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In the Name of Women. Comparing Gynecologists' Discourses About Abortion in Italy

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Abstract

For at least fifty years, voluntary termination of pregnancy has represented a terrain of struggles among different theoretical and political positions, often claimed 'in the name of women' (Pitch, 1992; Koralewska & Zielińska, 2022). The rate of objecting doctors and recent changes in the regulation of the pharmacological abortion have rekindled the debate on the actual access to the service in Italy. And, once again, the different parties refer to 'women's interests and well-being', sometimes explicitly in the name of a feminist position, sometimes in the name of human rights, sometimes on scientific evidence. Drawing on a field research based on in-depth interviews conducted with gynecologists and other specialists, this article explores the discourses around the legitimacy, the best techniques, and the most appropriate conditions of abortion to understand how these health professionals set their own 'threshold of legitimacy'. As we shall see, the need to reduce their own dissonance and value conflicts lead them to set a hierarchy of deservingness of abortion that put women's behavior into a moral ranking. Again, very different positions are rhetorically taken in the name of women, whose actual agency is discussed at the light of our research results.

Keywords: abortion, women's agency, female body.

1. Introduction

For at least fifty years, the voluntary interruption of pregnancy has represented a battleground for different theoretical and political positions. At

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the center of the disputes is the meaning attributed to abortion - should it be seen as an interruption of human life or not - but also the strain of bringing it into a worldview around women's rights and freedom, individual agency vs. structural conditions, access to public health services, and, among care providers, the right not to be discriminated against because of personal or religious convictions. As Luc Boltanski (2004) explains, abortion is performed in all cultures and populations, benefiting from a variable *threshold of legitimacy*, but it is hardly symbolically elaborated, because it lies at the heart of the contradictions of a society – namely, the principle of the uniqueness of beings and the postulate of their replaceable nature.

In addition to ethical and political divisions between those who recognize its legitimacy and those who do not, abortion is far from being unquestioned among people who accept it altogether. For example, there is debate regarding the extent to which is to be practicable and/or accessible for any woman, at any age and in any condition. Many divisions have arisen, for example, around its facilitation through pharmacological provision and/or telemedicine, and the risk of trivializing it. The premise underlying these discussions is that abortion is considered as a trauma to be prevented: its trivialization - using it, for example, as an alternative to contraception - should be avoided (some authors have questioned this interpretation, however: see Lalli, 2013). So even among those who support the right to abortion, the conditions of abortion are continuously questioned and are never assumed once and for all. The extent of legitimate intervention of the state over private decisions, the degree of access to abortion services and their availability, the appropriate number of abortions in a lifetime, the distinction between the use and the abuse of abortion, but also the most appropriate abortion technique, are all strongly debated issues among abortion supporters, in healthcare environments, political disputes and in civil society. What they all have in common, today as in the past, is that they are often claimed "in the name of women" and to protect them (Pitch, 1992; Kumar et al., 2009; Koralewska & Zielińska, 2022): each position produces and reproduces a specific vision of women's agency and, indirectly, a specific conception of the female body.

Contemporary Italy is an interesting field in this regard. In this Catholic country, abortion politics has been strongly politicized since the Seventies, when it was debated by political party representatives but also supported by lively street feminist movements. Today, while the right to abortion is generally recognized from a theoretical point of view, its actual implementation is far from being secured: Italy has the highest rate of medical objectors in Europe and the free access to abortion services is still questioned. According to feminist movements and experts, when abortion is not fully provided, women are forced to perform it illegally and in very risky ways, almost as it was before its

legalization. Interestingly, anti-abortion activists often claim to speak in women's interests as well: when abortion is too easily accessible, they argue, women see it in a trivialized way and are somehow forced to renounce maternity, which they believe contributes to the country's low fertility rate. Again, they all assume to speak 'in the name of women'.

After the Covid-19 pandemic, some important changes have occurred in the national abortion regulation. In August 2020, the need to decongest the hospitals led the Ministry of Health and the Italian Medicines Agency to push for the pharmacologization of the procedure - still largely surgical in the country - making it more accessible and extending the deadline when it can be used to interrupt a pregnancy. This could revolutionize the provision of abortion services and implicitly asks doctors to take a stance on the matter.

This article explores the discourses of Italian gynecologists and other expert figures regarding the legitimacy, preferred techniques and most appropriate conditions of abortion to understand how they establish their own *threshold of legitimacy*. As we shall see, the need to reduce their own dissonance and value conflicts leads healthcare professionals to set a hierarchy of deservingness of abortion that places women's behavior within a moral ranking. Again, very different positions are rhetorically taken in the name of women's interests and well-being.

2. Background and literature review

In 1978, the Italian Parliament passed law no.194, thanks to the efforts of feminist movements and party representatives who highlighted the suffering and risks women faced when obtaining illegal abortions (Ghigi, ed., 2018). The law allowed women to voluntarily terminate pregnancies for reasons related to health, social, economic and family factors, within the first 90 days of gestation. Since then, there have been changes in the contraceptive culture and sexual behaviors of the population, resulting in a decrease of the abortion rate. In 1983, the rate was 16.9 per 1,000 women aged 15-49, which dropped to 5.4 in 2022. Italy's abortion rate is among the lowest globally (Ministry of Health, 2022).

However, the implementation of law 194 has faced several challenges over the past four decades. As a compromise between different positions during the Seventies debate, the law granted health professionals the right to declare conscientious objection, allowing them to refuse to perform or participate in abortions based on ethical reasons. The declaration of objection prevents them from performing abortions in both the public and private sectors. Although this provision aimed to make the law more acceptable to society and enable already-hired healthcare professionals who were against abortions to continue working

without being forced to operate against their personal and religious beliefs, conscientious objection remains a highly preferred option, even among newer generations of gynecologists. In 2020, 64.6% of gynecologists, 44.6% of anesthetists and 32.2% of non-medical personnel[1] declared conscientious objection (Ministry of Health, 2022). The rate of objections is not evenly distributed across the country and can exceed 80% of gynecologists in some Regions. This regional variability leads to disparities in service implementation, requiring many women to travel between Regions to access timely abortion care and often resulting in late-term abortions.

Sociological research on abortion has predominantly focused on women's experiences as abortion seekers. This emphasis is understandable given that discussing the topic encompasses a wide range of issues, including the history of feminist movements, reproductive rights as human rights, gender regimes, welfare provisions, and the costs of motherwork, childlessness and childfreedom. As Walby (2011) recalls, while abortion, contraception and reproductive health are part of feminist projects within civil society, there are significant variations between countries, but the perspective of "maternal feminism" remains a central topic of debate. Feminist thinkers have been engaged in debates on abortion, pregnancy and mothering for decades. While they share the recognition that female fertility has been a site of dominant male power and knowledge, they have generated diverse responses to the experiences of pregnancy and motherhood. Some feminists argued that women's oppression stemmed directly from reproductive biology which needed to be challenged. Classic feminist writers like Simone de Beauvoir or Adrienne Rich proposed that women be released from the biological state of affairs; radical feminist Shulamith Firestone extolled the advantages of artificial means of reproduction to liberate women from the burdens of procreation; others, like Mary O'Brien or Iris Marion Young reassessed the bodily experience of maternity, highlighting its unique way of experiencing the world and freedom from male-regulated forms of knowledge (for a review, see Kawash, 2011; Sassatelli & Ghigi, 2023). One common point among these perspectives is certainly the acknowledgment that structural and cultural conditions significantly influence the experience and attitudes toward motherhood, as well as the reproductive choices of women.[2]

[1] For methodological reasons, in this article we focus specifically on the case of gynecologists and anesthesiologists, although in Italy different types of healthcare professionals can exercise conscientious objection and their choice also entails significant implications for ensuring access to the abortion service.

[2] Recent motherhood studies are shedding new light on the issues, allowing to understand the individual choice against a wider cultural and structural background (see

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In terms of abortion, there is a growing body of research on women's experiences, attitudes and conditions. Studies have examined the contextual factors surrounding abortion (De Zordo, Mishtal, & Anton, eds., 2016), the reasons and decision-making processes (Kimport, Foster & Weitz, 2011) and and the stigma associated with abortion (Cockrill & Nack, 2013; Hanschmidt et al. 2016; Kumar, Hessini, & Mitchell, 2009; for a review of these three strands, see Purcell, 2015).

However, research on the practices and attitudes of doctors and healthcare professionals regarding abortion remains relatively underdeveloped. Despite public debates that often present experts as strongly in favor or against abortion, empirical literature suggests a more complex and nuanced situation. The exercise of conscientious objection to abortion is influenced by a combination of contradictory ethical, religious, cultural and organizational factors, creating a far-from-smooth landscape. The empirical literature available on the topic, can be summarized into three main reasons for conscientious objection (Quaglia & Ghigi, 2023): a) ethical or religious motivations, based on the belief that the embryo is a person in all respects and the doctor's duty is to preserve and protect life. The literature highlights that even among those who object on ethical or religious grounds, there is heterogeneity in attitudes: for example, a study (Fink et al., 2016) identified three different types of ethical objectors – extreme, moderate and partial – and distinguished a wide range of perspectives and practices. "Extreme" objectors not only refuse to perform abortion, but also provide misleading medical/legal information to discourage women from accessing abortions, while "moderate" objectors do not perform abortions, but respect women's will and refer them to non-objecting colleagues; lastly, "partial" objectors performed abortions but only in specific circumstances. b) Some studies (e.g. Freedman, 2010; De Zordo et al., eds., 2016; O'Donnell et

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O'Reilly, ed., 2010; Kawash 2011). Choosing to have a baby in a context where the model of intensive mothering ("a gendered model that advises mothers to expend a tremendous amount of time, energy, and money in raising their children", Hays 1996, p.x) is prevalent, for example, can be considered as highly expensive in terms of opportunity costs if she wants to have a full commitment to her career and an ongoing dedication to life in the world outside home as well. At the same time, in a context where mother's workforce participation is still hindered by (a lack of) policies, precariousness, organization cultures and social attitudes, having a (new) child could amplify the gap between personal desires of equality, autonomy and financial independence and the expected experience of motherhood. Neoliberalism and consumer capitalism have produced new dilemmas in the social construction of motherhood and the idea of postmaternalism, but, according to some (Stephens 2011), this could provide impetus for an alternative feminist maternalism, now centred on a politics of care.

al., 2011) have highlighted that abortion stigma plays a significant role in the decision to conscientiously object. In fact, stigma not only affects women seeking abortions, but also physicians who perform them. Abortion stigma stems from the perception that terminating a pregnancy is equivalent to taking a human life or is the consequence of irresponsible and immoral sexual behaviors. The act of performing abortions is often viewed, with Hughes (1951), as "dirty work", similar to socially degrading activities such as street sweepers, gravediggers or executioners and others which involve contact with organic or disgusting or morally questionable elements (Harris et al., 2011: 1062). Therefore, the decision to exercise conscientious objection might also be a strategy to avoid abortion professional and personal stigma. This aspect is particularly relevant for gynecologists, as conscientious objection further divides a profession already characterized by a high internal fragmentation by acting as a dividing line between conflicting value systems (Spina, 2019). Those who choose to provide abortion services often find themselves marginalized and isolated. c) Organizational culture and career requirements can also influence the decision to object (Chavkin et al., 2017). In extreme cases, entire institutions publicly hold anti-abortion positions, and healthcare professionals must share the same perspective to work there (e.g. Keogh et al., 2019; Fleming et al., 2018). This is particularly relevant in the case of Italy, because despite the prohibition of institutional objection under law 194, there are several hospitals with 100% conscientious objectors[3]. Indeed, when conscientious objection is exercised in this way (although often informally, simply not providing the service in the hospital), it is more likely to significantly hinder women's access to sexual and reproductive health services compared to individual doctors' conscientious objection (Fiala & Arthur, 2014).

Additionally, in hospitals with high percentages of objectors, non-objectors who provide the service often bear the burden of increased workload, spending most of their working hours performing abortions, which can hinder their career progression. Therefore, a gynecologist's or anesthesiologist's decision to object may depend on individual motivations as well as the context. A pro-choice attitude does not necessarily translate into a willingness to provide the abortion services, and a pro-objection decision does not necessarily reflect an ethical opposition to women's right to terminate a pregnancy. The provision of abortion services does not always indicate a positive attitude towards performing the task.

[3] For example, see: https://espresso.repubblica.it/inchieste/2023/01/30/news/aborto_lombardia_medici_obiettori-385721841/ (last viewed 16/05/2023).

Collecting the voices of healthcare providers is crucial to understanding the underlying reasons behind their formal decision to object or not. Through their interpretation of women's needs and rights, gynecologists and doctors provide valuable insights into how female bodies continue to be political battlegrounds.

3. Method

The findings presented in this article are part of a broader research that was conducted in Italy from 2021 to 2022 with the aim of (a) identifying the main challenges in implementing law no. 194/78; (b) exploring the various reasons that influence doctors' decision to exercise conscientious objection towards voluntary termination of pregnancy; (c) examining the factors that lead gynecologists to choose a specific abortion technique (particularly, medical vs surgical abortion) and a specific type of anesthesia (particularly, local vs general anesthesia). To address these questions, 40 in-depth interviews were conducted with 33 gynecologists, 5 anesthesiologists working in public and/or private accredited facilities (the only authorized institutions allowed to provide abortion in Italy), and 2 epidemiologists. In order to gather diverse data, the interviewees were differentiated based on their gender; age; career stage (senior doctors vs. trainees); employment status (e.g. department heads vs ward doctors); employment context (Region); and opinions and beliefs regarding voluntary abortion. On average, the interviews lasted 60 minutes and were fully transcribed *verbatim*. Various strategies were employed to recruit participants. Firstly, key informants, who were recognized experts in the field at a national level. We asked them for contacts of potential participants and then utilized a snowball sampling method. Another sampling strategy involved searching online for publicly available contacts (such as hospital websites) to identify potential interviewees who matched the research criteria. Lastly, professional organizations, associations and professional social media groups were contacted to recruit participants. The privacy of the interviewees is ensured through pseudonymization and the removal of any identifying details.

4. Results

4.1 Being a gynecologist: for women and for life

One of the first questions we used to break the ice concerned the reasons for choosing the specialty: why did gynecologists choose to be gynecologists?

Many interviewees, both senior and junior, explicitly mentioned their desire to dedicate themselves to life, if not specifically to women. Since the specialty includes both gynecology and obstetrics in Italy, in many cases the latter aspect prevailed. When asked to share positive anecdotes about their work, interviewees (both men and women) often recounted moments of satisfaction in bringing new life into the world, whether it was after a long and difficult labor or in cases of management of infertility.

> There is a rational reason that stems from the fact that the profession is associated with life rather than death (...) It is the most profound connection with life that can exist, not just in terms of giving birth to children but also in giving birth to moms actually? (Female, trainee, 26).

The delivery room is described as the physical space where their profession is performed at its best. As such, it is also depicted as a place to strive for and "conquer" and one of the most coveted by trainees. In many cases, young gynecologists perceive themselves to be in fierce competition with each other to gain the attention of the chief who selects those who can work in the delivery room and perform emergency surgery during childbirth, which is a rare opportunity. Due to the significance of obstetrics in their choice of specialty, many gynecologists decided to pursue this path based on their desire to assist women in giving birth. For some gynecologists, this commitment is closely tied to their willingness to care for women, often displaying explicit sensitivity to gender issues or gender medicine. Female gynecologists may combine this sensitivity with active political engagement, advocating women's reproductive freedom both professionally and in civil society.

This point is particularly evident when comparing different cohorts of gynecologists. Older gynecologists often fuel their awareness with the memory of the circumstances surrounding unwanted pregnancies before the legalization of abortion in Italy. Some of them became gynecologists as a result of their feminist political activism. The experience of abortion scrapings procured by unprofessional midwives or by women themselves clandestinely, often in unsafe and unhygenic conditions, influenced many older gynecologists to choose this particular specialty from among the various medical disciplines. While it is possible that their perspectives are influenced by rationalizing in retrospect their own personal and professional paths, made up of daily choices and contextual and relational pressure factors, the memory of the pre-legalization era is certainly vivid in many older generation gynecologists.

> A woman died in my town. Of a procured abortion. When the law didn't exist yet. So I said 'I'm a doctor, a woman doctor, I will be a women's

> doctor!'. I mean, I don't call myself a gynecologist, I call myself a women's doctor. This was a strong motivation for me to choose the specialty of obstetrics and gynecology. (Female, retired gynecologist, 68).

As we have observed, the choice of specialty is often driven by the desire to bring life into the world. For this reason, abortion is sometimes seen as a sort of 'failure', even by those who are not objectors or who are not driven by religious beliefs: it is something that distorts or contradicts the reasons why they initially chose this job. This sentiment is particularly strong among younger generations of gynecologists, such as trainees, paradoxically those who entered the specialty after the law legalizing abortion was already in place and abortion was one of the possible tasks. They have no direct experience of dealing with women seeking abortion in a context of illegality, like managing complications of self-inducted abortions. Additionally, they report having minimal exposure to ethical courses surrounding abortion during the training and the graduate years at University.

In other words, younger generations have no experience of being compelled to take a stance on abortion. The older generations of gynecologists had to confront the issue more directly during the years when legalization of abortion was being debated. Nowadays, they are simply asked by their superiors at the beginning of the training whether they are willing to exercise conscientious objection or not, in order to manage abortion services and work shifts of the team. Consequently, young gynecologists are never required to justify their choice, or engage in discussions with colleagues about the social factors that may influence a woman's likelihood of undergoing one or multiple abortions throughout her lifetime. Furthermore, gynecology residents do not have the opportunity to explore the issue of women's reproductive freedom theoretically during their training. When such exploration does occur, it is usually driven by personal or extra-professional motivations.

As a result, the new generations of gynecologists appear to choose conscientious objection for career-related reasons, without deeply reflecting on the contradiction between their original reasons for entering the specialty (life) and their perception of abortion as the end of life. They often fail to question whether the abortion truly signifies the end of life or whether the woman's life itself should be taken into account.

4.2 "I'm Catholic. But."

When it comes to non-objecting healthcare professionals, directly engaging in concrete situations of abortion and clinical practice requires them to

contemplate their initial ethical and religious stances which may come into conflict with the actual health needs of women. For Catholic doctors in particular, this often necessitates reevaluating their values, and in some instances, it has even impacted their religious practices. Placing emphasis on clinical practice and professional obligations over personal beliefs entails the need for compromise and, at times, an ongoing internal struggle. However, as expressed by interviewees identifying themselves as Catholic, the priority remains with women, their rights, and their will:

> There is undoubtedly a personal awareness that prompts one to question many things, I have made the choice not to be an objector. Being a Catholic I find myself in a mystical crisis (smiles) like few others. But there is, and I know, there is a personal freedom for women that transcends a set of ethical principles, and therefore it is challenging, I used to be a practicing Catholic, until I entered specialization. Since then, I have stopped attending Mass. (…) At the moment I am experiencing an inner conflict of inconsistency. (...) The problem is that we are not entitled, fortunately, to decide who can and who cannot (obtain an abortion). Because we don't have to decide, but let's say that there are situations that truly make you question everything. Absolutely everything. (Female, trainee, 26).

Various discursive strategies have been employed to address the cognitive dissonance that arises from conflicting values. Some participants, like the one mentioned above, propose a hierarchy of values, prioritizing the autonomy of women over the ethical and religious beliefs of healthcare professionals. On the contrary, others reframe abortion practices using religious values to view their work in abortions as an altruistic act aimed at assisting women in need. For instance, Doctor Red[4], a retired chief gynecologist, identifies himself as a practicing Catholic and portrays his commitment to abortion and women's self-determination as a "service". He emphasizes the importance of suspending judgment and helping those in need. In his narrative, the legitimization of his position is constructed as opposed to those colleagues who, unlike him, become objectors out of convenience rather than personal conviction:

> If someone says: "This is life, I'm a murderer if I do it", I take my hat off because I understand, having been one of them. But good and evil don't exist, you have to make an assessment. If everyone withdraws, we'll return to a reality that I experienced, and it was inhumane. So, one must assume

[4] To protect the anonymity of the participants, all names in this article have been changed to pseudonyms.

> responsibility and guilt, and accept it, that's how it is (Male, retired head physician,72).

In this perspective, Catholic gynecologists view performing abortions as a sacrifice, a "murder", acknowledging the weight of guilt and considering it necessary to prevent an even worse scenario, that of clandestine abortions and their dire consequences.

Another discursive strategy employed by non-objector Catholic gynecologists involves distinguishing between their personal beliefs and their clinical practices. They argue that their ethical views, including those on abortion, only inform decisions in their private lives, not their medical practices. For instance, Doctor Brown, a practicing Catholic states that, while she would never have an abortion herself as a woman, she prioritizes women's right to safeguard their health as a doctor. In her words:

> I know religious people, practitioners, true believers, who are not objectors, because it's not a personal choice, but because they believe that the Italian law must be respected. For example, I am someone who probably would never have had an abortion in her life (…) and that (…) has always troubled me (…). Nonetheless, I've always been a non-objector here. (Female, senior gynecologist, 66).

A third commonly employed discursive strategy revolves around shifting the focus from the ethical choices of doctors to the autonomy of women. Participants argue that women should have the sole authority to make decisions regarding their bodies and conscience, while doctors have a duty to respect their choices and provide the necessary medical services:

> How did I reconcile it? I reconciled it because in my job as a doctor, I provide a 360-degree care, for everything a person needs. That's all. When I perform a pregnancy termination, I mean, a tube has nothing to do with my conscience, because it is the person I'm looking after who needs to resolve any hesitations or conscience-related issues. Does it concern me?... No. I'll take care of it, that's all. (Female, retired gynecologist, 68).

These illustrate the strategies doctors employ to reduce dissonance when choosing not to object, grappling with the contradictions between abortion and their chosen specialty, as well as between religious beliefs and the act of abortion. Their aim, they argue, is to meet women's needs and advocate on their behalf. Those who have decided to object, in most cases self-defined Catholics, do not appear to grapple with such dilemmas, as their choice seems to involve

fewer ethical costs and compromises. Instead, they tend to justify their decision to work for women and "in their name", as we will explore further.

4.3 Abortion deservingness

The interviewees, when questioned about topics such as abortion and objection, expressed an ongoing process of internal negotiation and construction of their own *threshold of legitimacy*. Doctors who identify themselves as religious (with the majority of our sample identifying themselves as non-practicing Catholic Christians) come to terms with the idea that women have the right to terminate an unwanted pregnancy, as we have seen. However, this moral compromise is not the sole ethical dilemma they must face. Within gynecologists' discourse concerning women, an inherent inclination emerges to establish an additional threshold of legitimacy: distinguishing between those entitled to and deserving of abortion and those who do not deserve it – thus making this job a frustrating practice. More specifically, women are positioned on a *continuum* of deservingness based on moral considerations. At the one end of the *continuum*, we find those fully entitled to abortion – women who seek it due to fetal malformations, health risks, or pregnancies resulting from circumstances out of their control, such as sexual abuse or forced prostitution.

> We must respect the choice, even the most absurd one. It happened to me once to perform the thirteenth abortion to a woman for whom in the end the ward staff collected the money to have her put in an IUD. She just couldn't afford it (Male, retired anesthesiologist, 73).

Proceeding along the continuum, there are pregnancies in very young women, often resulting from misinformation about contraceptives or limited access to safe contraception. While these types of pregnancies are generally deemed deserving of abortion, they may still attract negative commentary, given that access to contraceptive information and technologies is now guaranteed. Furthermore, there are cases of women seeking abortion because they already have other children, and sometimes the pregnancy was registered late. Their request for an abortion is tolerated, albeit contingent on accidental circumstances.

> There are women who, for one reason or another, even sometimes for a simply trivial question of difficulty in accessing a pregnancy test, or were unaware that their period had not not arrived. Many women who already have two, three or four children come to my office and say: 'No, I really

> didn't notice it because I was taken up with so many other things'. […] Well, I certainly welcome them from an ethical point of view. (Female, trainee, 27).

Finally, at the opposite end of the morality continuum, there are women who employ abortion as a form of contraception (as some interviewees have labeled it). That is, those seeking a fifth or sixth abortion. This phenomenon tends to be particularly interwoven with the origins of the women, often East European migrants.

> (As long as abortion is) something left to individual free choice, without controls, I'm worried about that, because we are importing people from Eastern Europe who have a truly wrong attitude towards this thing (…). In the ex-Soviet area this practice is used as birth control (...) and it is lived, in my opinion, with too much permissiveness, absolutely let's say (Male, retired anesthesiologist, 73).

Gynecologists sometimes acknowledge that performing multiple abortions for different individuals is not very different from performing multiple abortions on the same woman, for them as doctors. Nevertheless, they cannot help but pass judgment on women who seem to "take advantage" of the law, perceiving it as a means to effortlessly evade the (economic, physical, emotional and social) consequences associated with an unwanted pregnancy. Thus, gynecologists establish their own threshold of tolerance and legitimacy regarding the number of abortions a woman can reasonably undergo without falling into exaggeration. Phrases like "You can be wrong once or twice"; "I understand sometimes, but not five or six"; "You can't forget the contraception eight times!" frequently define this threshold, which tends to be lower where the socio-economic conditions of the woman make contraception accessible. Once the threshold is surpassed, the woman's behavior is negatively connoted from a moral point of view.

Implicitly, women are described as irresponsible for their sexual conduct through abortion, as they transfer the costs of their irresponsibility onto others - the public service, health providers, and even the embryo itself. In this case, interviewees mostly refer to certain women's misinterpretation of the law provision, which ultimately affects other women and health providers. Gynecologists thus see their mission (helping to give life) frustrated and their own role distorted. Interestingly, the lived experiences of women who undergo abortion, their body autonomy, and the complexities they face are not mentioned, as if the female body were the simple scenario within which women and doctors make their choices. Women who have multiple abortions are

viewed as someone lacking awareness of the risks associated with the procedure, and who have no recollection of their previous abortions.

This narrative is even more evident among gynecologists who do not identify themselves as believers but have chosen to object. When rationalizing their decision, rather than referring to career or contextual reasons, they often end by blaming women who "take advantage" of abortion for not assuming their responsibilities (as if having an abortion weren't an assumption of responsibility at all).

> (I do not object) because the Pope says so, or because a priest says so (…) but when I do an ultrasound, for example, at the eleventh week, have you ever seen it? (…) you can see the stomach, you can see the arms, (…) the heartbeat. So, it's a life for me. (…) And killing a life requires an important reason. Which is not using the (law) 194 as a contraceptive method. That is, I do not accept being told: "I was wrong". All right, you were wrong, well consequences are to be paid! So, you can't take a life just because you made a mistake. (…) But you see women who have five, six or seven abortions. It is unacceptable! (Male, gynecologist, 61).

Moral judgement, even if avoided in theory, unconsciously emerges in the words of the interviewees. Many objectors who performed abortion in earlier stages of their career say they were frustrated because some women trivialized abortion and "did not deserve it", as they often report. Interestingly, the role of the man involved in the pregnancy, his responsibility and his knowledge of contraception were never mentioned.

Paradoxically, women who have multiple abortions are accused of undermining the law by excessively relying on it. This perspective is exemplified by the views of Doctor Green, a 56-year-old objecting gynecologist. He chose to refuse performing abortions due to what he perceives as the permissiveness of the law, allowing women to have multiple abortions free of charge and with "no dignity". From his viewpoint, this situation leads to "anarchy" that will deprive women of this right. In other words, he too decided to object "in the name of women".

> Let's create a (new) law establishing very clear boundaries, where a woman knows she can be wrong once, she can be wrong a second time after two years, it's normal that this can happen, but she has to pay for the third time! You'll see, she will then understand and she will use an IUD, or a pill, etcetera. That is, we are in 2022. It is not possible to hear: "I want to interrupt because now I would have to start over with diapers". Clear? It's hard to accept this. (...) And so this becomes a problem and will take away women's freedom! Women's freedom will be taken away from those same women who

> continue to live in total anarchy. Anarchy [will] cause us big problems. The problem of doctors who don't want to perform interruptions is not linked to an ethical or moral problem, it is only linked to the fact that interruptions are done in a bad way, without any professional respect for women's dignity, and this is because there is a law that does not give dignity to women and people. It is not reasonable having women who interrupt 10 times, 7 times, 8 times (...) and take money away from other services, such as oncological research (Male, gynecologist, 56).

4.4 Medical paternalism and women's agency

Medicine has historically relied on medical paternalism, which entails the expectation that clinicians, as experts, would make the optimal decision for patients, without necessarily involving them in the decision-making process. Although contemporary medicine increasingly takes into consideration the patient's decisions and needs, the issue of abortion represents a critical case for clinical practices due to its association with autonomous individuals[5] voluntarily seeking a medical intervention or treatment related to their reproductive health. Just like other reproductive technologies, this specific feature can create a mismatch with the paternalistic behaviors of health care professionals.

One argument frequently employed by numerous physicians is that abortion has detrimental effects on women as it is perceived as a traumatic experience for them. Consequently, some argue that abortion should be restricted or avoided whenever possible. Doctor Purple, a 66-year-old objecting gynecologist, explicitly asserts that it is a tragic event that induces grief in women, regardless of the fact that they could be or not be aware of this:

> Let's face it, nine times out of ten abortion is a drama, even for the woman who says "No, I've decided", and seems to be resolute, it's not true, it's a drama anyway, and we as gynecologists should know it (Male, gynecologist, 66).

The perception of abortion as a trauma emerged not only in the narratives of conscientious objector physicians, but also in those of non-objector physicians, frequently influencing their justifications for choosing surgical abortion over medical abortion. For example, some physicians assert that they would never choose a pharmacological procedure instead of the surgical, as the

[5] As we shall see, the term 'patient' is more than problematic when referred to abortion seekers. Nevertheless, this aspect is often overlooked, even by those who focus on abortion terminology, see as example Kaller et al. (2023).

former involves multiple stages that require the woman to remain actively vigilant for several days (monitoring contractions, assessing the level of bleeding, etc.) in her own home. In contrast, the latter places the woman entirely in the hands of the surgeon within an institutional setting (the hospital) with the entire process completed in a matter of minutes. Other interviewees employ a similar line of reasoning to express their preference for general anesthesia over local anesthesia. The former is preferred as it ensures that the woman remains unaware during the (presumed) traumatic abortion experience, resulting in minimal recollection of the event.

> I think that the woman should be protected, from a mental point of view, with general anesthesia, for example, it is better that *she is not there* at that moment because letting her be awake at that moment would be cruel in my opinion (...) there are some things in which it is better that the subject *is not present*. In my opinion, once everything is a journey made in awareness, a brief absence, which means avoiding a negative, traumatic memory, etc., in my opinion is best for her (Male, retired anesthesiologist, 73).

In this case, the best option entails the *absence* of the woman during the abortion procedure, signifying her non-participation and even her lack of awareness regarding the proceedings. In other words, the ideal abortion is one that is not experienced by the woman.

Consequently, women are seen as problematic in two respects. Firstly, when they are not fully aware of the significance of the event encompassing the associated risks, economic burdens on the health care services, and its bioethical considerations, an attitude which drives them to trivialize abortion (and sometimes to have multiple abortions). Secondly, it is preferable if they remain entirely unaware of the experience itself, which is inherently deemed traumatic. The possibility that an abortion may not necessarily be traumatic is not contemplated by the majority of our interviewees, except for certain senior gynecologists, who base their professional decisions on active involvement in feminist movements and a commitment to the complete implementation of the law.

In this regard, the words of Doctor Pink, an epidemiologist who has drawn attention to the pervasive nature of paternalism within medical practice as a manifestation of a wider patriarchal culture, hold particular significance:

> Controlling the woman's body is the base for power. So I don't think that all those who interrupt pregnancy with general anesthesia (instead of local) have the explicit ambition or in any case the perhaps innate desire to control the woman's body. I say they are not aware of it. They participate in

> an ideology, they participate in a system, because culture is steeped in this history of the control of women. (Male, epidemiologist, 77).

Although the perception of abortion as harmful for women might be the result of a broader patriarchal culture that does not recognize women's self-determination, the actual experience and everyday clinical practice might challenge such assumption and promote a change in the woman-physician relationship.

> Pharmacological abortion imposes a cultural revolution: the doctor loses power. In the sense that obviously one carries out an a priori medical evaluation, ruling out contraindications, but then it is the woman who takes the pill. Let's say that the process which takes place in her body is analogous to a miscarriage. But (with pharmacological abortion) she is the one who manages everything. And this is really inconceivable for medicine, especially for medicine as we see it in our country. Where precisely there are all the criticisms of "women being left alone", and so on, it's precisely because (women's autonomy) is unacceptable (Female, gynecologist, 60).

In a minority of interviews, the explicit acknowledgement of women's autonomy in determining their bodily choices and reproductive options was explicitly mentioned as an indispensable criterion for being deemed a "good gynecologist". It is noteworthy that this perspective predominantly emanates from individuals engaged from a political point of view who exhibit concern regarding paternalist tendencies, reasoning around the specific choice of terms: "I do not call her a *patient*, I call her a *woman*, 'cause she's not sick! She just made a request, and the doctor has to respond"; "The doctor has to produce a *document*, not a *certificate*. Because the interruption of pregnancy is not *authorized* by the doctor, it's the woman's will", some of them state.

The notion of women's agency was at the core of many debates when the law 194 was discussed. This is evident in several provisions of the law, especially where it establishes that, after manifesting their willingness to interrupt their pregnancy to a doctor (who documents that), women must observe a mandatory waiting period of seven days. This requirement implicitly disempowers them, because it implies that their decision should not be taken too seriously, and on the contrary, it needs to be questioned in its foundation. The underlying assumption is that women should take more time to reflect on this (allegedly) dramatic decision and that probably they decided too quickly. However, in practical terms, this obligatory waiting period confers power in the hands of doctors, granting them the authority to determine whether the urgency procedure, which negates the waiting time, should be applied or not. In some

cases, due to the limited time available, this compulsory pause may hinder access to pharmacological abortion or even to abortion services in general.

> It may happen that a woman comes to ask for an abortion at sixty days (close to the term for pharmacological abortion). For me this is an urgency (…) and the seven days (waiting time) go to hell! I believe, in absolute science and conscience (that it is ok to overcome the waiting time), because pharmacological abortion is certainly better for woman's health than surgical. So I don't see why, when the woman comes and asks me to interrupt her pregnancy, assuming we talk to each other etcetera, I should make her lose the opportunity of taking the pill, just because she has to rethink it? Most women ask me "What should I rethink?" (Female, gynecologist, 62).

A minority of interviewees clearly expressed the importance of according priority to women's will, when it comes to selecting the method of abortion (surgical vs. pharmacological) and the choice of anesthesia (local vs. general). As some interviewees observed, to actively involve women in the decision-making process on abortion it is not sufficient to simply ask them which type of abortion technique or which type of anesthesia they would prefer. On the contrary, it is necessary to consider the specific situation and provide them with all relevant information so that they can make an informed decision. This is a far from easy task. A gynecologist, who had been actively involved in feminist movements during the Seventies, pointed out that women often adhere to the same paternalistic medical model as doctors. This leads them to frequently ask doctors to take the decision on their behalf, thereby perpetuating the passive sick role described by Parsons.

5. Discussion and conclusions

The present study explores the discourses of Italian gynecologists, anesthesiologists, and other expert figures regarding abortion and their justifications for establishing thresholds of legitimacy. A first striking result is that, in most cases, their positions, from the choice of the specialty to the attitude toward reproductive practices, are presented "in the name of women": even when expressing their refusal to perform abortions. However, by considering gynecologists' and anesthesiologists' working careers and life stories, we gain insights into how medical actions and discourses are situated practices influenced by specific cultural and organizational contexts. This understanding enables us to place their positions within a broader framework that encompasses generational cultures, political activism, and social

expectations (in line with De Zordo et al., eds., 2016). Within our sample, it appears that the older generation of gynecologists exhibits a greater awareness of the importance of ensuring access to abortion services, likely due to their direct experience with the dramatic situation before 1978.

Performing voluntary termination of pregnancy might lead healthcare professionals to be at odds with their ethical and professional beliefs. In this regard, an interesting result of our study is that many practicing Catholic doctors may prioritize women's health needs over their ethical and religious positions. With regards coming to terms with an inner conflict, a variety of discursive strategies emerged in the interviews: some interviewees have resorted to a hierarchization of values, prioritizing women's health over personal beliefs. Others have reframed abortion practices using rhetoric associated with Catholicism, such as emphasizing the importance to help women in need, to be altruistic and avoid judgment of other's actions. A third discursive strategy that has been used involves shifting the burden of the ethical choice onto the women themselves, rather than the physicians who perform abortion. In line with previous research (Ferrero & Pulice, 2021), in our study those who became objectors early in their careers also recognize women's right to their self-determination and do not explicitly oppose abortion. Nevertheless, they conceive the fetus as a human life and thus avoid committing what they consider an act of murder.

The inner need to reconcile conflicting values, such as women's right to terminate a pregnancy, the value of the embryo's life, career aspirations, avoidance of abortion stigma, reproductive freedom, and so forth, drives our interviewees to establish a threshold of legitimacy based on women's deservingness of abortion. This positions women along a *continuum* of deservingness imbued with moral judgments, ranging from those who unquestionably deserve the procedure (e.g. due to fetal malformations or pregnancy resulting from sexual assault) to those, at the opposite end of the *continuum*, who defy the law and trivialize it (e.g. using abortion as a form of contraception). The idea that emerges is that women who have repeated abortions are deemed less deserving of access to services, as they are perceived to misuse them and make medical practice frustrating. Interestingly, ethical concerns are raised by non-objecting Christian doctors, when they acknowledge the challenges associated with performing an abortion at a late stage, and some features of the fetus are already clearly visible. Conversely, objectors are more inclined to justify their choice as a political act, asserting that many abortions are preventable as they occur in contexts where contraception would have been readily accessible. In many cases they over-emphasize the phenomenon of multiple abortions in justifying their choice of objecting. According to their narrative, it is these women who compel doctors to object and render the

service inefficient, rather than the presence of conscientious objectors burdening their colleagues with such requests or the need for comprehensive contraceptive education.

Lastly, our interviews shed light on the conflict between medical paternalism and women's autonomy. In the realm of abortion services, gynecologists are still in a position of power compared to women who request them. Depending on their perception of women's role as either an active or passive recipient of care, they determine whether shared decision-making is possible. Consequently, our results align with previous findings that suggest even anti-choice positions can be justified as ways to *protect* women from the harmful consequences of abortion they are not fully aware of (see Koralewska & Zielińska, 2022).

In this scenario, what space exists for women's agency, given the organizational culture and conditions of service delivery? As long as a paternalistic model of health care informs the provision of abortion services, women will not have enough space to fully exercise their reproductive rights. In fact, and regardless of the political and ethical position on abortion of our interviewees, in most cases abortion was framed as a medical procedure, thus taking for granted the unquestioned social authority of doctors and, in particular, of gynecologists in the delivery of this service. As highlighted in the background section of this article, it is the law that determines the legal steps involved in the abortion procedure, as well as who is qualified to perform it and the specific circumstances under which it can be performed. In Italy, only doctors specialized in gynecology and obstetrics are permitted to perform voluntary termination of pregnancy. This is a particularly eloquent case of what Freidson (1970) defined as *medical dominance*, namely the power and control that the medical profession holds over the delivery of healthcare services in society. In the case of abortion, this entails different consequences. First of all, over time abortion has undergone a medicalization process, that has led to understanding its practice and implications mainly through a medical lens. Our interviews provide evidence in this regard. When questioned about the preferred abortion technique (medical vs surgical abortion), almost all respondents provided arguments related to medical aspects (e.g. more or less complications, the effectiveness of the intervention in expelling the conception product, etc.). Conversely, when asked about the lack of training on this topic during the specialization school in gynecology and obstetrics, the most common answer has been "It's not a big deal if they don't teach us abortion techniques, it's an easy procedure and there are protocols to follow". Framing abortion exclusively within a medical perspective reinforces a narrow perspective on this practice, and prevents a comprehensive consideration of its broader social, economic, and political context, as well as the perspective of

women. The insufficient attention paid to the social and political context of abortion in medical training contributes to a lack of understanding of the significant barriers that women face in accessing abortion services in Italy. This lack of knowledge may, in turn, incentivize early career gynecologists to opt for conscientious objection as a means to advance their own professional career and avoid abortion stigma.

Furthermore, medical dominance in the context of abortion emerged also in other circumstances. For instance, as highlighted in the fourth section, in Italy in order to have access to abortion a woman needs to ask for a medical "certificate", and after that she is required to wait for seven days to get an abortion. This certificate confirms the woman's pregnancy status, her request for abortion, and it certifies that the woman had a consultation with a doctor. Considering that this does not apply for other medical interventions, coupled with the substantial percentage of gynecologists who invoke conscientious objection, and in light of the fact that the doctor has the authority to assign or not the "emergency" status that would shorten the waiting time, this requirement effectively places medical professionals in a gatekeeping role, exerting control over access to a vital service for women's reproductive health.

A last consideration involves "who" can perform abortion. Medical professionals hold the total control and power over the provision of abortion services. Although the law 194 has been crucial in legalizing abortion, it has also formalized the primacy of medical knowledge and expertise in this domain. In fact, although in other countries non-medical providers, such as midwives or nurses, can provide safe and effective abortion services, in Italy abortion is still framed as a risky procedure that should only be performed by professionals in a hospital or clinical setting. This reinforces medical dominance by limiting the ability of different healthcare providers to provide the service and places more power (to facilitate or hinder access to abortion services) in the hands of medical professionals.

Drawing from the results of our study, several recommendations can be proposed. First of all, clinical training should include information about abortion techniques and discussion around their ethical implications, in order to let students have the information they need to make an informed decision. Additionally, clinical training should also provide relational/communication skills, in order to improve the doctor-woman relationship and make it more effective. Moreover, access to abortion services should be enhanced in general, as well as medical abortion, which is a technique that requires less medical resources and could thus be useful to overcome the barrier of conscientious objection.

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