The social origin of dilemmas and attitudes of Mexican doctors related to abortion's health care[1]

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In this paper we aim to discuss our findings concerning the social mechanisms that sustain the ambivalent role that Mexican doctors play regarding abortion care. We explore the social origin of perceptions, predispositions and practices which constitute the daily professional performance of male doctors working in public institutions. Further, we analyze how these predispositions have consequences on the way women access these services, and on the quality of care they receive.

Introduction

Through our previous research work we have been able to demonstrate that physicians' opinions and attitudes the attitudes and opinions held by doctors with respect to abortion, feminine sexuality and maternity are constitutive of their practice and act as 'filters' for the moral evaluation of patients (Erviti, Sosa & Castro, 2007; Castro & Erviti, 2003; Erviti, Castro & Sosa, 2006).

As a professional group, the doctors of Mexico and Latin America have maintained a conservative position with respect to the termination of pregnancy. Generally, doctors appear to agree with abortion for health reasons, but in other circumstances, they barely

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accept it. Medical training and the legal classification of abortion as a crime shape the professional's attitudes affecting the abortion's health care provided.

Contrary to the medical ideology, in which doctors assume medical practices and "clinical procedures" as "medical facts", in some cases, such in the case of abortion in medical settings, these [abortion] practices and clinical procedures are indeed shaped by the way in which the medical profession organizes its own practices and by the way in which doctors interact with their patients. The professional organization of medical practice and knowledge in medical settings, it's grounded not only in the formal curriculum, but also in the informal curriculum and know-how of the medical practitioners.

In this paper we propose as analytical tools, two concepts to study the sociological mechanisms that organize the medical practice, in abortion's health care services. The concept of medical ha*bitus* (Bourdieu, 1991) and the concept of *communities of practice* (Egan & Jaye, 2009). These concepts allow us to clarify two crucial aspects of central interest. On the one hand, the organization of institutional and professional responses for tackling what the medical profession have defined as a problem (in this case abortion)[4]; and on the other hand, the production of qualified agents (*professionals*) to respond to needs in medical field.

The concept of *communities of practice* refers to the process of social learning that takes social participation as the basis of learning (Egan & Jaye, 2009). This participation involves always an "active involvement in the practices of social communities and constructing identities in relation to these communities" (Wenger, 1998: 111). The concept allows the articulation of many elements of social reality at different levels (micro and

[4] The notion of "construction of professional objects" refers to the historical, specific and contingent aspects of the objects produced by each profession. This notion place in doubt the neutrality of these constructions revealing the political and ideological struggles implied in the process of their construction (Byron, 2003).

macro); because it shows how these communities mediate between the individual professional practice and health policies (which in turn shape the individual clinical practice). The notion of communities of practice, in the particular context of doctors who provide services in reproductive health settings, reveals the context and the social and professional values which acquire validity and are transmitted and legitimized by the members of this community (not excluding the existence of unresolved tensions and conflicts, not only within these communities of practice but at varying levels of these communities: individual, institutional, etc.) (Taylor, 2006).

For its part, the concept of medical *habitus* refers to the outcomes of the socializing process implied in the training of doctors. Or in other words, medical *habitus* refers to a systematic transformation of subjectivity (*self*) of the students in this profession, who learn not only specialized-technological know how but also *incorporate* (that is to say, they inscribe in their own bodies) the social structures in which they aspire to participate. Through professional *habitus*, doctors can behave "naturally" in their field, taking for granted the hierarchies and values assumed by the medical profession (*l'expérience doxique du monde)* (Bourdieu, 1991).

Additionally, we assume that all social interaction implies the production and dynamic assignment of moral judgment (Bergman, 1998). This signify, that place in doubt the apparently neutral orientation professed by the medical profession in order to justify its own activities concerning the interaction between doctors and patients. By this way, we do believe that the professional responses and attitudes are influenced by complex processes of patients classifications mediated on the basis of diverse individual attributes, social images and gender and class values (Roth, 1986; Ellison, 2003; Waitzkin, 1991).

These classificatory practices affect the treatment and willingness to provide health services to those requiring it, resulting in differential care standards which have consequences over the quality of the service rendered and (Steele and Chiarotti, 2004; Erviti, Castro, Sosa, 2007). In this sense, the case of those women who attend public hospitals which provide abortion's services represents an ideal context to analyze the function of the classificatory mechanisms within medical practice and the consequence of that, over the access and quality of heath care provided (Erviti, Castro, Sosa, 2006).

It is important to point out that the process of classification or the assignations of identities to the patients, works in a double sense: both reaffirming the identity of the medical profession as well as validating a certain *habitus*, which also indicates the social and professional membership to a defined community practice (Wenger, 1998). We thus sustain that professionally organized responses such as those which interest us here, cannot be analyzed in isolation, but instead should be studied both in terms of epiphenomena in the current hierarchies of the medical profession, and by revealing the political and ideological structures surrounding abortion and the restriction of its practice in a particular context, such as the Mexican one.

In Mexico, abortion is penalized except in the Federal District (D.F.) where in 2007, the practice was made legal for up to 12 weeks of pregnancy. In the other federal entities of the Mexican Republic maintain a restrictive legislation concerning abortion; and besides this any advances made concerning the subject of abortion. Recently, we have been seen a regressive tendency. For example, in the last months 14 federal entities within the country approved local constitutions and penal codes, in order to protect the right to life "from the moment of conception" and to forbid, without any exceptions, the legal termination of

pregnancy. This situation makes it difficult to trust in the reliability of data referring to the abortion rate.

During 2006, it was estimated that one in 6 women underwent an induced abortion have required hospitalization's services, in total 150, 000 women received care in public health hospitals, as a result of complications resulting from an induced abortion. This year the total estimated number of induced abortions has been 875 thousand and the abortion rate consisted of 33 out of every thousand women, between 15 and 44 years. Between 1990 and 2006, the rate of abortion rose and the seriousness of morbidity relating to unsafe abortion diminished (shorter hospital stays), even though the rate of hospitalization did not diminish (Juarez et al., 2009).

In previous research, we found that Mexican women requiring attention for complications related to abortion, either spontaneous or induced in public hospitals are saw as suspicious and the medical staff made them to feel guilty (Erviti, Castro and Sosa, 2006; Erviti, Castro and Collado, 2004). This is possible, because of the penalizing abortion strategies and of the authoritative character of the medical practice. At the same time, this explains how during the medical-patient encounter different hierarchical relations are deployed (for example hierarchical relations of gender, class, medical knowledge among others), as well as conventions and expectations relating to the circumstances in which the mandate of maternity should occur.

Thus, a context such as the Mexican one, where motherhood is overvalued (specially the maternity which "fulfills" certain social mandates) and where abortion is penalized and criminalized, contributes to reproduce the mistreatment of women attended for an incomplete abortion in the public health services, making this socially acceptable,

legitimizing the validity of a social order which perceives the practice of abortion as a threat.

METHOD

The following forms part of a qualitative study of public services undertaken in a federal entity, at the center of the Mexican republic, from 2004-2005. We conducted 31 in-depth interviews with male doctors working in public health institutions, relating to reproductive health care. We explored these doctors' schemes of perception and appreciation of both abortion and the women who request care to treat abortion related complications. We characterize these professionals' feelings and emotions and the concomitant professional practices of exclusion and punishment. An interpretative analysis was applied to the previously codified interviews.

FINDINGS AND DISCUSSION

The construction of the professional objects surrounding abortion

Surrounding abortion many professional objects have been constructed: abortion, women who abort, doctors who treat (or don't treat) these women, roles and medical identities and specific practices and skills, with their accompanying emotional dimensions.

Concerning the medical/patient encounter in the case of – an abortion, professional identity is performed (and reinforced), renewing at the same time, the professional adscription to a specific community of practice, through the deployment of several practices and values according to the professional *habitus*. The construction of abortion as a professional "object", the identity of the women having an abortion and the medical practices of the doctors who attend them, form a *continuum* whose components are entwined.

a) Abortion, women who abort (" *abortion provokers*") and the doctors who carry out induced abortions (" *abortionists*")

Doctors usually regard abortion from a dual perspective which acknowledges both the "good" and the "bad". They apply criteria that go further than a strictly clinical view classifying abortion as either *spontaneous* (in this case without any negative moral charge towards the women who is having one), and *induced* (evoking a moral condemnation towards those women who demand these and the professionals who carry them out) and those interviewees who refer to abortions as "criminal". And it is from this standpoint as guardians of morality, that doctors act giving sense and legitimizing their professional practices and discourses. These findings illustrate the functioning of social and professional devices inherent in these institutions, which play a central role as much for reproducing specific notions concerning sexuality, maternity and abortion, as for defining specific professional practices.

In the discourses of the doctors interviewed, appear several reasons relating to 'ethical', moral, legal and health aspects, from which they construct and interpret abortion and classify women who request this health care, in terms of certain negative identities, depending on the 'type' of abortion. Abortion tends to be viewed by the participating doctors as something which happens to women with certain characteristics, for example the fact of having "informal partners", of being "very young", of being "individuals who neither work nor study", of being "people with no education, because if they were remotely cultural they wouldn't be requesting this service", etc.

It is not surprising then that the participants in this study usually describe the medical encounter treating a women with complications resulting from an abortion, as an opportunity to "instruct them" about certain hegemonic values:

> "…that which you are doing is not correct, nor is it adequate, besides in our country abortion is not legal, and as Catholics, we have no right to take someone's life, I am against abortion", even if these individuals have been raped, or the babies manifest certain incompatibilities with life, we should maintain this life until God does not require it any longer, because we cannot either give life or take it away" (E065)

On the basis of the descriptions given by the doctors of the care which they provide for women with an abortion in progress, we become aware of the classifications which they construct, referring to diverse types of abortion ("spontaneous" or "induced", "trustworthy" or "suspicious") and the reconstruction of the social origin of these categories. On the other hand, it is possible to foresee how the classification assigned to diverse cases of abortion constitute a principal, tending to either reaffirm or restore (depending on the case) the social order assumed to be the only legitimate one, in terms of maternity values and the reproductive role played by women.

This 'moral evaluation' and the assignation of stereotypical, social identities influence the type of medical attention and treatment offered. Doctors usually maintain punishing attitudes towards patients attended for complications relating to abortion, in conformity with their assigned identities.

> "…patients come to me and say: "doctor I am here requiring a scraping of the uterus because I aborted" and … one will perceive emotions, pain and the suchlike, but when one notes considerable indifference (in the patient) … then I believe they transmit this to you and likewise there is indifference towards this patient, not mistreatment or anything just (indifference) …" (E053)

Concerning these medical attitudes towards women who present an abortion, there are other intervening factors, such as the perception that the abortion is a problem which deviates resources assigned to other objectives; considered by the medical profession to be

"more important' or having 'priority'. Notwithstanding it is generally assumed that the doctors are professionals, trained to deal with these problems (incomplete abortions) and that it is necessary to provide this care, as a part of their professional duty.

When alluding to abortion, doctors make reference to social dimensions related to pregnancy and maternity such as "get rid of a pregnancy", and "to lose the baby". Otherwise, women who request attention for an abortion are seen as *mothers* rather than as *women.* This contributes to reinforce the *professional* construction of "the life of the fetus" in opposition to "abortion", even when legal, ignoring the rights of women and negating recognition of these laws.

Besides this, arguments about the economic aspect of clandestine abortions also emerge ("it a business", "a trade") which together with moral arguments ("a good doctor doesn't do this"), providing the basis for the condemnation and stigmatization of professionals who practice induced abortions:

> "…that they should classify you within your medical profession, as the uterus scraper or abortion performer, as some call this, well because of my medical principals, I state: 'I have no wish to be a part of this'" (E043)

These constructions and classifications act as mechanisms for professional surveillance and assignment, even though they may be invisible to doctors because they are presented as "scientific" practices, within a framework of religious ideologies and values.

In this way, intra-professional pressures are deployed, as much in terms of pressures and punishments of religious character, as in terms of institutional norms and laws. For example, those interviewed narrated the case of a doctor who carried out abortions and was expelled from the institution where he worked, serving as a disciplinary warning to others not to partake in these practices.

b) **The professional roles and development of practical skills for identifying the doctors and women involved in the transgression of "abortion"**

The professional construction of the "objects" developed in the previous point is central concerning the construction of the professional roles of doctors, as well as the development of practical skills for identifying all those medical practitioners and women who are involved in the transgression of "abortion". Even if the professional identity of these doctors covers many other aspects other than abortion, it is in terms of this event that the system of values and norms of the medical profession is expressed, as this forms a part not only of the formal curriculum but also of the informal one.

It is remarkable, in the light of questions concerning legal abortion, that those interviewed made reference to therapeutic abortion (by medical prescription), referring to the doctors as the informed ones (those who have the information) and those that must make decisions relating to the termination of pregnancy. Whereas legal abortion because of rape generates evident bad feelings and opposition; partly because of the interference of other professionals outside the field of health, the judges, as well as the "lower level" professionals (such as the forensic experts), "who do not know", and who should not participate in these decisions and even less so give an order which doctors are obliged to fulfill:

> "…here ….we have an obligation in specific cases of rape and it falls on me … we begin to appear to be vulnerable in this situation, we recently had a case where in truth, we should not have lowered the switch. In the end if a judge says to you: "you have to carry out an abortion", then well you may be a judge, but I cannot finish anyone off, or rather, just because it was a case of rape, it is still a human being, (…) thus our opposition derives from this, they say: "it is the law which obliges you , and besides this is an order from a judge", but it is an order which still remains very vague, and if we play with this statement then we will definitely find the necessary arguments not to carry this out (E064).

Pressure exists within the specialist community of gynecologists which produce several mechanisms for negating the provision of health care relating legal abortion, where the recognized hierarchies in the health community play a very important role. Thus, those professionals who agree to intervene in legal abortion are qualified as "doctors without scruples", whether they do this freely or are obliged to do so because they hold subordinate positions, either in professional or gender terms. In other words, they occupy the lowest positions in the profession, as indicated by one of the doctors interviewed: "as I was in charge of resident doctors who are lower in the hierarchy, I didn't participate", or they are women doctors.[5] Or otherwise they appeal to institutional bureaucracy and formal procedures, in order to distance themselves from the matter and negate health care even in the case of legal abortion:

> "…but here we find something that may detain us and to which we may adhere, the judges order says: "order the gynecologist to carry out the uterus scraping for such and such, under-age patient, as long as there is no risk to her life ". Carrying out a uterus scraping puts life at risk, administering an anesthetic puts life at risk, thus from here we can take a position and say: "I'm not doing it because it is putting the girl's life at risk". However, within about a week this patient circumvented us and arrived at the gynecologist early in the morning and went straight to the boss, "a patient for the boss"; she is sent to the boss, these are people who know each other, we are at the base level, we have different ideas, other criteria. They send these cases to the boss, and the boss just writes a note saying: "patient with a viable, extractive and reactive product which is well adhered and thus we do not see any reason for terminating this pregnancy, thus the pregnancy will continue". The next gynecologist arrives to take up his turn: "patient that has been sent to undergo a uterus scraping, living, active product, to be left to evolve, refer to boss". 3, 4, 5 turns pass and each one defers the responsibility to the boss and the boss says: "No order exists" and so then we all start in: "and are we going to carry out the uterus scraping? Why should we, if no order exists to carry out the uterus scraping?" and **everyone joins in: "no, it's a live product, why are we going to carry out a uterus scraping?".** Noone can force you to kill a product of 15, 16 weeks, that is alive, however there are ways of provoking abortion, both without and within an institution: a **woman doctor** arrived, and checked her at the weekend and immediately gave her medicine to provoke an abortion (…) but we never ordered

[5] Obviously we are facing here a hierarchical system for allotting tasks as described by e Everett C. Hughes (1971) in his famous essay "Good people and dirty work". *The Sociological eye*, Aldine-Atherton.

> this, **furthermore noone, none of the gynecologists dared** to prescribe an abortive medicine, however someone arrived at the weekend and prescribed this, without any names appearing … (E064).

This clearly relates to a manipulation of the risk, inherent in the moral notion which declares that all forms of life precede the rights of women and even a judge's orders. In this account, the construction of discourse which also functions as a consensual imposition can be appreciated.

In spite of this, it is important to point out that the reluctance to carry out an abortion may be defeated, in personal situations. For example, in the case of a sister, aunt, or wife who has been raped, or a doctor who has had a close personal experience of an unwanted pregnancy, the tendency to reject abortion is replaced by a position more "open" about it:

> E. What would be the outcome of this type of conscientious objection, on the part of doctors dealing with their own rape case?
> M: In truth I have not consulted opinion, to see whether they would agree or not, but I can assure you that the majority, if you question them or present such a case, they will agree with you, because at times, when one transfers to the context of your own family and imagine that someone in your family is in this situation … and for that person the law negates this, making abortion illegal, are you going to let this pregnancy continue? no, no. No, thus I can assure you that in almost 99% of cases, they would have no objection to it going ahead … (E043).

Finally in the context of the penalization of abortion in Mexico, the perception of women who come to receive treatment for complications resulting from abortion as being 'guilty of a crime' is an obstacle to women accessing appropriate health care services and contributes the violation of their rights, because they are suspected of acting outside the law (outside the social order) and because of this, they have no chance of exercising their legal rights, when faced with mistreatment and abuse in public medical settings. In this way the penalization of abortion increases the social vulnerability of women suffering from complications related to abortion, as they access health care within the public services.

CONCLUSIONS

The medical encounter related with abortion in public hospitals in Mexico, commonly reveal how doctors impose emotional and symbolic violence over their patients. This is possible, given the system of hierarchies within which institutional medicine functions, which promotes both the subordination and increased vulnerability of the service users, and in certain circumstances also contributes to the infringement of the reproductive rights of women.

We assume that the classifications constructed by doctors surrounding the abortion should be seen as the expressions of different (and intersecting) structures (power, professional, gender, racial) etc. to which these doctors belong and which exists as a product of the strong relationships within the medical profession. This signifies that the classifications and assignations of identity (and labels) applied by doctors, concerning women who require health care for an abortion in progress, form part of the disciplinary devices and pedagogic activities which reinforce and reproduce the existing doctor-patient social order (Bourdieu and Passeron, 1970).

We subscribe an approach which defines the medical encounters as social processes at a micro level, occurring in specifics social contexts, shaped by medical and lay ideology which refers to the macro level of the participants in this encounter. By adopting this approach, we aim to understand that which the patients and doctors *say* and *do* during the medical encounter, has a dual character in terms of *being* both an expression of particular current ideological concepts, which uphold the role played by medicine in terms of the legitimization and reproduction of a social order regulating human bodies, restricting the rights of women, and reproducing the structures of class and gender (Waitzkin, 1991).

The professional construct of abortion and that of women who abort or become pregnant cannot be separated from the collective construct of abortion and maternity, emphasizing -as in the case of Mexico- the intersection of several social inequalities which contributes to shape and construct identities, differentiated in relation to a social hierarchy.

Using these analytical tools provided by the social sciences, we can place in doubt both politically and morally, the construction of *objects* such as abortion in the medical field, as well as the definition of a "priority problem" for health in terms of the institutionalization of responses at this level of action. Because of this, it is possible to reveal the impact of these constructions and responses as they impact the bodies and reproductive rights of women. We can demonstrate this hierarchical construction, not only referring to different types of maternities, but also referring to the bodies of women, which are assigned labels in terms of class (*classified*), gender (*in gender terms*) and race (Sargent & Larchanche, 2007) (among others) recognizing their centrality of the power structures within an ethically diverse society, like the Mexican one.

Nor should we lose sight of the role played by structural restrictions in the practice of the medical profession. The objectives and political and institutional priorities play a structuring role in the social organization of medical practice. Also, the definition of these objectives and priorities conditions professional practice and the attention offered as a result of the pressures and restrictions exercised at a number of levels: administrative, costing, etc.

In summary: the professional, social and legal restrictions concerning abortion contributes the punishment and condemning attitudes in the medical profession and increase women's vulnerability when being treated for complications resulting form an abortion. These moral judgments may be conceptualized as part of a process of *exclusion*

which obstructs the access to quality health care services. Also the intra-professional pressures falling on those doctors who attend women in the process of abortion promote mechanisms for denying this care and obstructing access to these services.

In the light of these findings, further research is required in contexts where this procedure is legal such as Mexico City, in order to make an in-depth analysis of the persistence or otherwise of these mechanisms, as well as those changes derived from the legalization of abortion and its resulting impact on the accessibility of services and also in terms of respect of the reproductive rights of women.

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