Legal abortion: Doctors' reports at a reference hospital

Aborto legal: relatos de médicas em hospital de referência

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Abstract

Although Brazilian legislation allows abortion in cases of rape, risk of maternal mortality, and fetal anencephaly, the medical professional holds the authority to diagnose and advise on abortion and the right to claim conscientious objection to refuse to perform the procedure. This article aims to analyze the accounts of six gynecologists-obstetricians interviewed at a hospital specializing in abortion procedures to reflect on their perceptions. We assessed that sociocultural implications strain individual perspectives on victimization and abortion. Moreover, the multidisciplinary medical practice conditions, given the division of roles within the hospital structure, affect service delivery and are incompatible with academic training. Nevertheless, understanding the crime seems to prevail in favor of care, respecting the preservation of the reference service in attending to the victims of this violence.

Keywords: Sex Offenses; Rape; Abortion; Conscience; Medical Care.

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DOI 10.1590/S0104-1290202524040365en

Resumo

Ainda que a legislação brasileira preserve o abortamento em casos de estupro, risco de mortalidade materna e anencefalia do feto, a pessoa médica é autoridade para o diagnóstico e orientação ao abortamento, assim como tem o direito da objeção de consciência reivindicado para recusar a execução o procedimento. Este artigo visa analisar relatos de seis médicas ginecologistas-obstetras entrevistadas em hospital especializado no procedimento de abortamento para uma reflexão sobre suas percepções. Foi possível avaliar que implicações socioculturais tensionam a perspectiva individual sobre a vitimização e o aborto. E que as condições multiprofissionais para a atuação médica, diante da divisão das funções na estrutura hospitalar, afetam a prestação do serviço e são entendidas como incompatíveis com a formação acadêmica. Entretanto, a compreensão do crime parece prevalecer em prol dos cuidados com respeito à preservação do serviço de referência no atendimento às vítimas desta violência.

Palavras-chave: Violência Sexual; Estupro; Aborto; Consciência; Atendimento Médico.

Introduction

In most developed countries, the laws allow abortions to be performed to preserve the health of the person with a uterus. In Brazil, abortions are permitted in cases of rape, risk of death, and anencephaly. In the latter two cases, medical professionals are authorized to diagnose them. In cases of rape, however, these professionals face discrepancies regarding abortion. In this sense, to assess the recognition of this type of violence, we aimed to understand the experiences of professionals responsible for performing abortions at a referral service for violence victims in a city in Minas Gerais, Brazil..

The laws of countries that approve abortion advocate preserving the physical and mental health of people with a uterus to guarantee sexual and reproductive rights (Duarte et al., 2010). When not classified as from cases of rape, risk of death, or anencephaly, abortion is a crime in Brazil. However, this procedure is performed clandestinely and contributes to the increase in the mortality rate: in 2019, there were 677 deaths from direct obstetric causes: hypertension (370 deaths: 20%), hemorrhage (195 deaths: 12.4%), puerperal infection (69 deaths: 4.4%), and abortion (43 deaths: 2.7%) (Brazil, 2021).

For this article, we analyzed the reports of six (6) professionals specialized in gynecology and obstetrics (GO) in a discussion that involved legislation, technical standards, and the institutional protocol of the service. According to the studies reviewed and the experiences reported, despite the difficulties faced in the services, the services are essential to the care and redefinition of the lives of people with uteruses. Therefore, the State should dedicate greater attention to expanding these services and valuing those that already exist, recognizing the responsibility of health teams to identify victimization, which is intrinsically linked to the historical struggle to guarantee the right to abortion.

Abortion legalization background

The right to abortion in cases of rape was established in the Brazilian legal system in 1940

with the enactment of the Penal Code. However, the first service to assist victims of this sexual violence was implemented at the Dr. Arthur Ribeiro de Saboya Municipal Hospital in São Paulo in 1989, that is, 49 years after it was established in the code.

It was based on a study by the Women's Health Advisory Board that the publication of Ordinance N° 692 of April 26 by the Municipal Health Secretariat made it mandatory for the hospital network to offer medical care for abortion (Cólas et al., 1994). The hospital management was also sensitized, and judicial bodies at the municipal and state level and the Regional Medical Council (CRM) were consulted for the approval and creation of the service, which had a team made up of two social workers, two psychologists, a lawyer, and doctors hired to implement the Legal Abortion Program. Primarily, the abortion guidelines "qualified" the patient if the pregnancy was twelve (12) weeks (two and a half months), along with a Police Report (BO) – a document that communicates the crime to the police authorities for conducting an inquiry per the appropriate investigations – a report from the Forensic Medical Institute (IML) – a document to legitimize the evidence through the collection of evidence of the crime – and, finally, the accompaniment of a responsible person in the case of a minor or mentally incompetent individual.

The discussions fostered by the implementation of referral services became more complex. In 1996, the First Interprofessional Forum on Implementation of Legal Abortion, organized by the Center for Research on Maternal and Child Diseases of Campinas (CEMICAMP) and the Department of Obstetrics and Gynecology of the State University of Campinas (Unicamp) (Faúndes et al., 2004, p. 90) contributed to the debate that extended to the Brazilian Federation of Gynecology and Obstetrics Associations (FEBRASGO), with the establishment of the National Specialized Commission (CNE) on Sexual Violence and Legal Abortion.

In 1999, the technical standard "Prevention and Treatment of Injuries Resulting from Sexual Violence against Women and Adolescents" by the Ministry of Health (MS) (Brazil, 2012) was published to support violence victims. It has undergone revisions and reissues and must be aligned with the technical standard "Humanized care for people in situations of sexual violence with information recording and collection of evidence" (Brazil, 2015), which defines the flow of multidisciplinary care to prevent re-victimization.

That said, if the first care standard provided that the victim should report the violence suffered in different services: a police officer to register the Police Report (BO), having requested an expert report from the IML, and the registration of the report by a multidisciplinary hospital team, since 2005, the BO has been waived, and sexual violence traces can be collected within the hospital unit.

However, seeking health services does not replace public safety functions and duties. Given the cases analyzed in the research, per the review conducted for this study, rape is a crime in which the victim is usually the only witness, and once reported to the authorities, the safety of the person living with the perpetrator is compromised. This is especially true because such a crime usually occurs in the home context by a member part of the family. Even if the police authorities are called, the time it takes to investigate, gather evidence, try, and sentence the crime poses risks to the victim.

The complexity surrounding abortion is now focusing on the elements necessary to prove the crime. In 2020, to secure evidence, represented by the collection of biological samples, the Federal Public Defender's Office (DPU) argued that abortion should be limited to cases of "a woman's death risk", even suggesting the repeal of the 2005 technical standard. The Ministry of Health then changed the Procedure for Justifying and Authorizing Pregnancy Termination (Ordinance N° 2.561) to "preserve" material evidence of the rape crime to identify the perpetrator (Brazil, 2020). To this end, even embryo or fetal fragments for possible subsequent genetic analyses should be handed over to official experts and the police authority under the provisions of Federal Law N° 12.654 of 2012.

In this sense, the individual's decision still faces difficulties, and bills are proposed in an attempt to annihilate the autonomy of the sexual violence victim. Even with the unification of the crimes of rape and violent outrage of modesty, and the redefinition of the provisions on sexual harassment,

according to Law N° 12.015 of August 7, 2009, which amended the Penal Code regarding crimes against "sexual freedom" since male or female can suffer harm caused by non-consensual forms or through vulnerability to these crimes, people with a uterus stumble on a "critical path" when faced with unwanted pregnancy.

Although there have been advances in mandatory and comprehensive care, with multidisciplinary support in hospital units (Brazil, 2015; 2012; 2011a; 2011b), the reports of the doctors interviewed in this research reveal a significant psychological impact related to what we deduce as a vulnerability of femininities. If the rates show that most girls and women are sexually abused, represented by 87.3% (UNICEF, 2024), this vulnerability is structurally due to gender violence and the multiple markers (Bandeira; Amaral, 2018) that affect the dignity of feminized bodies, including women, girls, underage boys, people with disabilities and older adults. Unwanted, rape-derived pregnancy in people with a uterus increases the scale of violence experienced and the challenges faced by victims and health professionals who care for them. Thus, we highlight the need for research that operationalizes the categories of gender identity and sexual orientation to assess such vulnerability and the psychological effects on doctors responsible for abortions.

Methods

This research aimed to analyze the experience reports of six (6) GO professionals responsible for abortion in a hospital referral service specialized in treating cases of violence. The proposal was previously submitted and approved by the Ethics Committee.

A literature review was conducted in the SciELO database to support the discussion, using the descriptors "abortion" and "rape", applying filters for 2002 to 2020 and the language "Portuguese". This procedure returned 23 articles. Recognizing possible limitations, the same process was repeated with the descriptor "sexual violence" associated with "abortion", resulting in 21 articles. The exclusion criteria were studies that did not address the role of health professionals, particularly in reports by doctors. The 2018 and 2019 medical records were consulted to assess the care provided in the service studied, under the service coordinator's supervision, from April to June 2022, to identify the outcome of cases resulting in abortion.

At the time, the researcher was part of the team as an intern and invited professionals to the interviews conducted individually between March and May 2022 at the hospital. Each interview lasted an average of 20 minutes and was recorded on digital media. A guide topic roadmap based on Gaskell (2015) contained 18 questions addressing aspects such as 1. Service seniority; 2. Perceptions about care for victims of violence and abortions resulting from rape; 3. Institutional training and qualifications; 4. Personal experiences; 5. Psychological preparation; 6. Opinions about abortion in cases of rape; 7. Impacts of work on personal life.

The interviews were transcribed and analyzed with the online tool Voyant to count and correlate the frequency of words following an intentional thematic analysis (Bardin, 2011) structured into three units: service, conscientious objection, and perception of the experience.

The units were analyzed as interrelated components based on the "critical path" concept, a process marked by conflicting feelings during care to ensure the violence victims' dignity. Thus, we contextualized this "critical" situation to present the reports by analyzing the professional demands as generators of psychological effects related to the perception of vulnerability associated with femininity, particularly in unwanted sexual violence-derived pregnancies.

A "critical route" to abortion

According to the study by Oliveira et al. (2005), many women do not seek health services after sexual violence because they believe a police report is necessary, feeling afraid and unable to perform basic daily activities (Oliveira et al., 2005, p. 379), which is escalated when the perpetrator lives close to or inside their residence. They also add the lack of knowledge of a hospital referral service, essential to prevent conception, up to 72 hours after the crime, as they receive emergency contraceptive medication

and the embarrassment of the forensic examination at the IML. In short, trauma marks this violence, and the victims are afraid of revenge if they seek help since many are threatened. When the decision to seek help after discovering the pregnancy, a "critical route" between health services and the police is faced (Oliveira et al., 2005) because legal abortion requires a team, based on objective and subjective elements, to produce an investigation requiring reports added to the victim's account. Not being of a police nature,

> the practice of the investigation investigates the truth of the occurrence of violence and produces the meanings to define the subjectivity of the woman as a victim. In general, there is no evidence of the rape scene - it is necessary to believe what the woman says who presents herself as a victim and witness of her violence (Diniz et al., 2014, p. 293).

During the event narration, "truth tests" are imposed to question how the victim's subjectivity is expressed. "It is as a figure holding the truth that the teams question the woman – not immediately as a victim holding a right" (Diniz et al., 2014, p. 297), according to the study by Diniz et al. (2014) performed in five reference legal abortion services with 82 professionals, including doctors, nurses, nursing technicians, psychologists, and social workers. In this study, one of the five services required a police report, even though it is not necessary for an abortion to be performed in cases of rape. Therefore, the victim's word is considered insufficient for an abortion, and the hegemony of victimization is established, contradicting the legal frameworks for reproductive and sexual rights, which do not limit the right to abortion to cases of sexual violence.

The justification for evaluating the victim would be the causal link: "The cause is rape, and the effect is pregnancy" (Diniz et al., 2014, p. 294), relating the date of the patient's last menstruation with the date of the reported violence and the gestational age (GA), which does not necessarily prove that the rape did not occur. An ultrasound examination is performed to check the gestational age (GA) to proceed with the choice of method: pharmacological (misoprostol and oxytocin), intrauterine aspiration (manual or electric), or curettage (dilation to scrape the uterine cavity), with adequate pain control being essential (Brasil, 2011a, p. 33). If the GA exceeds the established for the procedure, the victim is forced to maintain an unwanted pregnancy.

This "critical route" can include the right to conscientious objection (CFM, 2019, p. 15, 20), according to the study by Faúndes et al. (2004), who selected a sample of gynecologists and obstetricians associated with FEBRASGO, where 84.5% stated that they did not accept abortion under any circumstances and 30% used religion as an important influence in their responses. However, there is also the fear of legal proceedings and the stigma of being called "abortionists" (Madeiro; Diniz, 2016, p. 564).

Also, in this research by Faúndes et al. (2004), 92.8% of participants knew that abortion in cases of rape is legal. However, 76.6% agree with this legal protection, and 4.5% defend the prohibition under any circumstances. Only 2% admitted to accepting the procedure after being referred to another professional to "help" them use misoprostol, a medication used for cervical dilation and egg expulsion, and 48% of these would approve if it were a family member. Finally, 77.6% of the female doctors who responded to a completely unwanted pregnancy had an abortion, and 79.9% of the male doctors who responded to the procedure had experienced such a situation with their partner, from which they concluded that:

> The closer the problem is to ourselves, the greater the tendency to accept that, in this particular and very exceptional case, pregnancy interruption is justified, without this meaning that we change our natural rejection of abortion itself (Faúndes et al., 2004, p. 94).

If the research by Faúndes et al. (2004), Diniz (2011), Madeiro et al. (2016), Madeiro and Diniz (2016) stated that religiosity is the primary justification for conscientious objection, Madeiro et al. (2016, p. 90) still raise the hypothesis of the lack of information about care for rape victims and the right to abortion in medical training, which encourages professionals

to use conscientious objection as a "refuge" arguing that they are not competent since they have not been prepared. As a result, we can state that the difficulties in the service provided to patients who are violence victims are implications of professional skills and the qualification of information per the legislation, which competes with the right to conscientious objection.

"Critical" care and the distress flow

Violence victims are cared for in the reference service studied in this work and divided into different sectors by victim's age and gender. A team specializing in GO has been working there for twenty years. In the first five years, the flow was divided between maternity, for cases in which the victim was identified as pregnant, and emergency care for immediate care in cases of physical violence. In the last four years, children began to be referred to pediatrics. The service flow is divided as presented in Table 1

Regarding violence care, 168 victims were recorded in 2018, with 146 sexual violence cases, 68 of whom were against women; in 2019, 241 sexual violence cases were recorded, and 190 were against women. There were no reports of elderly victims in 2018, while one case was treated in 2019. Regarding pregnancies, abortion was the option for seven (7) of the eleven (11) victims in 2018 and seven (7) of the twelve (12) victims in 2019, all of whom were students in the "up to 12 years of age" age group.

Such data are important for considering the justifications for professional practice within the scope of the service and the option of abortion. According to the doctors' reports:

> **Children always have a greater impact!** [...] They cannot defend themselves. (Doctor 1, emphasis added)

> There have been cases where I have finished treating and did not even know what to say. Because as I said before, the patient sometimes expects to hear something to comfort them... but then you cannot. However, every treatment for a sexual violence victim, which is what we receive... every treatment is very tense! In the end, you always leave very... [...] In the case of these victims, it is not just because the treatment is slow; it is because of the **psychological toll** it takes. Always! Once the treatment is over, you must go out and get some water and clear your head before continuing the other treatments. [...] **What impacts me the most is age. [...] Cases involving children or older adults bother me the most.** Very much! They affect me! [...] What affects me the most is that most of the victims I treat are **people close**. That is very sad! Whether it is **the father who was supposed to protect them, the brother, the uncle, or the stepfather**. That is very sad! (Doctor 2, emphasis added)

Table 1. Care at the reference service

Victims " 12 years		Victims ≥ 12 years Gender: Male	Victims ≥ 12 years Gender: Female	Pregnant women
Sexual violence	Pediatrics Location 1: weekdays from 7am to 7pm or Emergency Room (ER) 24 hours a day	24-hour Maternity	24-hour Emergency Room	24-hour Maternity
Physical violence		24-hour Emergency Room	24-hour Emergency Room	24-hour Emergency Room or 24-hour Maternity

Source: Prepared by the researcher based on the institutional internal protocol.

[...] **the proximity of the perpetrators, who are usually very close.** They are... it is rarer to see those on the street, those who approach. **Usually, it is the father, the stepfather, or the uncle.** In the vast majority of cases. (Doctor 3, emphasis added)

The patient's condition and age. **Children, we always feel more**... more like that... right? Always! We feel so sorry for children in everything. Children are not meant to go through these things. [...] **An adult uses them** for a long time! We treat children here who have been abused for four years! Right? So, it is very sad to see. **I think children should not suffer.** (Doctor 4, emphasis added)

Before, I did not... I used to say: 'Oh, but these people are fussy'. Fussy, not at all! Even me, pregnant, right? However, after she was born... I do not know why these things, **especially with children**...I do not even like to hear about them. (Doctor 5, emphasis added)

The psychological impact, faced with a "critical route" of reception to assess the subjective criteria that would guarantee an ideal reception, reflects the doctors' evaluation of the service. The hospital structure, forming the same care environment for the reception of violence victims and women in labor, will affect the way of thinking about the abortion protocol. The division of labor, especially the lack of sufficient human resources and the priority given to attending births, means that violence victims are sent to the reception area, as we can understand from the following reports:

[...] They question our doctor training. They do not question the training of the rest of the chain, do they? That bothers me, too. [...] You get to the door, and she arrives with a form... the notification form that someone filled out at the door, who is also someone who only has the training to be a receptionist. (Doctor 1).

[...] I had a case where I went in with a patient to be seen, with the victim, and the companion outside ended up opening up to other companions of other patients, which had nothing to do with it. And speaking! [...] There is no room for them to be separated. They wait at the reception [...]. They stay at the reception. I have seen a scared child because a woman was screaming in labor outside! [...] extremely scared pre-teen. [...] because they are being treated in a high-risk maternity hospital, with a huge flow of patients, and you are here treating this victim who will have a million paperwork to fill out, a million bureaucracies to do... it takes much time! Moreover, out there, there are pregnant women who you know may be giving birth. (Doctor 2)

It is an hour of care! You are there with five, six, or seven pregnant women waiting! (Doctor 5)

Furthermore, the doctors believe that delayed care could be resolved if medical experts attended to the IML for prophylaxis, suturing, and abortion, thus reducing the care flow provided by GO doctors. Therefore, the expert's competence is questioned:

[...] I know it is not an official expert report, right? However, that is what we do! That should be done in the expert report and transferred here with the discourse, the justification of helping the victim. I do not think it helps. Honestly, I do not think so! [...] **These would be expert report activities. I am not a medical expert. I am a specialist in my field: gynecology and obstetrics. Being a specialist in gynecology and treating women in situations of violence does not make me a specialist and qualified to perform expert reports!** (Doctor 1, emphasis added)

I have already been called to testify in a case where I did not write about the child's behavior or how he was that day. Then... 'Ah! The psychologist wrote it down.' I said: 'These are different care types.' **My care is very focused on playing the role of expert, which should not be mine either. That bothers me. Even though they say we are not playing the role of expert reports. However, in practice, we are!** So, I have to play this role, and I have to play the role of medicating, treating, and curing. (Doctor 2, own emphasis)

> [...] I think it should be clear, in my opinion, that the institution's objective is the prophylaxis of sexually transmitted infections, **and not to technically pronounce if... and technically affirm whether or not there was rape. Why? Because there is a doctor trained for this, called a forensic doctor. A medical expert. I am a gynecologist and cannot; I do not have the technical capacity to make certain statements that are often necessary and required in the report. Even in cases where I have been called to testify.** (Doctor 3, own emphasis)

We, therefore, understand that there is a greater impact related to working conditions in defining roles for compliance with the protocol. A "critical route" embarrasses professionals and victims in the maternity ward, which can escalate anxiety about abortion. As we will discuss later, although the doctors recognize the right to abortion in rape-related cases, the procedure is not desirable in light of individual values, favoring the doctor's right to conscientious objection. Therefore, the team should be sensitized on sexual violence, especially since they consider themselves incompetent to assess the behavior of violence victims, among other subjective aspects interpreted as being of an expert nature. Notably, as doctors specialized in GO, they reported that they could technically perform the procedure without being held responsible for functions outside the clinical scope.

The doctors' experience

According to the Code of Medical Ethics, professionals can abstain from performing an abortion due to conscientious objection, and the Penal Code protects the right of rape victims to an abortion. Since this is not a medical obligation in the autonomous exercise of the profession, the exception occurs in the absence of another professional in the face of an emergency or urgency that harms the patient's health (CFM, 2019, p. 15). Although, according to research by Faúndes et al. (2004), Duarte et al. (2010), Diniz (2011), and Madeiro et al. (2016), Madeiro and Diniz (2016), the justification of religiosity predominates to oppose the performance of the procedure, the six medical professionals interviewed in our research argued that they give priority to professional practice given the violence factor. Even the three who define themselves as religious would not activate the right to conscientious objection, as seen in the table 2 below.

Personal convictions concern feelings, but most said they did not interfere with work. However, we can infer that psychological effects are involved in performing the function that deserves attention to evaluate professional training since graduation, besides teamwork, awareness-raising training, and, more particularly, implementing abortion.

Therefore, even with the right to conscientious objection, there is an ethical discomfort in subjecting another colleague to the procedure. Faced with the victimization of the patient, who was raped, the doctors think empathetically, besides ethical compliance focused on their work. This fact reinforces the analysis by Faúndes et al. (2004, p. 94) that this is a particular, exceptional case, but that, even so, would not change the rejection of abortion, and it is relevant to consider the sociocultural aspects more specifically religiosity, which must be included in the training.

This situation occurs because the reports highlight conflicting feelings, as can be seen in the reports below, which can corroborate the defense of maintaining the pregnancy to proceed with an adoption, as in the case of the actress, a victim of sexual violence, who did so (Oliveira; Blotta, 2022), or even recognizing the risks as in the case of a girl of just eleven years old (Mayer, 2022) who had the abortion procedure denied amid the uproar of an organized group in front of the hospital calling the doctor a murderer.

> I am not going to leave here. I am going to attend to whatever comes my way. I cannot say no. I cannot refuse to provide this service. I cannot refuse to make this appointment. However, there are other points where people can refuse to provide this service, which bothers me. **No one can refuse to provide this service.** [...] I try to put myself in that place. **I do not know what I would do in the same**

situation. However, I would like to know that I have this option. (Doctor 1, emphasis added)

I am in favor of abortion in cases of rape, meaning that I have no difficulty in doing it. I do it. No (stutters)... at this moment, I do not (stutters)... **I prefer not to think too much about religion. Because if I were to look at religiosity, I would not do it. If I were to look at religiosity in isolation, I would not do it. No way.** (Doctor 2, emphasis added)

[...] I would like to... although I have the right to say that I cannot, will not do it... I compromise my next peer, who also does not want to do it. **It is something that no one wants to do.** So... if it happened... **it was bad luck to fall on my shift.** I think I have to since I accepted to work at this institution, and I accept it! I end up having to override my religion and my principles. [...] **I put myself in her shoes. If it were me, I do not know what I would do. Maybe I would opt for an abortion. Maybe not.** (Doctor 3, emphasis added)

I do not like to see patients, but I see them. [...] **I would not do it! However, I respect that woman, right? It is her right! So, period. [...] I... are you in favor of abortion? I am not in favor of abortion, but it is a situation... if it happened to me if it happened to my daughter... I would not want her to have one.** I always think like that and try to put myself in their shoes. What if it were me? How would I want to? Right? (Doctor 4, emphasis added)

[...] I am not in favor. **As a matter of principle.** Because I believe. So much so that here at the maternity hospital, as far as I know, they would say: 'There are two people here who do not do it'. It would be me and another doctor. **I do not do it. Thank God! I do not know about my shift. If they said: 'Look, you will be arrested'. I would be arrested. 'You will lose your CRM'. I would lose my CRM. I would not do it. I do not do it, and I never have.** Even when there is a case, for example, of an abortion due to anencephaly. I do not put misoprostol in. **Now, if I get the shift, the patient is there and bleeding, an emergency, and needs to have a curettage after it happened. Then I do it.** I am assisting the patient. [...] Because of conscientious objection. (Doctor 5, emphasis added)

It needs to be identified and done as soon as possible. [...] the person has the right to have an abortion because she could die during pregnancy. (Doctor 6)

Generally, abortion is justified when the risk of death and a series of complications can develop during a pregnancy, from the first trimester (from 1 to 13 weeks of gestation) until the end of the pregnancy. When analyzing the 2018 medical records of the conceptions, 4 of the 11 cases were not referred for abortion, and in 2019, 5 of the 12, for the following reasons: court decision, advanced gestational age, non-hospital post-abortion curettage (fetus without Fetal Heartbeat - FHB) and the option to maintain the pregnancy (see Table 3). However, for the doctors, there is greater attention to cases of rape of vulnerable people, children under 14, and when the same patient is victimized and treated within a short period. These situations give rise to the responsibility to report situations of violence, given the probability that they are conditioned by a relationship "consented" by fathers or mothers. However, they reported feeling uneasy about the persistent situation that sometimes is not understood by family members, nor by the victim herself, to the point of being characterized as rape.

That said, a condition of vulnerability affects people with uteruses who seek the service to exercise their right to abortion and reflects the anxiety related to an unequal structure between masculinity and femininity (Bandeira; Amaral, 2018). In rape, absolute male power is justified as an injunction that marks a place of preservation of hierarchically positioned masculinities.

The doctors who treat the victims and perform the abortions are left with the psychological

Table 2. Relationship between conscientious objection and religiosity

	Religious	Non-religious
No conscientious objection	3	1
Conscientious objection	1	1
Total	6	

Source: Prepared by the researcher.

Table 3. Final disposition

2018	
Did you give up legal abortion?	
No	7
Yes	2
Advanced GA	1
Fetus without FHB	1
total	11
Case outcome	
Legal abortion	7
Abortion not performed (Court decision)	1
Advanced GA (pregnancy + donation)	1
Non-hospital abortion/curettage	1
Opted for pregnancy	1
total	11
2019	
Have you given up on legal abortion?	
No	7
Yes	3
Advanced GA	1
Fetus without FHB	1
total	12
Case outcome	
Legal abortion	7
Opted for pregnancy	2
Advanced GA (pregnancy)	1
Non-hospital abortion/curettage	1
GA disagrees with the violence date	1
Total	12

Source: Prepared by the researcher based on medical records.

effects, as evidenced in the reports of distress - including nightmares, fears, and distrust of "men" - and the perception of the need for a technical and humanized practice, considering the number of female victims and male rapists. The dualism that persists between an active pole for masculinity standards and a passive pole for femininity justifies rape to "force" women to "assume" a position of subordination (Bandeira; Amaral, 2018) since it is an exercise of the male power sovereignty.

When they expressed anguish related to choices of clothing, expected behaviors, social values attributed to motherhood and infant care, and feelings heightened by the hospital experience of caring for victims of sexual violence and abortion as a result of rape, a femininity vulnerability effect is evident. Considering the accounts of these female doctors for further research is important to assess the impacts of this dynamic in the contexts that correlate violence and health.

Final Considerations

The doctors say they must assist patients seeking the service, but they feel embarrassed when summoned to testify in the cases. However, four of the six respondents defended abortion in rape-derived pregnancy cases, one in cases of complications that result in mortality, and another in cases of delegitimization of abortion. As mentioned in other studies, legitimization is usually empathetic. By "putting oneself in the victim's shoes", sexual violence legitimizes abortion. Given these effects on the lives of doctors inside and outside the institution, it is essential to include the topic in basic and continuing education, along with communication within the network of professionals, so that investments in infrastructure guarantee protection in the reception for the victim's proper care.

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Contribution of the authors

Kétlen Martins conceived and designed the study, reviewed the articles, conducted the interviews, collected and analyzed the data, and produced the manuscript; Daliana Antonio supervised the research, review of the articles and data analysis, and contributed to writing and reviewing the text.

Financing

This study was approved by the Research Ethics Committee (Approval No. 5.287.191; CAAE No. 56145622.0.0000.5146). It was self-funded and received institutional approval under the supervision of the coordinator of the Maria Barbosa Maternity Unit, which hosts the Assistance Service for Individuals Experiencing Violence at the Clemente de Farias University Hospital (HUCF). This service is the regional referral center for cases of sexual violence and legally authorized abortion in the macro-northern region of Minas Gerais State, Brazil. The present article is based on a monographic thesis submitted in partial fulfillment of the requirements for the Bachelor's degree in Social Sciences, entitled "Rape and abortion: the experience of female physicians who attend to victims of sexual violence," and is available in print format.

Editors: Ivia Maksud; Miguel Ângelo Montagner
Received: 05/15/2024
Resubmitted: 08/05/2024; 10/11/2024; 11/28/2024
Approved: 12/16/2024