortion. The duration of *psychological follow-up* changes according to the positive or negative impressions psychologists have of women's behaviour after abortion. As professionals I interviewed underlined, these meetings may help them understand how women are reacting to their abortion: how often women speak about their pregnancy, or how often they have dreams related to their pregnancy, for example. Woman may experience post-traumatic stress and the evolution of the feelings women experience after abortion is summarised in the reports psychologists write at the end of each meeting. Usually,

⁹ The Italian law on abortion does not provide a specific model of assistance for women who ask for termination of pregnancy after sexual violence.

the *psychological follow-up* ends when health providers declare women have overcome abortion without any trauma or negative consequences for their future life.

As psychologists underlined, apart from women who show signs of severe depression, psychological meetings after therapeutic and non-therapeutic abortion are recommended, but not mandatory. Despite this, several women who do not have any negative symptoms agree to meet psychologists at least once, as they want their good health to be confirmed. This attitude shows how care programmes intended for exceptions can generate health needs that may become the norm. Dominique Memmi's theories are, again, a suitable tool to analyse such a situation. In her most recent book *La revanche de la chair* (2014), she underlines how a new bio-political apparatus has emerged within the hospital space over the last few years: the so-called *gouvernement par la chair, la parole et la psychologie* (Memmi 2014, p. 261). This is centred on doctors' suggestions and narratives as described in the first part of the article, but also on psychologists' counselling and advice. The main distinguishing element of this new mechanism of control is the increasing attention given to psychological aspects connected to physical experiences. The growing importance of the role of psychologists in therapeutic and non-therapeutic abortion can be understood as an example of this innovative system of control on one's individual life and health. In this regard, Michela, 37, who choose not to attend the *psychological follow-up*, describes psychological meetings as a way to keep women in the role of patients, by making them feel sick from a physical and mental point of view:

These meetings with psychologists give women the idea they need to be helped after abortion. In my opinion, women do not need to meet any specialist after abortion, since they are not sick. It would be better to make us feel like people who have made a choice, and not as people who run the risk of having a personal crisis or some psychiatric problems because of abortion.

Finally, the psycho-medicalisation of the moments proceeding and following abortion involves the two members of the couple in a different manner. In the case of voluntary termination of pregnancy, male partners are not always included in the meetings with psychologists. As health professionals explained, this choice results from the idea that the physical and psychological consequences of termination of pregnancy affect more women than men. By contrast, in therapeutic abortion, the male presence is expected, and even required, before and after the intervention has been accomplished. Men can be part of psychological counselling together with their female partner, but they can also attend the counselling alone. The assumption, in this case, is that psychological consequences will affect both parents of the future baby.

Conclusion

The analysis I propose in this article shows how, even in hospitals where there is no conscience-based refusal of abortion, women's right to choose if, when and how to end their pregnancy can be subjected to a number of influencing factors. The findings from my case study highlight how several elements may have an impact on women's choice.

The first element has to do with doctor-patient interactions. Doctors employ a different linguistic code depending on whether abortion is required or needed by women. Information may also change according to women's family situation. In this regard, one of the results that emerge from my study is a strong sense of responsibility health professionals perceive in the information process. Communication regarding voluntary termination of pregnancy does not present the same characteristics in interactions with married women and those with women who do not have a stable relationship. In the same way, information about therapeutic abortion differs depending on whether women are considered able to take care of a future child with health problems. Therefore, social stigmatisations and moral classifications of patients play a role in the information process and, through it, in women's decision-making process. Moreover, the time doctors spend on informing women can have an impact on their choices. Devoting more or less time for information, according to women's social profile, can increase inequalities, to the point of being perceived as a form of discrimination by foreign patients.

A second element that may have an impact on women's choice is the growing importance of male partners both in therapeutic and non-therapeutic abortion. The presence of male partners during medical consultations can be a source of support, but it can also become a limit for women who want to express their personal will. Gender balance depends on the couple relationships, as well as on the attention health professionals pay to women's individual needs.

Finally, psychologists have an influence on choices related to therapeutic and non-therapeutic abortion. Meetings with these professionals before, and sometimes after, abortion can be understood as moments of exchange and spaces of care for women, but they can also be perceived as an obstacle to overcome for patients who have already had a previous abortion, and a new way of managing abortion as 'trauma' (see Mattalucci in this volume).

Although, as highlighted in the article, these elements present different characteristics in therapeutic and non-therapeutic abortion, each can contribute to limit women's autonomy and women's right to choose. If we add to this the low substitution rate of the physicians who have historically been supportive of women's reproductive rights by a new generation of militant doctors, the destiny of the right to abortion appears even more relevant a question to address at a medical, political, social and cultural level.

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