# The use of documentary in medical course and a reflection on ethical issues associated with abortion

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**Abstract**

The teaching of the humanities in medical education, especially ethics and bioethics, is essential for the future doctor-patient relationship. The use of cinematographic art as a teaching-learning instrument has emerged as an effective and contributory method in this process, as it makes the student more reflective and prepared to deal with the various conflicts of medical practice. This is a descriptive study, with uses a qualitative methodology, applying the thematic analysis technique that aimed to evaluate the use of the film "À Margem do Corpo" as a teaching-learning instrument of medical ethics and also to identify the main ethical issues faced by the students and their positions in front of them. A group of 50 students from the second period of the medical course participated in the study. Four main themes were discussed: vulnerability and reduced autonomy; objection of conscience; dehumanization and neglect in health care; abortion.

**Keywords:** Motion pictures as topic. Ethics, medical. Bioethics. Vulnerability analysis. Humanization of assistance. Abortion legal.

**Resumo**

**Uso de documentário no curso de medicina e a reflexão sobre temas éticos associados ao aborto**

O ensino das humanidades na graduação de medicina, principalmente da ética e bioética, é imprescindível para o sucesso da futura relação médico-paciente. A arte cinematográfica vem se destacando como instrumento eficaz de ensino-aprendizagem, pois prepara o aluno para refletir e lidar com diversos conflitos da prática médica. Trata-se de estudo descritivo, com método qualitativo e emprego da técnica de análise temática a partir do documentário "À margem do corpo" como recurso didático para identificar as principais temáticas éticas abordadas pelos alunos e seus posicionamentos em relação a elas. Participaram deste estudo 50 alunos do segundo período de curso de medicina. Quatro temáticas principais foram discutidas: vulnerabilidade e redução da autonomia; objeção de consciência; desumanização e negligência na assistência à saúde; e aborto.

**Palavras-chave:** Filmes cinematográficos. Ética médica. Bioética. Análise de vulnerabilidade. Humanização da assistência. Aborto legal.

**Resumen**

**Uso de documental en la carrera de medicina y reflexión sobre temas éticos asociados al aborto**

La enseñanza de las humanidades en la carrera de grado de medicina, principalmente de la ética y la bioética, es imprescindible para la futura relación médico-paciente. La utilización del arte cinematográfico como instrumento de enseñanza-aprendizaje viene destacándose como un método eficaz y contributivo en este proceso, pues torna al alumno más reflexivo y preparado para lidiar con los diversos conflictos de la práctica médica. Se trata de un estudio descriptivo, con metodología cualitativa, aplicando la técnica de análisis temático que tuvo como objetivo evaluar la utilización de la película "Al Margen del Cuerpo" como instrumento de enseñanza-aprendizaje de la ética médica e identificar las principales temáticas éticas abordadas por los alumnos y sus posicionamientos frente a éstas. Participó de este estudio un grupo-clase del segundo período de la carrera de medicina compuesta por 50 alumnos. Se discutieron cuatro temáticas principales: vulnerabilidad y reducción de la autonomía; objeción de conciencia; deshumanización y negligencia en la asistencia sanitaria; y aborto.

**Palabras clave:** Cine como asunto. Ética médica. Bioética. Análisis de vulnerabilidad. Humanización de la atención. Aborto legal.

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Research

Formerly, physicians were, besides scientists, artists dedicated to the arts and the understanding of the human being in its integral context. However, advances have widened with the advent of scientism to medical practice, requiring from medical graduates to dedicate themselves to the learning of technical aspects of medicine. Thus, in order to satisfy this curriculum, technical subjects were prioritised to the detriment of the humanities, contributing significantly to the training of professionals focused on rationalisation, disregarding the inherent subjectivity of the human being [1].

The teaching of ethics and bioethics, in the medical course, is essential for the training of health professionals. Treating for the cure of diseases is not less important than to to know their influence in the patient's life, considering the patient's feelings, culture and religion. It is in this aspect that ethics contributes to the formation of the professional, helping him or her to deal with particularities in a fair and correct way, always looking for what is better and more dignified for the patient. Therefore, promoting the search for ethical knowledge in a didactic and engaging way becomes a challenge for the educator.

The beginning of medical ethics teaching in college, with discussions about professional attitudes even before the student has come in contact with the patient, often discourages student's engagement because it is something far from their reality, which ends up harming the process of teaching and learning. In this sense, films can be an interesting and effective teaching tool because they bring scenes of reality that can make the students experience concrete situations related to future practices [2]. Images can arouse emotions, bringing students closer to real conflicts, opening space for discussions in which they expose their feelings and doubts [2]. The communicative force of cinema can enhance teaching-learning by presenting realities that words could not evoke [3].

"À Margem do Corpo" (A Disembodied Woman), by Débora Diniz [4], has the Brazilian state of Goiás from 1996 and 1998 as scenery. It tells the true story of Deuseli, 19, who was violently raped by a man. Aware of the unwanted pregnancy, fruit of the rape, she sought her right to assisted abortion, which was not performed. The pregnancy followed its natural course and the child was born. Deuseli ended up murdering her daughter 11 months after her birth and was arrested. It transpired that she was pregnant again. She gave birth but died a few months later due to generalised organ failure. The video deals with several themes which should be considered, evaluated and discussed as they are important for society and, especially, for good medical education.

The purpose of this study was: 1) to evaluate the use of the video "À Margem do Corpo" as a teaching-learning instrument of medical ethics; 2) identify the main ethical issues addressed; and 3) to know the position of medical students about those issues, taking into account the importance of the subject for the education of medical professionals and for their relationship with patients in their daily professional life.

## Method

This is a descriptive study with qualitative method and thematic analysis that was part of the project "The teaching of humanities in the Escola Bahiana de Medicina e Saúde Pública (Medical e public health school of Bahia - EBMSP) which had started in 2013. The sample comprised of 50 students from the second period of the medicine course at the EBMSP. All participants watched the documentary "À Margem do Corpo" and there was no exclusion, being the sample composed of 31 women (62%) with a mean age of 20.84 ± 2.35 years. The film was screened during the ethics and bioethics class. There was a discussion about the topics covered in the documentary after its screening . Subsequently, a questionnaire was submitted to all participants with six subjective questions, which were answered in writing (Table 1).

The pre-analysis of the questionnaires answered included skimmed and exhaustive reading, in order to analyse the representativeness, homogeneity and relevance of the material. Hypotheses and objectives were raised. In the exploration phase of the material, we categorised the questionnaires and analysed the answers one by one, aggregating similar concepts and opinions and ordering them by theme in order to contribute to a significant analytical result. In the third and last stage, we described the results, interpreting and discussing the themes found [5].

## Results and discussion

After reading and exhaustive analysis of the questionnaires, four themes were identified that are relevant to the teaching of ethics and bioethics

in health education: 1) vulnerability and reduction of autonomy; 2) conscientious objection; 3) dehumanisation and neglect in health care; and 4) abortion.

### *Vulnerability and reduced autonomy*

There were several definitions of vulnerability among students, referring to complementary concepts. Most of of the students defined vulnerability as a condition of fragility and risk of suffering harm:

*"Vulnerability is the risk condition in which a person is"* (Student 1);

*"Vulnerability is the quality that is given to someone who is susceptible to physical, moral, or social harm because of their frailties"* (Student 35).

Others defined vulnerability as loss of autonomy and inability to defend their rights and interests:

*"Vulnerability is a condition in which individuals loses their capacity to manage their autonomy as citizens"* (S13);

*"Vulnerability is a condition in which the individual is unable to defend their own interests and rights"* (S32).

The minority defined vulnerability as being incapable of exercising freedom or being in conditions of socio-political and cultural inequality. Some have stated that vulnerability is to submit to something or to someone:

*"Vulnerability is the condition of inequality in social, cultural, political and economic function"* (S40);

*"Vulnerability expresses the human condition of subjection to something, due to factors conditioning the precariousness of his or her existence, being deprived of essential rights as a human being, and therefore of autonomy as well"* (S26).

Etymologically, the term "vulnerability" comes from the Latin *vulnus*, which means "wound." In other words, it refers to the possibility of being injured [6]. Seeing that vulnerability is considered to be a condition of fragility and risk of suffering harm, it should be understood that all human beings can be vulnerable. The very condition of existence and finitude brings to the individual the possibility of being hit by something or someone and therefore be included in the condition of being vulnerable.

A differentiated look at the concept of vulnerability reinforces the idea of defining it as a principle, that is, an inherent condition in every human being. Therefore, the obligation to watch over, care for, and respect the inherent vulnerability and personal integrity "should be taken into account" [6], as stated in the *Universal Declaration on Bioethics and Human Rights* [7], adopted in 2005, on its article 8.

Despite the universality of this concept, there are situations that can aggravate the vulnerability of individuals, making it more complex. Aggravating factors relate, among others, to various cultural, socioeconomic, psychological and physical issues. For example, there are cultures that are considered inferior and , as historical victims of prejudice, they are in a situation which is favourable and conducive to the aggravation of vulnerability [8].

The distribution of the power of production and consumption in Brazilian society highlights the fragility of the poorer classes [8]. The lack of financial privilege sharply aggravates the condition of the individual. Lack of health, education, basic sanitation and family structure negatively affects the individual and can lead to crime, thereby exposing the individual to critical situations, making them extremely vulnerable. In contrast, in a scenario of great social and economic inequality, more stable conditions can also bring fear and insecurity, thus reflecting the vulnerability of individuals to the large amount of violence spread throughout the country.

It is in this context that ethical concepts must clarify and contribute to the performance of physicians in order to minimise the vulnerable condition of those individuals and make them more autonomous beings. The establishment of vulnerability as an ethical principle reinforces the obligatory character of moral action imposed on the moral conscience of physicians in their practice [6].

Lack of autonomy is strongly linked to vulnerability, as was mentioned by some of the students interviewed. In the Brazilian reality, these two points must be analysed from the dialectic point of view, since they are always present in the individual and interact with each other [8]. The dialectical way of thinking about autonomy and vulnerability in health care emphasises both the need to respect the decisions of the patient a the need to help the patient. In this sense, health professionals should be proactive in securing the rights of the individual under their care.

Autonomy is intrinsically linked to socioeconomic, cultural, ethnic, gender, health, age, and other factors. When questioned about



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aspects that interfered in this question, the majority of the students pointed out economic condition, educational level, gender and colour; some still pointed to age. Others mentioned lack of good family structure, stigmatised illnesse, lack of access to basic services and profession. Some students also mentioned sexual abuse, living conditions, health status, sexual choice, practice of stigmatised behaviours and decision-making power.

In the list of responses, they also highlighted beauty standards, susceptibility to violence, lack of food, lack of freedom, unemployment, chemical dependence and culture as important factors. Living frustrating moments (such as abortion), geographical location, religion and lack of information were also pointed as factors that interfere with this principle. The vulnerable condition was also related as a precipitating factor of the lack of autonomy:

*"We have as examples of these factors: low income, gender, ethnicity, illiteracy, stigmatised illnesses, stigmatised practices, specific groups"* (Student5);

*"Factors such as social class, educational level, gender, age, ethnicity, culture, among others, affect the autonomy of the individual, interfering in their state of vulnerability"* (S7);

*"She was black, had no schooling, low economic income, rape victim, part of a marginalised part of society"* (S14);

*"The socioeconomic, cultural, mental and physical situation in which individuals find themselves, taking into account some characteristics such as age, gender, race or ethnicity, sexual choice, schooling, housing, access to services and food, among others"* (S27).

Considering that autonomy is the right to have one's decisions respected [7], its lack can generate several conflicts, mainly in the biomedical area. The individual must have full ability to choose in order to have full autonomy . When this is not possible, for any of the §several reasons already mentioned, protective actions may be necessary [8], and the health professional is fundamental to guarantee it.

### *Conscientious Objection*

This was another aspect addressed by the participants. When asked if the allegation of conscientious objection made by the doctor who attended Deuseli was correct, most agree with the professional's position except in imminent risk of death or in the absence of another professional. Others evaluated the conduct as incorrect, stating that the physician should not oppose abortion unless another practitioner could do so:

*"The doctor could not object to carrying out the procedure, since it is legal in case of rape, unless there was another doctor in the area who was willing to perform the abortion"* (S1);

*"Yes, the doctor has every right to refuse to perform the abortion, claiming conscientious objection, even if the pregnant woman's desire is within the framework of the legal requirements, except when: there is a risk of death for the woman; in the absence of another physician who may do so, and the woman may suffer damage or injury due to the doctor's omission and assistance in complications arising from unsafe emergency care"* (S11);

*"The Code of Medical Ethics makes it clear that conscientious objection is a right of the physician, who must exercise the profession with autonomy and must not perform undesirable procedures, but the doctor can not object to a procedure when his or her refusal can bring irreversible damage to the patient or in cases of urgency"* (S48).

Conscientious objection is a subject that lies between responsibility and law, being a normative device for the protection of professionals in situations of moral conflict, and may even meet public duties and individual rights [9]. That is, ethical, moral, cultural and religious principles of every citizen should be respected, even when they collide with legal procedure to be carried out. The Code of Medical Ethics describes this right in its first chapter, "Fundamental Principles," item VII, when it states that the physician *is not obliged to provide services that contravene the dictates of his or her conscience* (...)*, except for the absence of another doctor* (...) *or emergency* [10].

In the video "À Margem do Corpo", the objection is linked to the condition of legal abortion, as well as in several discussions in the ethical range. With this, the absolute character of this right has been rethought, considering whether it would should be adaptable, given the need of people seeking the public health service. Two theses on conscientious objection arose from this discussion: that of incompatibility and that of integrity [9].

The incompatibility thesis says that conscientious objection should be prohibited in situations such as legal abortion because it goes against the fundamental principle of medicine to care for the health of individuals [12]. The issue involves

a question: if the professional is a conscientious objector in relation to legal abortion, why work in an institution which is indicated to attend women who want to legally abort? In this way, the right of these women can be denied if there is no other professional that enforces it.

In defense of this thesis, it is thought that the health professional has the right to have his or her moral and religious convictions and also to defend and fight for those convictions; however, when the professional is working for the State in a public health service, he or she must be neutral in order to guarantee the well-being of all citizens [12].

The thesis of integrality defends another aspect, referring to conscientious objection as an inviolable right [13]. Even if there is an overlapping of physician with moral subject, it is known that, before being a health professional in the service of the State, the physician is part of a community that has its moral, cultural and religious precepts. Therefore, physicians have their whole life and history based on duties of conscience, being able to choose what is right and wrong for them in the exercise of medicine.

This thesis presents a radical aspect and a more flexible one. The most extreme is that, in addition to having the right not to perform procedures that the physician judges to be wrong, the objector may also not want to inform the patient of their rights or refer the patient to another professional [13]. From this point of view, the woman who has the right to abortion would be totally unassisted, obstructed by moral justification [9].

The more flexible version highlights the importance of conscientious objection as an instrument for protecting the objector's ethics. However, it also brings as professional responsibility the duty to guarantee the patient's rights by informing them about their rights in order to ensure their health and well-being [9]. It is in this perspective between the right and the duty of the physician that the Code of Medical Ethics addresses professional autonomy as a prerogative and also addresses emergency and urgent care or referral to another professional in a way that does not cause harm to the patient [11].

However, conflicts arise when the reference health care center professional becomes a selective objector. Since women have the right to terminate gestation caused by sexual violence [9], another thesis was considered: the justification. This thesis establishes that the selective conscientious objection in an abortion reference center of the Sistema Único de Saúde - SUS (Unified Health System) should be analysed by the institution in order to guarantee the right of the physician and the protection of his or her values, but also to guarantee that women do not have their rights obstructed. It is a matter of understanding that not every individual belief must be unquestionable in view of a basic human right such as women's health [9].

Regarding the institution's procedures in relation to the conscientious objection claimed by the doctor, the students stated that the State should provide professionals to carry out the procedure. Others said that the institution should penalise the doctor who refused to carry out the abortion:

*"The institution should take appropriate measures, including the punishment of the doctor, since according to the Penal Code, in case of omission the doctor may be held civil and criminally responsible for the death of the woman or for physical and mental damages she may suffer, as the doctor could and should act to avoid such results"* (Student 1);

*"In this way, it is the duty of the State to ensure, in public hospitals, the presence of professionals ready to perform an abortion"* (S9).

As to the act of declaring conscientious objection, the Code of Medical Ethics [11] states that it is the right of every physician to refuse to perform any procedure that, even permitted by law, is contrary to his or her moral conscience. Therefore, *a priori,* doctors should not be punished, unless they have caused, with their refusal, harm to the patient's health. In this case, personal and / or institutional responsibility will apply. However, even claiming conscientious objection, it is the professional's duty to inform and instruct patients about their rights, referring the patient to another professional. It is also the duty of the State to maintain doctors who are not objectors in public hospitals so that every woman has the right to abortion guaranteed, when permitted by law [11].

Most students don't see the need for authorisation from a Judge or the Conselho Regional de Medicina – CRM (Regional Medical Council) to stop the pregnancy. However, some students disagreed:

*"It was necessary the authorisation of the judge and the CRM for the interruption of the pregnancy in the case of Deuseli"* (S18);

*"It was not necessary for the doctor to request the authorisation of the judge and the CRM to carry out the termination of the pregnancy of Deuseli because, according to the Penal Code, it is not a crime and*



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*no medical abortion is punished if the pregnancy resulted from rape"* (S26).

According to the Norma Técnica sobre Prevenção e Tratamento dos Agravos Resultantes da Violência Sexual contra Mulheres e Adolescentes (Technical Standard on Prevention and Treatment of Offences Resulting from Sexual Violence against Women and Adolescents) of the Ministry of Health [15], only the consent of the woman and her decision to have an abortion are required to stop pregnancy resulting from sexual violence. In this case, the woman's word is enough to legally carry out the procedure and no police report or any other document proving the rape are necessary. The objective of the health service is not to judge the fact, but to provide assistance to the victim, aiming to guarantee her well-being and health [15,16].

### *Dehumanisation and Neglect in Health Care*

Another topic related to medicine that is currently addressed is dehumanisation in medical practice. Considering the current scenario and the analysed documentary, the care provided to Deuseli after the rape was put into debate. The doctor who was going to carry out the examination asked the victim to go home to take a bath because she was "dirty" and should return later. The students classified the attendance as "negligent", "inadequate", "inconsistent with the law" and "inhuman":

*"In relation to the care given to Deuseli after the rape, in my opinion, it can not even be said that there was care, since the doctor who 'attended' simply said that it was for her to take a shower, when she should have examined Deuseli „(Student4);*

*"It was a poor service, going against the legal principles of the Constitution and the moral and ethical principles of medicine"* (S6);

*"It was a dehumanised service, in which a vulnerable citizen had her autonomy and her rights completely disregarded"* (S20).

Medicine, which has the care of the human person as its foundation, is today exhaustively seeking its rehumanisation. The mere mention to this concern is contradictory and alarming, since medical science is based in human beings and in their illnesses. With the intention of guaranteeing dignified and humanised care and a good doctor-patient relationship, the Code of Medical Ethics brings among its Fundamental Principles that medicine must serve the human being and be exercised without any kind of discrimination (item I), and that the health of the individual should be the center of the attention of the physician, who must act with the maximum of zeal and professional capacity (item II) [11].

The weakening of the doctor-patient relationship generates several problems, both in health and in the increasing reliance on courts of law for addressing medicine. This relationship must be based on ethical parameters, emotions and, not least, on science and professionalism. Surely a more humanised view, based on respect for beliefs, culture, history, anguishes and worries, would minimise the feeling of neglect and the lack of trust in the relationship doctor-patient.

Study [17] carried out in a public maternity hospital in Salvador, capital city of Bahia in Brazil, interviewed 11 women hospitalised for curettage after abortion. Three of these women had had a miscarriage and the other eight had abortion induced by Cytotec. Health professionals were also interviewed, and 69% said that doctors and nurses are often prejudiced against women who have abortions. However, 43% reported no discrimination in relation to the conduct of professionals of the service searched. Yet some patients interviewed reported having witnessed cruel scenes of discrimination in relation to women in these conditions [17].

In order to evaluate the watching over and care provided to SUS users in the process of abortion, a study [18] compared data from three cities in the Northeast region: Salvador, Recife and São Luís. A total of 2,804 women were interviewed (1,652 in Salvador, 391 in Recife and 761 in São Luís). More than half of the interviewees had completed high school, 71.2% already had two children and 35.2% mentioned previous abortion of which 45.8% had been induced abortion [18].

Most of them reported having received respectful care during the uterine evacuation examination. However, 235 women said they felt discriminated against, and 67.6% of them attributed this to the suspicion or certainty that the abortion was provoked. On pain relief before the procedure, a considerable number of the women in the three cities did not receive sedation [18]. The Manual de Atenção Humanizada ao Abortamento (Manual of Humanised Attention to Abortion) of the Ministry of Health [19] reinforces the importance of accepting and not judging the patient in the context of abortion, whether spontaneous, induced or provoked. It also advocates welcoming and counselling, during and after abortion, as essential elements for the quality and humanised care of potentially vulnerable women [19].

***Abortion***

Abortion, its legalisation and nuances as a public health problem was another theme debated. Abortion is considered one of the main causes of maternal death and it is estimated that more than one million abortions are induced per year in Brazil [19]. This subject has been researched for more than 20 years, which demonstrates its importance and influence in the health care area and, consequently, the merit in discussing it in medical courses.

The students were asked about the profile of women who notify their abortion as it is legally required in Brazil and if this profile resembles that of Deuseli. Many of the students stated that women between the ages of 20 and 29 in a stable union with up to eight years of education, catholic, working, who have at least one child, use contraceptive methods and take misoprostol to cause an abortion are the ones that most notify their abortions in Brazil. Others added characteristics such as color (white or black), poverty, and financial dependence on the husband or partner. As for the similarity of this profile with Deuseli, the students mentioned the age, the fact of being a worker, catholic, have a low level of education and low income:

*"The profile of women who notify their abortion in Brazil shows that they are young women (the incidence is higher between 20 and 29 years of age), with up to eight years of schooling, in a stable union, Catholic, with at least one child. They usually use contraceptive methods, and they use misoprostol for abortion"* (S3);

*"Black women, young and poor"* (S10);

*"The profile of the woman who notifies abortion in Brazil is young, predominantly adolescents between 17 and 19 years of age, in an established marriage relationship, economically dependent on the family or the partner and the abortion is due to an unplanned pregnancy"* (S24).

In 2009, the Ministry of Health [20] published a study on 20 years of research on abortion in Brazil, listing several papers on the subject, the profile of women who abort, and the consequences of unsafe abortion procedures for the public health. Although the research has limitations due to the fear of exposing women to criminalisation, they show the great importance of discussing and studying abortion and the evident need discuss the issue in several spaces.

Most studies include women between the ages of 10 and 39 and reveal that the highest rate of discontinuation of pregnancy occurs in the 20-29 age group [20]. The insertion of women into the labour market and access to education may be related to the highest number of abortions in this interval. Jobs which are traditionally women's jobs, such as domestic work, in commerce, hairdressing and manicure, are among the main occupations of women who abort. Other important factors are being students, financially dependent on the family, and earning up to three minimum wages per month. When analysing the marital situation, studies show that the majority of women who abort live in stable union and the Illegal acquisition of misoprostol is often done by her partner himself.

As for the profile of these women, more than half already have children. As for religiosity, the majority who had induced abortion declared themselves catholic, spiritist in the second place and Protestant in the third. The majority that had induced abortion in the South and Southeast regions mentioned their use of contraceptive methods, mainly oral contraceptives, which reveals the inappropriate and / or irregular use of this method. In the Northeast, most of the women who went through the procedure stated that they did not use any contraceptive method when they became pregnant [19]. In view of this profile, it can be inferred that the women who had abortion did not plan or desire pregnancy and, therefore, they decided to end it using abortion as a tool for family planning.

As for this induction process, there was a significant change in the choice of method over time. Since 1990, the discovery of misoprostol as an abortifacient drug has made it the most used resource in this practice. Studies show that from 54.4% to 84.6% of women use it to induce abortion because it poses a lower risk to women's health and reduces the time and cost of hospital admission after the abortion [19].

Still related to this change, it is observed that abortion is no longer the main cause of maternal death in Brazil since the 1990w, despite still being one of the main causes. Maternal mortality rates are known to have fallen from 140 per 100,000 live births in 1990 to 75/100 in 2007 [21]. However, in some cities, such as Salvador, induced abortion remains the leading cause of maternal mortality , with the main victims being young women aged 15-24, black women and women living in peripheral metropolitan areas [21].

It is worth mentioning that many women who seek to end their pregnancy end up not looking for the health service, and therefore, many cases are not even registered. Therefore, the numbers and

consequences of induced abortion are probably underreported and not presented in their real dimension to society.

It is precisely because of health problems related to the process done in improper conditions and in an insecure way that abortion has been considered a serious public health problem. When discussing this in the questionnaires, on why the issue is a public health problem, the students pointed out that its criminalisation leads women to have abortion in an inadequate way, aggravating their health condition. Others claim that the fact that it is intrinsically linked to ethnic, social, economic and cultural issues characterises it as a serious public problem; others see abortion as a public health problem because it is one of the main causes of maternal death in the world:

*"Especially in underdeveloped countries, where there is no legalisation of abortion, this act ends up becoming a public health problem regarding the practice of abortion without adequate conditions; thus, women are referred to the hospital after having done some self intervention in pregnancy, which can lead to complications in health, infection and death. In addition, high hospital costs are generated"* (Student 16);

*"Abortion is a serious public health problem. After all, it represents one of the main causes of maternal mortality in Brazil and in the world. In addition, curettage after abortion represents the third most performed obstetric procedure in the units of public hospital admission"* (S28).

Induced abortion performed in an insecure manner has been recognised worldwide as a public health problem seeing that women submitted to the process can end up having several health problems. The fact that an induced and unsafe abortion is considered the fourth cause of maternal death in Brazil [22] and the first cause of death in some capitals, such as Salvador [23], demands a great deal of discussion and reflection on this problem. It is known that legal abortion is only predicted in cases of risk to the pregnant woman's health, pregnancies resulting from sexual violence and in cases of anencephaly [21].

More than the socioeconomic issue, the reason why women opt for abortion may be intrinsically related to issues such as moral doubt between "right" and "wrong" in the face of the theory of the sacredness of human life and lack of partner support and / or family support [22]. Christianity, like other religions, opposes abortion, and emphasises the view of the sacredness of life, regardless of the will of women [24].

In contrast, the beginning of human life has been much discussed in the scientific field, where biological and evolutionary arguments are opposed to metaphysical ones [22]. The beginning of human life can occur when the pregnant woman establishes an affective relationship with her embryo or foetus [25]. By placing pregnancy as something sacred, women's autonomy and their sexual and reproductive freedoms end up in the background. In addition, paternalism, authoritarianism and patriarchalism are factors that directly influence the exercise of women's autonomy - for example, the difficulty of negotiating the use of condoms in sexual relationships, which expose women to sexually transmitted diseases and unwanted pregnancies. This gender violence occurs independently of social class, economic class or level of education [22].

Based on the discussion of the video, the students were asked how criminalisation of abortion interferes with public health. Most of them pointed out abortion in precarious and inadequate conditions, without security and in clandestine clinics as an aggravating factor in this process:

*"The criminalisation of abortion ends up causing many women to have abortion under inadequate conditions, leading to various health problems, including mental health problems and even death"* (S1);

*"Criminalisation does not stop women of having abortion, it only makes this procedure to be carried out clandestinely, triggering public health problems"* (S40);

*"The criminalisation of abortion interferes with this process as it makes difficult to have 'healthy' access to this practice, causing women to put their own lives at risk"* (S47).

The main researches carried out in Brazil indicate that the criminalisation of abortion seriously damages the health of women. In addition to not curtailing the practice, it contributes to increase social inequality, since the majority of the victims are low-income women who do not have the resources to carry out the procedure in a safe way [20]. In Brazil, research [26] carried out with literate women who live in urban areas showed that at the age of 40, one in five had already had an abortion. That is, the number of women who have abortion and suffer its consequences is even greater than the research shows seeing that many cases are not reported because of the illegality of abortion.

The criminalisation of abortion and the difficulty of accessing the procedure, in legal cases,

lead women to insecure and often lethal practices. Despite the fall in abortion-related maternal mortality rates in Brazil [27], coincidentally, from the start of the use of misoprostol as an abortifacient, the number of women seeking hospitals to complete abortion initiated elsewhere or to treat procedural complications is still alarming. One study [28] reports that curettage is the second most frequently performed medical procedure in public maternity hospitals in Salvador.

As the medication became known to women as a safer abortion method, it began to be used on a large scale - this is proven by a study [20] which showed that 76.1% of women hospitalised for this reason knew the drug. However, despite showing a decrease in morbimortality rates due to abortion, the use of the medicine in question did not increase the number of abortions, as shown in a study [20] carried out at a time when the drug was still being sold freely in pharmacies.

Correlating the annual volume of sales of misoprostol in Brazil to the number of hospitalisations for induced abortion and maternal mortality by this procedure clearly shows that it caused changes in the choice of abortive method, but also made the procedure safer without becoming epidemic [20].

Despite the popularisation of misoprostol, half of the women who provoke abortion still do so without the help of drugs, and therefore do so in precarious and unhealthy conditions, especially those women with low educational level [26]. Thus, hospitalisation rates and complications still generate many damages to women's physical and emotional health, since half of those who have abortion are hospitalised for complications related to the procedure [26].

Therefore, it is necessary to break the taboo related to this problem, reflecting on the autonomy of women, their reproductive sexual freedom, vulnerability in case of unwanted pregnancy, correlating it with the various factors that contributed to this situation such as sexual violence, socioeconomic difficulties, lack of access to health care, lack of access to education and information, lack of emotional support from both the partner and the family, the woman's wishes and plans, and simply her choice to be a mother or not and the time she deems appropriate for it.

## Final considerations

The documentary "À Margem do Corpo" ( A Disembodied Woman ) used as a teaching-learning instrument promoted enriching debates and significant learning on ethical and bioethical aspects related to the theme of this research. We discussed subjects such as women's vulnerability and autonomy, physicians' right to conscientious objection and neglect in health care, as well as the negative effects of improper conduct on care in cases of abortion allowed by law. The exhibition of films in medical education can contribute positively to more humanised practices and professional conduct, considering individuals in their biopsychosocial context.

## Referências


1. Landsberg GAP. Vendo o outro através da tela: cinema, humanização da educação médica e medicina de família e comunidade. Rev Bras Med Fam Comunidade [Internet]. 2009 [acesso 28 nov 2017];4(16):298-304. Disponível: https://bit.ly/2OfXJ1C
2. Dantas AA, Martins CH, Militão MSR. O cinema como instrumento didático para a abordagem de problemas bioéticos: uma reflexão sobre a eutanásia. Rev Bras Educ Med [Internet]. 2011 [acesso 28 nov 2017];35(1):69-76. Disponível: https://bit.ly/2pBtyGt
3. Blasco PG, Gallian DMC, Roncoletta AFT, Moreto G. Cinema para o estudante de medicina: um recurso afetivo/efetivo na educação humanística. Rev Bras Educ Med [Internet]. 2005 [acesso 28 nov 2017];29(2):119-28. Disponível: https://bit.ly/2OeD5iv
4. Diniz D. À margem do corpo [DVD]. Brasília: ABA; 2006. 1 DVD: 43 min., cor.
5. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 12ª ed. São Paulo: Hucitec; 2010.
6. Neves MP. Sentidos da vulnerabilidade: característica, condição, princípio. Rev Bras Bioética [Internet]. 2006 [acesso 28 nov 2017];2(2):157-72. Disponível: https://bit.ly/2x8SdqW
7. Organização das Nações Unidas para a Educação, a Ciência e a Cultura. Declaração universal sobre bioética e direitos humanos [Internet]. Lisboa: Unesco; 2005 [acesso 28 nov 2017]. Disponível: https://bit.ly/1TRJFa9
8. Anjos MF. A vulnerabilidade como parceira da autonomia. Rev Bras Bioética [Internet]. 2006 [acesso 28 nov 2017];2(2):173-86. Disponível: https://bit.ly/2x8SdqW
9. Diniz D. Objeção de consciência e aborto: direitos e deveres dos médicos na saúde pública. Rev Saúde Pública [Internet]. 2011 [acesso 28 nov 2017];45(5):981-5. Disponível: https://bit.ly/2QnbSvo

10. Conselho Federal de Medicina. Código de ética médica: Resolução CFM nº 1.931/09 (versão de bolso) [Internet]. Brasília: CFM; 2010 [acesso 28 nov 2017]. p. 30-33. Disponível: https://bit.ly/2gyRqtD
11. Savulescu J. Conscientious objection in medicine. BMJ [Internet]. 2006 [acesso 28 nov 2017];332:294-7. Disponível: https://bit.ly/2MrLX2k
12. Pellegrino ED. The relationship of autonomy and integrity in medical ethics. In: Allebeck P, Bengt J, editores. Ethics in medicine: individual demands versus demands of society. New York: Raven Press; 1990. p. 3-15.
13. Asch A. Two cheers for conscience exceptions. Hastings Cent Rep [Internet]. 2006 [acesso 28 nov 2017];36(6):11-2. DOI: 10.1353/hcr.2006.0087
14. Brasil. Ministério da Saúde. Prevenção e tratamento dos agravos resultantes da violência sexual contra mulheres e adolescentes [Internet]. Brasília: Ministério da Saúde; 2012 [acesso 28 nov 2017]. Disponível: https://bit.ly/1vztCad
15. Brasil. Ministério da Saúde. Portaria nº 1.508, de 1º de setembro de 2005. Dispõe sobre o Procedimento de Justificação e Autorização da Interrupção da Gravidez nos casos previstos em lei, no âmbito do Sistema Único de Saúde-SUS [Internet]. Diário Oficial da União. Brasília; 1º set 2005 [acesso 28 nov 2017]. Disponível: https://bit.ly/2Mqfr0s
16. McCallum C, Menezes G, Reis AP. O dilema de uma prática: experiências de aborto em uma maternidade pública de Salvador, Bahia. Hist Ciênc Saúde [Internet]. 2016; [acesso 28 nov 2017] 23(1):37-56. Disponível: https://bit.ly/2PieFJn
17. Aquino EML, Menezes G, Barreto-de-Araújo TV, Alves MT, Alves SV, Almeida MCC *et al.* Qualidade da atenção ao aborto no Sistema Único de Saúde do Nordeste brasileiro: o que dizem as mulheres? Ciênc Saúde Coletiva [Internet]. 2012 [acesso 28 nov 2017];17(7):1765-76. Disponível: https://bit.ly/2MpylEY
18. Brasil. Ministério da Saúde. Atenção humanizada ao abortamento: norma técnica [Internet]. Brasília: Ministério da Saúde; 2011 [acesso 28 nov 2017]. Disponível: https://bit.ly/1FXLHT2
19. Brasil. Ministério da Saúde. 20 anos de pesquisas sobre aborto no Brasil [Internet]. Brasília: Ministério da Saúde; 2009 [acesso 28 nov 2017]. Disponível: https://bit.ly/2D1usX8
20. Zordo S. Representações e experiências sobre aborto legal e ilegal dos ginecologistas-obstetras trabalhando em dois hospitais maternidade de Salvador da Bahia. Ciênc Saúde Coletiva [Internet]. 2012 [acesso 28 nov 2017];17(7):1745-54. Disponível: https://bit.ly/2CQmsZb
21. Sandi SF, Braz M. As mulheres brasileiras e o aborto: uma abordagem bioética na saúde pública. Rev. bioét. (Impr.) [Internet]. 2010 [acesso 28 nov 2017];18(1):131-53. Disponível: https://bit.ly/2p4X8oD
22. Menezes GMS. Aborto e juventude: um estudo em três capitais brasileiras [tese] [Internet]. Salvador: Universidade Federal da Bahia; 2006 [acesso 28 nov 2017]. Disponível: https://bit.ly/2Dvpul2
23. Durand G. Introdução geral à bioética: história, conceitos e instrumentos. São Paulo: Loyola; 2003.
24. Kottow M. A bioética do início da vida. In: Schramm FR, Braz M, organizadores. Bioética e saúde: novos tempos para mulheres e crianças? Rio de Janeiro: Editora Fiocruz; 2005. p. 19-38.
25. Diniz D, Medeiros M. Aborto no Brasil: uma pesquisa domiciliar com técnica de urna. Ciênc Saúde Coletiva [Internet]. 2010 [acesso 28 nov 2017];15(Supl 1):959-66. Disponível: https://bit.ly/2zwWCI3
26. Brasil. Ministério da Saúde. Saúde Brasil 2009: uma análise da situação de saúde e da agenda nacional e internacional de prioridades em saúde [Internet]. Brasília: Ministério da Saúde; 2010 [acesso 28 nov 2017]. Disponível: https://bit.ly/2ioyaLb
27. Simonetti C, Souza L, Araújo MJO. Dossiê: a realidade do aborto inseguro na Bahia: a ilegalidade da prática e seus efeitos na saúde das mulheres em Salvador e Feira de Santana. Salvador: Imais; 2008.

**Participation of the Authors**

Ianna Muniz drafted the text and analysed the results. Liliane Lins participated in the design of the project, guided the work, interpreted and analysed data and performed a critical review. Marta Silva Menezes collaborated in the project design and critical review. All authors were responsible for the final approval of the text.

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Research

## Annex

**Table 1.** Guide for assessing perception about the documentary film "À margem do corpo"

| | |
|---|---|
| 1 | Based on the documentary, what aspects can interfere with the autonomy of the people? |
| 2 | According to what is observed in the film, how would you approach the issue of humanisation by health care teams? |
| 3 | What are the rights of professionals in relation to the issue presented by the documentary and how should the health service proceed? |
| 4 | What is your opinion about the medical care provided to the main character after the occurrence of violence and during the unfolding of the case for the pregnancy interruption? |
| 5 | In your opinion, what is the profile of the woman who notify aborts in Brazil? |
| 6 | In your perception, is abortion a public health problem? Does the criminalisation of abortion interfere with this process? |