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Rewriting abortion: Deploying medical records in jurisdictional negotiation over a forbidden practice in Senegal

Siri Suh

Department of Sociomedical Sciences, Columbia University, 722 West 168th Street, 5th Floor, New York, NY 10032, USA

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ABSTRACT

Boundary work refers to the strategies deployed by professionals in the arenas of the public, the law and the workplace to define and defend jurisdictional authority. Little attention has been directed to the role of documents in negotiating professional claims. While boundary work over induced abortion has been extensively documented, few studies have examined jurisdictional disputes over the treatment of abortion complications, or post-abortion care (PAC). This study explores how medical providers deploy medical records in boundary work over the treatment of complications of spontaneous and induced abortion in Senegal, where induced abortion is prohibited under any circumstance. Findings are based on an institutional ethnography of Senegal's national PAC program over a period of 13 months between 2010 and 2011. Data collection methods included in-depth interviews with 36 health care professionals, observation of PAC services at three hospitals, a review of abortion records at each hospital, and a case review of illegal abortions prosecuted by the state. Findings show that health providers produce a particular account of the type of abortion treated through a series of practices such as the patient interview and the clinical exam. Providers obscure induced abortion in medical documents in three ways: the use of terminology that does not differentiate between induced and spontaneous abortion in PAC registers, the omission of data on the type of abortion altogether in PAC registers, and reporting the total number but not the type of abortions treated in hospital data transmitted to state health authorities. The obscuration of suspected induced abortion in the record permits providers to circumvent police inquiry at the hospital. PAC has been implemented in approximately 50 countries worldwide. This study demonstrates the need for additional research on how medical professionals negotiate conflicting medical and legal obligations in the daily practice of treating abortion complications.

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1. Introduction

> Sometimes we're not sure if it's a case of induced or spontaneous abortion. But the midwife may write spontaneous (in the register) if she's not sure or even if she knows if it's an induced abortion because of the possibility of being called to testify. It happens often (Midwife).

A midwife at a state hospital illustrates the delicate position of health care professionals in Senegal who treat complications of abortion. Although induced abortion is prohibited in Senegal under any circumstance, the national post-abortion care (PAC) program has trained medical providers to treat complications of induced or spontaneous abortion (miscarriage) irrespective of the law. While the law does not explicitly require providers to report suspected cases of induced abortion to the police, this ethnographic study suggests that the severity of the law may lead providers to believe they are obligated to report such cases to the police to avoid being considered accomplices to an illegal act. Treating abortion complications in this context requires a delicate negotiation between medicine and criminal justice.

Scholars of reproduction have traced multiple jurisdictional disputes over abortion between health care professionals, paramedical practitioners, religious authorities, pro-choice and anti-abortion activists, women, and the state (Carranza, 2007; Freedman, 2010; Halfmann, 2011; Joffe, 1996; Luker, 1985; McNaughton et al., 2004; Mhlanga, 2003; Mohr, 1978; Reagan, 1998). Less attention has been directed to the practice of record-keeping in maintaining professional jurisdiction over abortion. Medical records such as patient files or ward registers do not simply

E-mail addresses: jss2054@columbia.edu, sirisuh@gmail.com.

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represent 'what happened' during the clinical encounter. As the institutional footprints of medical practice, these documents represent the 'preferred account' of the encounter (Berg, 1996; Berg and Bowker, 1997; Heath, 1982) in which providers' decision-making is rendered visible to those outside the clinic.

This paper examines how medical providers in Senegal deploy medical records in their strategies to negotiate professional jurisdiction over abortion in a context where this practice is highly restricted. I argue that the medical record represents a site where providers produce a particular account of 'what happened' through a series of medical practices such as the patient interview and the clinical exam. By classifying the majority of abortions treated as spontaneous abortion, this preferred account permits providers to contain suspected cases of illegal abortion within the hospital, undocumented and unreported to criminal justice authorities. In other words, providers render suspected cases of illegal abortion invisible in hospital records. This study seeks to advance our understanding of medical records as fundamental tools in the protection of professional autonomy from political interference, or what scholars have called 'boundary work (Gieryn, 1983)'.

2. Background

National estimates of induced abortion in Senegal have not been established. Although the 2010–2011 Demographic and Health Survey reports the maternal mortality ratio at 392 deaths per 100,000 live births, it does not estimate the contribution of unsafe induced abortion to maternal death (ANSD, 2012). The World Health Organization estimates the rate of unsafe abortion in West Africa at 28 unsafe abortions per 1000 women of reproductive age. This is less than the estimated 36 unsafe abortions per 1000 women in Middle and East Africa, but far greater than the 6 unsafe abortions per 1000 women in developed regions (WHO, 2011). Hospital data offer limited insight into the scope of induced abortion in Senegal. Maternal death reviews in hospitals have found that hemorrhage is the leading cause of maternal death while abortion accounts for very little mortality (Dumont et al., 2006; Kodio et al., 2002). However, complications of induced abortion are often misclassified as hemorrhage or sepsis (Barreto et al., 1992; Khan et al., 2006).

In response to studies of abortion conducted in Senegalese hospitals during the 1990s, the public health community deemed complications of abortion a significant public health problem. Between 1993 and 1994, a study conducted in four hospitals in the capital city of Dakar estimated that nearly a quarter of patients admitted with complications of abortion had an induced abortion (Diadhiou, 1995; Goyaux et al., 2001). Complications of abortion accounted for 7.4% of maternal mortality (Diadhiou, 1995). Between 2000 and 2002, a review of client records in 6 district hospitals and 12 health clinics in two regions of the country found that 95% of abortions were recorded as spontaneous (CEFOREP, 2003; EngenderHealth, 2003). Yet, up to 35% of PAC patients admitted that the pregnancy was unwanted. Among these women, 17% admitted to having an induced abortion (CEFOREP, 2003). Another study conducted between 2002 and 2003 at the national teaching hospital in Dakar showed that induced abortion accounted for only 5.6% of all abortions treated in the hospital (Cissé et al., 2007). The researchers note that induced abortions were likely underreported. In addition to significant variation in estimates of induced abortion among these hospital-based studies, this evidence is further limited by the omission of women who did not seek medical care for abortion complications.

Senegal's abortion law derives from the Napoleonic Code enacted in France in the early 19th century, prohibiting induced abortion under any circumstance. Women and any accomplices who procure induced abortion are subject to imprisonment and fines. Providers convicted of abortion may lose their professional license for up to 5 years or permanently in addition to imprisonment and fines (CRR, 2003; Knoppers et al., 1990; Scales-Trent, 2010). Although the penal code forbids induced abortion, the code of medical ethics permits therapeutic abortion if the woman's life is endangered by the pregnancy (CRR, 2003). According to Article 35 of the code of medical ethics, eligibility for therapeutic abortion must be confirmed by two other physicians, one of whom is a court-approved expert (CEFOREP, 1998; Touré, 1997). Health care professionals who participated in my study indicated that due to these administrative requirements, therapeutic abortion is rare.

The law does not require medical providers who treat complications of induced abortion to notify law enforcement officials. Article 7 of the code of medical ethics requires health providers to respect patient privacy (*le secret professionnel*). A law on reproductive health passed by the National Assembly in 2005 grants citizens the right to confidential health services. However, my review of the Senegalese press found that medical providers do indeed report suspected cases of illegal abortion. Over a span of just two months, between September and October 2011, three cases of suspected induced abortion brought to the attention of the police by medical providers were reported in Dakar newspapers (Diedhiou, 2011a, 2011b; L'Observateur, 2011).

In the late 1990s, the Senegalese Ministry of Health introduced post-abortion care (PAC) to address mortality and morbidity related to unsafe abortion (Thiam et al., 2006). The global reproductive health community developed the PAC model in the early 1990s to train medical professionals to treat complications of abortion irrespective of the legal status of abortion (Corbett and Turner, 2003; Greenslade et al., 1994). The Ministry of Health introduced specialized registers for PAC to maternity wards in secondary and tertiary level hospitals throughout the country starting in the mid-2000s. Similar to other maternity registers for family planning and delivery, PAC registers retrieve a combination of clinical and sociodemographic data from patients, such as length of gestation, complications, name, age, address, and date and hour of arrival. The PAC register includes a column requiring medical providers to differentiate between induced and spontaneous abortion. Unlike the other specialized registers in the maternity ward, the PAC register requires providers to document the patient's marital status.

Recently, several civil society organizations and government agencies have advocated for the revision of the abortion law in Senegal. *L'Association des Juristes Sénégalaises* (AJS)/(Association of Women Lawyers) attempted to allow safe abortion for cases of rape and incest in the 2005 reproductive health law (Scales-Trent, 2010). Although abortion was eventually struck from the law, AJS continues to mobilize for social and legislative change. For example, AJS has held workshops with police officials, judges and health professionals to clarify the law and discuss strategies for managing cases of rape and incest. At the time of this study, the Ministry of Culture and Gender was in the process of advocating for coherence between Senegalese law and international treaties ratified by the Senegalese state such as the Maputo Protocol of 2005, which permits abortion for rape, incest, and the woman's physical and mental health. In 2010, the *Division de la Santé de la Reproduction* (DSR)/(Division of Reproductive Health) of the Ministry of Health conducted a strategic evaluation of unsafe abortion to increase awareness of this public health problem among policymakers (DSR, 2010). *L'Association des Médecins Femmes*/(Association of Women Physicians) delivered a presentation on the public health implications of unsafe abortion at a conference for International Women's Day in March 2011 that urged reform of the abortion law (Thiam, 2011). Scholars also actively contribute to the national discussion on abortion. That same month, in response to the case of a 14-year-

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