

Article

The Impact of Information Sessions on Women's Anxiety When Facing a Voluntary Termination of Pregnancy (VTP)—A Case Study about Geneva University Hospitals (Switzerland)

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Abstract: Women going through a termination of their pregnancy (VTP) face a stressful situation that should be managed by hospitals in a multidisciplinary way: law, public health, and communication. This paper aims to analyze how the information sessions organized by hospitals influence women's decisions when facing a VTP. To achieve that, we resorted to four main methodologies: (a) literature review about law, public health, and communication; (b) a 4-week participant observation at *Port Royal Hospital* (France) and in a social restaurant in Katowice (Poland), as well as three focus groups in the first institution (2012); (c) an online survey addressed to 500 women in Poland, France, and Switzerland (2012–2014); and (d) two focus groups and one deep interview with doctors and nurses from *Geneva University Hospitals* and *Lausanne University Hospital* in Switzerland (2017–2018). Based on our quantitative results, we developed a medical protocol to help doctors interact with patients going through a VTP. This protocol was approved by the *Geneva University Hospitals'* Ethics Committee (BASEC 2018-01983). We concluded that women's informed consent is an intimate, reciprocal decision; doctors should help them to make independent decisions; and hospitals need to establish a harmonized discourse based on a code of internal communication, train their doctors in communication skills, and help them adopt a more flexible approach when taking care of these patients.

Keywords: public health; human rights; communication; hospitals; voluntary termination of pregnancy



Citation: Medina, E. The Impact of Information Sessions on Women's Anxiety When Facing a Voluntary Termination of Pregnancy (VTP)—A Case Study about Geneva University Hospitals (Switzerland). *Societies* **2022**, *12*, 126. <https://doi.org/10.3390/soc12050126>

Academic Editors: Costas S Constantinou, Panayiota Andreou, Monica Nikitara and Alexia Papageorgiou

Received: 12 July 2022

Accepted: 8 September 2022

Published: 9 September 2022

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1. Introduction

Hospitals were the first organizations to offer patients a voluntary termination of pregnancy (VTP) as well as a medical interruption of pregnancy (MIP), especially in countries such as Switzerland and Russia. Even when legal frameworks concerning both issues were still not clear, some hospitals carried out these medical practices. VTP refers to a woman's personal decision to stop her pregnancy, meanwhile MIP can be defined as a medical decision made by a Medical Committee to interrupt a woman's pregnancy in certain cases. Sometimes, hospitals and health authorities do not verify whether patients' consents for VTP or MIP cares are given or not, which constitutes a risk for patient's autonomy and dignity. To efficiently protect patients, hospital organizations should manage communication in a more professional way. Communication affects patients' decisions concerning VTP and MIP as well as doctors' medical responsibilities, and contributes to improve hospitals' legal framework and, in this way, protect patients' rights in a more efficient way. Communication plays a key role when protecting the principle of autonomy of the will. Doctors explain to patients the impact of every medical decision: nevertheless, patients' will should always prevail. This way, they can establish a mutual agreement based on mutual responsibilities and avoid legal uncertainties. In the positive law (PL), patients' informed consents are required before every medical act. According to this basic principle, when patients' informed consents differ from their true personal will, this last one should

always prevail. Three reasons highlight the importance of patients' informed consent: (a) it is a psychological disposition that determines patients' behaviors; (b) it summarizes patients' will; and (c) in most cases, it matches with patients' true personal will. That is why communication and information play a key role in public health: if doctors do not communicate in an efficient way, patients can make wrong decisions that negatively affect their own health.

This paper aims to analyze how the information sessions organized by hospitals influence women's perceptions and decisions when facing a VTP. To achieve that, we carried out a literature review about law, public health, and communication, and more precisely about the legal, medical, historical, and communication influence of VTP and MIP on patients' health. To perform this, we considered patients' experiences in different countries such as Switzerland, France, Spain, and Poland. Then, we conducted a quantitative analysis including three different methodologies. *First*, in 2012, we carried out a 2-week participant observation at *Port Royal Hospital* (France), along with the Head of the Gynecology Department; in addition, we organized three focus groups with this doctor and his medical team (two nurses, four sexual counselors, and a psychologist) as well as 50 patients facing VTP. To complete this first stage, we implemented another 2-week participant observation in Katowice (Poland), where, in a social restaurant, we met 200 women who had faced a clandestine VTP. *Second*, in 2012–2014, we designed and implemented an online survey to analyze 500 women's experiences in Poland, France, and Switzerland when facing a VTP. To design this survey, we considered as main theoretical framework the Hospital Anxiety and Depression Scale (HADS). *Third*, in 2017–2018, we designed a medical communication protocol at *Geneva University Hospitals* (GUH) in Switzerland. This protocol was approved by this hospital's Ethics Committee. To develop this protocol, three main research initiatives were implemented: (a) a focus group with doctors and nurses from the Department of Gynecology (GUH), (b) a focus group with doctors and nurses from the Department of Gynecology at *Lausanne University Hospital* (LUH), and (c) a deep interview with one of the Heads of the Department of Gynecology at *Geneva University Hospitals*. We proposed this medical communication protocol as a tool to help doctors in the gynecology departments to take care of these patients in a more efficient way. Finally, we highlighted five conclusions whose main objectives were to help patients, doctors, and academics to develop this area during the next years.

2. A Multidisciplinary Analysis of VTP

2.1. Information as a Patient's Subjective Right

Every year, 139 million women are pregnant worldwide: only 4.45 million of them go through a VTP or a MIP [1]. According to the United Nations (2014), three million VTPs are carried out in the world for helping women aged 15–19 years [2]. Based on patients' age, many hospitals refuse women termination of their pregnancy: apparently, patients' age prevents them from efficiently expressing their will. This situation constitutes a threat for patients' autonomy and makes them more vulnerable. Patients' autonomy and vulnerability are narrowly related: establishing legal limits to both becomes difficult in some medical contexts [3]. Health organizations apply laws when patients cannot efficiently communicate with doctors and make their own medical decisions: in these cases, doctors help patients and decide on their behalf. In this context, information plays a key role. According to Vialla (2013), information is considered a patient's subjective right: in other words, information does not exclusively belong to doctors, but also to patients [4]. On the other hand, the principle of duty determines doctors' behaviors: health professionals must respect patients' dignity and, therefore, share with them the information they need to make their own medical decisions [5]. Unfortunately, patients' dignity is often not respected: some doctors impose medical decisions that radically affect patients' physical and emotional health. Different experts in health law, such as Zusmann (1993), have proved that patients' decisions are very often determined by doctor's personal opinions: in fact, only 20% of medical decisions consider patients' will [6]. Ferrand et al. (2001) demonstrated

that only 0.5% of patients actively participate in medical decisions concerning their own health [7]. Doctors should consider patients' will: recognizing the autonomy of the will involves sharing information with patients and respecting medical ethics, as well as legal frameworks [8].

2.2. Medical Ethics and Patients' Autonomy of the Will

The development of patients' autonomy theories is directly related to social movements that took place in the United States and Europe in the 1960s for promoting medical ethics. Doctors, but also philosophers and sociologists, helped hospitals to integrate these theories into medical cares: as a result, in the 1980s, most schools of medicine worldwide started teaching courses about ethics to future doctors. One of the main concepts analyzed in these courses is the informed consent, which constitutes a reaction against doctors' paternalism [9]. Informed consents allow patients to be respected, especially when facing a VTP or a MIP. This concept establishes the jurisprudence in the European legal frameworks and is consistent with hospitals and public authorities' commitment to share medical information with patients and respect the patients' final choices. To efficiently respect patients' rights, hospitals resort to different communication initiatives: communication becomes a social tool that allows doctors to be more efficient and, in this way, help patients improve their medical outcomes [10].

Despite its positive influence on patients' and doctors' behaviors, the informed consent remains a controversial concept: some doctors behave in a paternalistic way and impose medical treatments without considering patients' opinions [11]. These unprofessional behaviors lead patients to suffer from different physical problems: 20% of doctors worldwide are reported for medical mistakes at least once throughout their professional career [1]. In addition, these attitudes destroy doctor–patient relations and make it difficult for hospitals to become an efficient organization [12]. As Xavier Bioy (2016) pointed out, the patient–doctor relationship is asymmetric in terms of knowledge and information, and hospitals should urgently address this issue: otherwise, patients' rights will always be threatened [13].

2.3. Patients' Vulnerability and Hospitals' Communication Initiatives

According to Russ and Leguil (2012), patients need to understand their diseases and treatments and, based on that, make a decision, which represents an intellectual act [14]. In Europe, medical and legal frameworks protect the patient's right to receive quality information before signing an informed consent. Doctors' duty to inform is essential for hospitals and patients but is not enough when it comes to women's rights to terminate their pregnancy [15]. In 1954, Louis Portes (1954: 163), Head of the Gynecology Department at *Port-Royal Hospital* in Paris (France) and president of the *French Medical Association*, shared his concerns about this issue: "In front of an inert, passive patient, doctors do not think they are dealing with a free, equal human being, a peer whom they can really instruct. Patients are not at all aware of their own misery, and therefore, they cannot consent to what is affirmed about them, either to what they are proposed." Portes' concerns highlighted how important is for patients interested in terminating their pregnancy to receive quality information [16]. Louis Portes (1954: 165) also criticized some doctors for being aggressive with these patients: "They do not hesitate to pretend they recognize patient's inherent pain, adorning that with virtues that are expiatory (following a logic that evokes penances imposed to sinners) and preventive of recurrence" [16].

In 2017, Michel Teboul, Head of the Gynecology Department at *Port-Royal Hospital* in Paris (France), asked public authorities and hospitals to improve the information shared with patients, and recommended hospital to train their doctors in interpersonal communication skills [17]. One year later, despite many doctors' relative ignorance on the legal impact of information, French Public Authorities reaffirmed the principle of duty to inform: all doctors were required to provide patients with quality information [18].

According to the sociologist Luc Boltanski (2004), control in childbirth directly refers to doctors' personal opinions about patients' irresponsibility: some doctors are not willing to share their knowledge with patients [19]. As Marcel Gauchet (2001) affirmed, radical social changes have led health organizations to neutralize facts concerning patients' rights and impose a subjective approach to public health. Nevertheless, the principle of autonomy of the patient should not be subjectivized [20]. Patients are free to conform to their personal ethics [21]. The European Law also protects this principle of freedom [22]. Health organizations should always protect patients' rights, and to achieve that, they have to consider the principle of self-determination [23]. The autonomy of the patient and the informed consent must always prevail over medical interferences.

2.4. Public Health, Women's Rights, and Social Support

In Spain, in 1936, Catalonia was the first region to legally authorize VTP [24]. Three years later, when the Spanish dictator Franco controlled the country, he banned VTP in Spain. Under his dictatorship (1939–1975), thousands of women were criminally prosecuted for terminating their pregnancies or helping other women to perform the same: many of them were sent to jail [25]. Santiago Barambio, founder of a network of clinics specializing in abortion, stated that under Franco's dictatorship, the Catholic Church supervised hospitals and, therefore, VTP was forbidden: "When I was a medical student in the 1960s, women used to go on Friday to different hospitals for clandestine abortions because, afterwards, they could recover during the weekend. Doctors used to write appendicitis and practice an open curettage, to push patients not to do it again. I have seen women screaming and dying on these Fridays. I told myself that I would never do what those doctors did because I saw women with blood, begging, who asked for anesthesia. It was a torture." [26].

Since 1985, Spanish public authorities have allowed VTP in case of "psychological risks" for women: this framework makes it possible for hospitals to take care of these patients up to their 22nd week of pregnancy [27]. However, this legal context did not guarantee the continuity of the principle of autonomy of the patient's will: most of them do not have access to social reimbursement systems for these medical practices [28]. According to the Spanish Ministry of Health, the main reason why the number of VTPs has increased by 73% from 2005 to 2015 is the failure of health authorities when sharing quality medical information about contraception with patients [29]. In 2010, Spanish public authorities changed this legal framework and started considering VTP as a legal medical procedure: nevertheless, 70% of doctors in Spain continued to apply their conscience clause and refused to treat these patients [30]. In 2013, Spanish Public Authorities tried to approve a new bill that completely penalized VTP, including in case of malformation of the fetus, dangers for women's health, rape, etc. For the sociologist Francisco Gonzalez de Tena (2002: 25), Spanish Public Authorities' decisions concerning abortion are based on ideologies, and not on public health criteria: "Let us imagine that tomorrow a bill is proposed to abolish women's right to vote. Everyone would laugh out loud. We can see that the right to abortion is much more fragile" [31].

Despite this new legal framework aiming to decriminalize abortion, the autonomy of the will of women does not really exist in the country [32]. The interpretative controversies concerning this legal issue reveal several disagreements among Spanish Public Authorities when it comes to recognizing the autonomy of women facing unwanted pregnancies [33]. These patients need to be reassured, informed, and supported [34]: unfortunately, most of them affirm that they feel they are constantly judged by health professionals [35]. Doctors and patients do not agree on the kind of medical, personal accompaniment that these patients need [36]. To fix these misunderstandings, hospitals should promote social interviews among patients and doctors and integrate in these interviews at least one sexual counselor [37]. These professionals play a key role: (a) they share information and experiences with patients before medical surgeries; (b) they assume a role of psychologist, doctor, and lawyer; and (c) they promote the hospital's duty of inform. Unfortunately, some doctors consider these counselors as intruders who are not experts in public health. As Touraine

(1992) stated, health professionals' use of language causes patients to lose their prominence and live in a fictitious autonomy [38].

2.5. VTP and Hospitals' Communication Challenges

Promoting a legal framework for VTP and MIP constitutes a medical and a communication challenge. Patients' autonomy is directly related to public health and law, but also communication, history, sociology, and gender studies: in other words, this area refers to human rights. Unfortunately, in many countries, women's right to choose VTP or MIP is not considered a human right [39]. In Europe, public authorities should address this issue and protect pregnant women in a more efficient way: train health professionals, promote the informed consent, protect patients' rights to receive accurate medical information, integrate sexual counselors into these medical processes, define medical responsibilities in a clearer way, establish legal frameworks when patients face medical mistakes, etc., and to achieve that, public authorities and hospitals need to resort to communication. Thanks to communication initiatives, hospitals help doctors to enhance some of their professional skills, which positively influences their relations with patients as well as the patients' satisfaction with medical services [40]. Internal and interpersonal communication initiatives in hospitals have become an essential activity for protecting patients' rights [41].

For many years, hospitals have not managed corporate communication in a professional way, which has made it difficult for them to establish good relations with some stakeholders, such as patients, employees, public authorities, or media companies [42]. Implementing corporate communication strategies based on a health education approach allows these organizations to become reputed brands [43]. On the other hand, hospitals' corporate communication initiatives should be consistent with emotional and social challenges faced by patients [44]. In other words, integrating social sciences such as law, psychology, sociology, or philosophy into the hospital's communication initiatives allows these companies to become more human organizations and, in this way, establish better relations with patients [41]. Finally, patients become more and more demanding with health organizations, which is why these companies must be more flexible and consider their stakeholders' opinions when making strategic decisions concerning communication [45]. To achieve that, health professionals must be involved in some of the interpersonal, internal, and external communication initiatives launched by the hospitals [43].

3. Methodology

Based on the literature review, the main topics related to VTP and IPM were analyzed, as well as the roles played by different academic fields in this area, such as public health, law, communication, history, and sociology. These topics were considered when designing our quantitative methodologies. To analyze how information sessions determine women's decisions going through a VTP, we implemented three main methodologies.

First, in 2012, a 2-week participant observation was carried out from 2 to 15 September at *Port Royal Hospital* (France), along with the Head of the Gynecology Department in this hospital. Based on these observations, three focus groups were organized from 11 to 24 November with this Doctor and his team (two nurses, four sexual counselors, and a psychologist), as well as 50 patients facing a VTP and five sexual counselors. The conclusions obtained thanks to these participant observations were complemented by another 2-week participant observation conducted in the same year, from 2 to 15 December, in Katowice (Poland), where, in a social restaurant, we met 200 women who had faced a clandestine VTP (see Appendix A).

Second, in 2012–2014, based on the knowledge gathered during the previous stage, an online survey was created to analyze 500 women's experiences in Poland, France, and Switzerland when facing a VTP or a MIP (see Appendix B). This survey considered the Hospital Anxiety and Depression Scale (HADS) as main theoretical framework. HADS is a scientific tool allowing doctors to evaluate patients' anxiety and depressive disorders. The main reason why we chose these countries was the different level of professionalism

concerning the legal framework existing for addressing VTP and MIP: Switzerland (premium level, one of the best systems in the world), France (medium level, because of the conscientious objection), and Poland (low level, VTP is considered as an illegal practice). We carried out this online survey from 1–20 March 2014.

Third, in 2017–2018, based on the insights gathered in the two previous stages, a medical communication protocol was designed at *Geneva University Hospitals (GUH)* in Switzerland to help doctors to interact with patients going through a VTP or a MIP in a more efficient way. To achieve that, a two-year work plan was established with one of the Heads of the Department of Gynecology. We conducted three main activities: (a) a focus group with doctors and nurses from the Department of Gynecology (*GUH*), (b) a focus group with doctors and nurses from the Department of Gynecology at *Lausanne University Hospital*, and (c) a deep interview with one of the Heads of the Department of Gynecology at *Geneva University Hospitals* (see Appendix C). Based on all these inputs, we designed and developed a medical communication protocol. This protocol (BASEC 2018-01983) was approved by the *Geneva University Hospitals' Ethics Committee* [46].

4. Results and Discussion

The main results obtained with this research are summarized and grouped into three main sections: (a) participant observations and focus groups at *Port Royal Hospital*, France, and the social restaurant in Katowice, Poland (2012); (b) online survey in France, Poland, and Switzerland (2012–2014); (c) focus groups, deep interview, and medical protocol in Switzerland (2017–2018). These results proved that information sessions influence women's decisions and perceptions about VTP, which means that health professionals, especially doctors and nurses, should consider this communication tool as part of medical protocols implemented in these organizations to treat these patients.

4.1. Participant Observations and Focus Groups at Port Royal Hospital (France) and a Social Restaurant in Katowice, Poland (2012)

The different participant observations carried out at *Port Royal Hospital* allowed us to better understand how public hospitals in France took care of women going through a VTP. Three main conclusions were highlighted. *First*, the high number of patients attending this hospital and the lack of human and material means in this organization made it difficult for healthcare professionals working in the Family Planning Unit to efficiently harmonize their discourse concerning VTP. *Second*, healthcare workers' personal opinions about VTP as well as their own ethical principles determined many patients' decisions, which represented a barrier for the hospital to harmonize a common legal framework. *Third*, patients were not forced to interact with psychologists, which constituted a risk for these patients' health because they were only treated from a technical point of view, and not from an emotional and psychological standpoint.

Based on these inputs, we organized three focus groups along with the Head of the Gynecology Department at *Port Royal Hospital* and his medical team (two nurses, four sexual counselors, and a psychologist), as well as 50 patients facing a VTP. Thanks to these experiences, we gathered three main conclusions. *First*, patients were highly influenced by their family and friends, as well as by their own ethical principles and the increasing social pressure concerning VTP. This situation made patients feel less free when making their decisions. *Second*, doctors did not implement a clear process allowing psychologists to interact with every patient, which damaged patients' rights to receive clear information as well as an integrated medical service. *Third*, given that VTP was not considered as a patient's right, doctors shared with them their personal opinions, which made it impossible for the hospital to harmonize an official discourse about this medical treatment. Participant observations and focus groups highlighted how important patients' interactions with their relatives and with doctors are when it comes to making a decision concerning VTP.

In order to compare our results with other patients' experiences in other countries, we decided to launch fieldwork in a social restaurant in Katowice (Poland). We interacted with

200 women who had a clandestine VTP. We concluded that these patients' lack of freedom and autonomy led them to suffer from serious mental problems after VTP (sequela, guilt, denial). In addition, most women choosing a clandestine VTP came from low-income social groups: the gaps in the local legal framework concerning VTP, as well as these patients' lack of resources, have created a two-tier society in terms of VTP care. Finally, most of these patients felt a high social pressure because local authorities and governments had launched different campaigns against VTP, and because most patients could not ask their families for help.

Results gathered in this first stage allowed us to prove that hospitals need to treat these patients in a more multidisciplinary way: public health, medicine, law, communication, and even emotional intelligence are some of the fields that help these patients to improve their medical outcomes.

4.2. Online Survey in France, Poland, and Switzerland (2012–2014)

Thanks to the Hospital Anxiety and Depression Scale, online surveys could be implemented in a respectful, efficient way to analyze women's anxiety when facing a VTP or a MIP. Results confirmed that these patients did not have enough information about these medical procedures: 76% of women interviewed affirmed that they had suffered psychologically after VTP because of this lack of information. On the other hand, most of these patients were influenced by their fathers and the society, as shown in Table 1. According to our results, 38% of women had a "no doubtful profile", 32% a "doubtful profile", and 23% a "desperate profile", which means that they had no choice, that they could not efficiently interact with their doctors to explain their personal situation, and that they did not receive the required information. On the other hand, 11% of women were forced to go through a VTP: most of them were forced by their parents (63%). These quantitative results allowed us to reinforce our previous results gathered in 2012 and prove that family and doctors directly influence patients' decisions going through a VTP. In other words, hospitals need to consider the emotional aspects of these patients' medical experiences.

Table 1. Have your relatives and friends influenced you?

	Not at All	A Little Bit	Much	Too Much
Father	43.21%	18.52%	18.52%	19.75%
Mother	72.73%	7.79%	6.49%	12.99%
Medical staff	71.62%	13.51%	2.70%	12.17%
Friends	65.33%	24.00%	8.00%	2.67%
Society	55.26%	18.42%	9.21%	17.11%

4.3. Focus Groups, Deep Interview, and Medical Protocol in Switzerland (2017–2018)

Our experiences in France, Poland, and Switzerland from 2012 to 2014 were essential to prepare the last stage of this research in Switzerland. The focus group organized with doctors and nurses from the Department of Gynecology at *Geneva University Hospitals* allowed us to obtain three main conclusions. *First*, healthcare professionals had implemented a harmonized discourse allowing them to treat patients in an efficient, equal way. *Second*, internal procedures in the hospital were well structured and integrated, which facilitated patients' experiences and protected their rights to autonomy and freedom. *Third*, doctors and nurses respected patients' rights, which involved, on the one hand, that they did not share with them their personal opinions about VTP, and on the other hand, that most of these doctors did not resort to their conscience clause to prevent patients from accessing VTP. In other words, *Geneva University Hospitals'* effort to efficiently train its health workers on VTP from a medical, legal, and emotional point of view allowed patients to be more respected and improved their satisfaction with the organization.

To compare our results and confirm some hypotheses, we carried out another focus group with doctors and nurses from the Department of Gynecology at *Lausanne University Hospital (LUH)*. Three main conclusions were highlighted. *First*, the local legal framework in Lausanne (Vaud) led to a lack of harmonization in terms of communication: every hospital in this region worked in an independent way, which made it difficult for patients to be treated in an equal way. *Second*, many patients complained because they did not have enough time to explain to doctors and nurses their concerns about VTP: medical, social, and emotional. *Third*, this lack of harmonization negatively influenced patients' mental health, as well as their satisfaction with the hospital's services related to VTP.

Based on the knowledge gathered from these two focus groups in Geneva and Lausanne, we interviewed one of the Heads of the Department of Gynecology at *Geneva University Hospitals*. According to this doctor, nurses were considered as "technical doctors" who play a key role in internal research processes (clinical trials), as well as in the hospital's initiatives to improve medical treatments and patients' experiences related to VTP. These technical doctors carried out a true intellectual reflection to better understand patients' needs: to achieve that, the hospital allowed these employees to participate during their working hours in different multidisciplinary projects (technical aspects, psychology, emotional support) aiming to improve patients' satisfaction with VTP. Doctors and technical doctors implemented a true harmonized discourse about VTP that, on the one hand, positively influenced patients' perceptions, and, on the other hand, led the hospital's managers to make some decisions to protect patients' rights and improve employees' skills in this area.

Results gathered from these two focus groups and the deep interview proved that information affects patients' perceptions about VTP and MIP: doctors' duty to inform and educate patients was highlighted as a key element in this process. Based on this idea, we designed a medical protocol that was approved by the *Geneva University Hospitals'* Ethics Committee: BASEC 2018-01983. This medical protocol proposes a communication model that hospitals can implement to efficiently take care of patients going through a VTP (see Table 2).

Table 2. Global process.

Key Stages	Period	Methodology	Interlocutors/Clinical Study
1. First inputs about the information sessions. The hospital's call center contacts patients suffering from unwanted pregnancies who are interested in VTP.	- Every day for 4 months.	<ul style="list-style-type: none"> - The interlocutor presents the objectives of the study (stress reduction) and the potential benefits of information sessions about VTP. - Call center employees explain to patients that: (1) attending these sessions is not mandatory; (2) participants are chosen randomly; (3) these sessions take place every Wednesday at 5 p.m. in a meeting room in the hospital (Gynecology Department); (4) the study is anonymous; (5) different people participate in these sessions, not just women interested in VTP. 	<ul style="list-style-type: none"> - The link person is the head of the call center at <i>GUH's</i> Gynecology Department. - Call center employees randomly select patients from those interested in attending these sessions, and specify which patients will finally participate in this study, and which ones have refused. - The head of the call center at <i>GUH</i> Gynecology Department sends an email to participants to explain to them how sessions are organized. Patients should send an email to confirm their attendance. Finally, every Wednesday, Eva Medina sends a weekly report to the Head of the Gynecology Department concerning the main outcomes gathered in these sessions.

Table 2. Cont.

Key Stages	Period	Methodology	Interlocutors/Clinical Study
2. Written agreement. Patients confirm by email (first informed consent) and attend a 45 min information session taking place on Wednesday at 5 p.m.	- Every Wednesday for two months.	<ul style="list-style-type: none"> - The speaker explains the content to patients in the meeting room for 45 min. - There are two main tools available: a PowerPoint presentation (speaker), and a notebook (participants). This way, the participants can take notes. - The session is anonymous. Only the link person is present. Participants ask questions at the end of the session (10 min). They can also interact with each other if they wish. - The hospital's call center should recruit 5 patients per week so that every month a session including 20 participants can be organized. 	<ul style="list-style-type: none"> - The link person is Eva Medina (Institute for Global Health, Faculty of Medicine, <i>University of Geneva</i>). - Participants must send their informed consent and attend the session. Those who send their informed consent but do not attend the session are not considered. - At the end of the session, patients are asked to fill out a satisfaction questionnaire (5 min, 8 questions). - Thanks to this questionnaire, we can help doctors to better follow up with patients during the HADS test, and better understand the VTP team's reactions concerning the influence of this study on patients.
3. Online survey. Patients are invited by email to participate in an online survey to (1) verify the stress reduction; (2) list secondary outcomes (provide information to the hospital); and (3) determine the sample size.	- One month later.	<ul style="list-style-type: none"> - Eva Medina (link person) sends an email to patients to ask them to participate in the online survey. - The software automatically provides sample size calculations. - Subsequently, the research team, along with the hospital's Gynecology Department, verifies these calculations and validates, or not, the research hypothesis: "Information sessions about VTP help patients to reduce their stress and reinforces the hospital's duty to inform". 	<ul style="list-style-type: none"> - The link person is Eva Medina (Institute for Global Health, Faculty of Medicine, <i>University of Geneva</i>). - The positive impact of this study could lead hospitals to implement these information sessions as a part of their medical procedures for patients interested in VTP. This protocol allows women to better know their rights (medical decisions, VTP, etc.). It also contributes to reducing the number of patients who regret having gone through a VTP as well as the number of women suffering from psychological consequences. - Once approved by the <i>Geneva University Hospitals'</i> Ethics Committee, this study will be published in a scientific journal. - Three main reasons can explain patients' selection bias: (a) the follow-up about patients was not properly performed; (b) patients finally did not go through a VTP; and (c) patients exaggerated their personal situation.

Implementing this protocol requires a multidisciplinary team (doctors, lawyers, journalists, psychologists), written materials (brochures, informed consents), a meeting room in the hospital, and the involvement of the hospital's VTP Unit (Department of Gynecology) and the call center. Health professionals record and archive patients' informed consents before organizing every session. Once the information session starts, three main inputs are presented to patients: (1) legislation, (2) technical and medical aspects concerning VTP, and (3) feminism and religion (See Table 3). Afterwards, a 3 min video produced by the

hospital's Family Planning Unit showcases a women's testimony about her experiences and perceptions before, during, and after a VTP.

Table 3. Information session: main content.

Topic	Duration	Title	Target
1. Bioethics: Legislative aspects of VTP	8 min	<ul style="list-style-type: none"> • VTP treatments in Europe: legislation • VTP treatments in Switzerland • VTP treatments: best practices in the world (WHO) • Participants' profile: personalized support • VTP treatments in Poland 	<ul style="list-style-type: none"> • Knowledge: patients learn about their rights concerning VTP (informed consent, principle of autonomy).
2. Bioethics: Medical procedures for VTP	8 min	<ul style="list-style-type: none"> • VTP treatment: health • VTP (surgical abortion) with general or local anesthesia • VTP treatments based on drugs 	<ul style="list-style-type: none"> • Knowledge: patients understand the whole process (accessibility, efficiency, progress).
3. Ideological variables: Feminism	8 min	<ul style="list-style-type: none"> • VTP treatments in Europe: ideological variables • Feminism 	<ul style="list-style-type: none"> • Attitudes: develop an objective attitude towards VTP. Ban blameful feelings.
4. Ideological variables: Theology	8 min	<ul style="list-style-type: none"> • Positive theological approach • Arts and feminism • Protection of women's rights • Oldest principles of law • Freedom of choice vs. lobbying groups 	<ul style="list-style-type: none"> • Attitudes: promote reflection and awareness. Improve patients' self-confidence and involvement in collective medical decision-making processes.
5. Video: Testimony of a patient having gone through a VTP	3 min	<ul style="list-style-type: none"> • Feminism: effects and challenges 	<ul style="list-style-type: none"> • Culture: promote professionalism in VTP practices and reinforce transparency and information sharing between doctors and patients, benevolence, and neutrality.
6. Questions	10 min	<ul style="list-style-type: none"> • Dialogue with participants 	<ul style="list-style-type: none"> • Culture: promote information sessions as a corporate tool that hospitals implement for improving VTP practices.

At the end of each information session, patients fill out a questionnaire allowing doctors to evaluate patients' experiences. This feedback also helps health professionals to evaluate their own experiences when dealing with patients interested in VTP. This information is archived in the hospital's databases, along with every patient's informed consents. Finally, VTP Unit employees analyze these databases considering different criteria such as information, medical practices, and social support. Based on that, they propose different ideas to improve the whole process for the next information sessions with patients (see Table 4).

Table 4. Evaluation system.

Entry	Exit	Knowledge Multipliers	Targets	Impact
<ul style="list-style-type: none"> - Human resources: health professionals, health lawyers, health communication experts, and psychologists (volunteers for the project). - Written material: brochures, patient information sheets. - Premises: a meeting room in the hospital. - Corporate support: HUG's Gynecology Department. - Agreement. 	<ul style="list-style-type: none"> - Session information for a group of women requesting VTP care. - Previous meeting among health professionals for designing the content and format of this session. 	<p>KNOWLEDGE</p> <ul style="list-style-type: none"> - Knowledge acquisition about different areas related to VTP. - Promote knowledge sharing among health professionals concerning VTP. - Learn about how to implement discussion groups with patients. - Consolidate doctors' knowledge about communication and therapeutic education. 	<p>KNOWLEDGE</p> <ul style="list-style-type: none"> - Know their own rights concerning VTP (informed consent, unavailability of their body, personal autonomy over their own body). - Be informed about VTP (accessibility, efficiency, and progress). - Understand the psychological consequences of VTP, and better know the hospital's social support system (Family Planning Unit, VTP Unit). 	<ul style="list-style-type: none"> - Develop better knowledge about patients' rights concerning VTP, reinforce their own professional skills, and help them make better decisions. - Decrease the number of patients who regret having gone through a VTP. - Decrease the number of women suffering from psychological consequences due to the lack of information about VTP (previous stage). - Strengthen the hospital's engagement with doctors' duty of information.
		<p>ATTITUDES</p> <ul style="list-style-type: none"> - Develop a neutral attitude towards patients interested in VTP. - Reinforce doctors' skills in counseling patients and sharing medical information with them. 	<p>ATTITUDES</p> <ul style="list-style-type: none"> - Develop a neutral attitude towards VTP care and ban the guilt complex. - Promote reflection and awareness, improve their self-confidence, and reinforce their involvement in collective medical decision-making processes. 	
		<p>BEHAVIOURS</p> <ul style="list-style-type: none"> - Listen to patients in a more respectful way. - Adapt their language to these patients' needs in terms of information and emotional support. 	<p>BEHAVIOURS</p> <ul style="list-style-type: none"> - Be able to promote the patient's involvement in collective medical decision-making processes: evolve from intentions to decisions. 	

Table 4. Cont.

Entry	Exit	Knowledge Multipliers	Targets	Impact
		CULTURE		
		- Promote a health communication culture based on different values such as professionalism, transparency, information sharing, objectivity, and social support for women.		
		STRUCTURE		
		- Implement information sessions as a corporate tool used by hospitals for better satisfying patients' needs (information, social support).		

This protocol positively influences health professionals, patients, and the hospital's Department of Gynecology. Thanks to this protocol, *health professionals* participate in health education initiatives, share VTP-related information with patients, develop open-minded attitudes allowing them not to discriminate this kind of patients, reinforce their role as experts in medicine, and promote better communication relations with patients. This protocol allows *patients* to better know their rights concerning VTP, reinforce their knowledge about medical procedures, interact with the hospital's psychological support units, strengthen their own opinions about VTP in a non-discriminatory way, and enhance their participation in collective medical decision-making processes. Finally, thanks to this protocol, the *hospital's Department of Gynecology* promotes values that are especially important for patients (professionalism, transparency, benevolence, medical impartiality), strengthens its engagement with health education initiatives (information groups, videos, brochures), and reinforces women's empowerment (access to medical and legal information), which helps patients to make better decisions and, in this way, reduce their stress as well as the negative psychological consequences of VTP.

The quantitative and qualitative research led from 2012 to 2018 highlighted how important it is that hospitals become more multidisciplinary institutions and integrate social sciences into their medical protocols. Many patients we met in France, Poland, and Switzerland complained about the lack of integrated services in the Gynecology Department, which made it more difficult for them to decide about VTP. These departments need to integrate medicine, public health, communication, law, and emotional intelligence in a more efficient way in order to protect patients' rights.

Implementing information sessions for patients allows them to reinforce their empowerment and their skills in health education [47]. Doctors play a key role in these health education initiatives because their behaviors (ethics, information sharing) directly influence patients' satisfaction [48]. In this framework, the principle of personal autonomy becomes crucial: doctors and health organizations cannot consider patients as objects or damage their physical integrity. The principle of unavailability of the human body makes patients still more independent [49]. When it comes to VTP or MIP, this principle is very often ignored. Informed consent emerges from patients' autonomy, which is why hospitals should consider it a patient's right [49]. Unfortunately, it does not allow a "de facto recognition" of VTP as a human right [1]. Even if in some Eastern European countries VTP has been recognized as a fundamental right since the 1920s [50], in most countries patients are not yet considered independent. The quantitative analysis carried out in this paper proved that in France, Poland, and Switzerland women are not still free to make some decisions concerning their own body. Public authorities should reformulate the legal framework concerning VTP and consider it as a human right [33].

This quantitative–qualitative research constitutes a true added value for experts in public health, gynecology, law, communication, and human rights. Despite the medical and managerial effect of this paper, three main limitations must be highlighted. *First*, the different legal frameworks in the three countries considered (Switzerland, France, and Poland) made it difficult to compare the influence of VTP in their health systems. *Second*, this research did not consider the economic impact of VTP in hospitals, or the business interests that some companies have in this area. *Third*, we could not find papers using the same methodology to compare our results with other research conducted in other countries. Finally, and based on our results, several research avenues can be suggested for the next years: social relations between VTP and human rights, the economic repercussions of VTP in public health systems, the legal role of hospitals' Ethics Committees, or the strategies needed to integrate VTP and artificial intelligence.

5. Conclusions

Promoting public health and respecting human rights has become a priority for health professionals, hospitals, and public authorities all over the world. To achieve that, several initiatives can be implemented, including recognizing VTP as a human right that positively influences women's health from a physical and emotional point of view. This paper aimed to analyze the impact of information sessions organized by hospitals on the perceptions of women who go through a VTP. Our quantitative, qualitative results confirmed the positive impact of these sessions on patients (knowledge, social support, and emotional and physical wellbeing). Thanks to information sessions, patients better understand what VTP is, how it can affect their lives, how to interact with doctors, and especially how to protect themselves against some external social influences (family, friends) and, in this way, make decisions in an independent manner. These sessions about VTP help patients to reduce their stress and reinforce the hospital's duty to inform. In other words, information sessions about VTP contribute to reinforce patients' empowerment and protect their rights.

In order to help public authorities to implement these information sessions and recognize VTP as a human right, we suggest five main conclusions. *First*, patients' informed consent is an intimate decision that is also reciprocal: in other words, patients and doctors are equal. Doctors cannot use their legal, professional influence to impose their will onto patients [51]. Women have the right to express their consent in different ways (written documents, gestures, dialogues), and doctors have the duty to respect their patients' will. *Second*, doctors must help patients to make independent decisions: to achieve that, health professionals need to improve their skills in language, law, public health, gender studies, history, and psychology. *Third*, hospitals need to implement a code of internal communication allowing doctors to respect a harmonized, consistent discourse when interacting with patients going through a VTP: this code should also include references to health law and human rights. *Fourth*, hospitals need to train their doctors in interpersonal communication, emotional intelligence, and social values. Many medical mistakes are due to misunderstandings and lack of information [52], which causes patients to suffer from a physical and emotional point of view [53]: this situation is especially dangerous for patients coming from low-income classes, and facing both linguistic and intellectual vulnerabilities [54]. *Fifth*, hospitals' CEOs and managers should implement continued learning programs allowing doctors and nurses to change their mind and adopt a more flexible approach when interacting with patients interested in VTP.

Funding: This research received no external funding.

Institutional Review Board Statement: This protocol was approved by the Geneva University Hospitals' Ethics Committee (BASEC 2018-01983).

Informed Consent Statement: Not applicable.

Data Availability Statement: The data presented in this study are available on request from the corresponding author. The data are not publicly available due to privacy reasons related to patients analyzed.

Acknowledgments: We would like to express our gratitude to Michal Yaron and her team (Department of Gynecology, *Geneva University Hospitals*, Switzerland); Christine Renteria (Department of Gynecology, *Lausanne University Hospital*, Switzerland); Michel Teboul and his team (Department of Gynecology, *Port-Royal Hospital*, France); Françoise Bousez and his team (*University of Paris II Assas*, France); and Toni Gonzalez Pacanowski (*University of Alicante*, Spain).

Conflicts of Interest: The authors declare no conflict of interest.

Appendix A

Participant observation at *Port Royal Hospital* (France). Five main topics considered:

1. Gap between theories and practical implementation of the legal framework concerning VTP.
2. Internal procedures for welcoming patients when they arrive at the hospital.
3. Patients' right to information, and role of the patients' free and informed consent.
4. Patients' social influence: family, friends, social pressure.
5. Procedures to implement pharmacologically-induced VTP and surgical VTP.

Three focus groups at *Port Royal Hospital* (France). Five main topics considered:

1. Interpersonal communication among employees working in the Family Planning Unit.
2. Healthcare professionals' personal opinions about VTP and the influence on patients' decisions.
3. Patients' autonomy and freedom when making a decision concerning VTP.
4. Role of psychologists in collective decision-making process between doctors and patients.
5. Internal communication and coordination among different departments taking care of these patients.

Participant observation in a social restaurant in Katowice (Poland). Five main topics considered:

1. Patients' social influence: public authorities, family, friends, etc.
2. Patients' perceptions about health professionals, hospital practices, and legal framework in this country.
3. Patients' knowledge about VTP, medical risks, and legal frameworks in Poland and other European countries.
4. Emotional influence of VTP on patients' lives.
5. Physical and psychological impact of VTP on patients' health.

Appendix B

Online survey. The main questions included the following:

1. Why have you decided to stop your pregnancy?
2. Could you specify the main reasons why you have decided to go through a VTP?
3. Did you hesitate when making this decision?
4. How did your progenitor react when you told them that you wanted to go through a VTP?
5. Have you been influenced by your family and friends?
6. Have you been influenced by your family or the hospital's doctors?
7. Could you define your main feelings after having gone through a VTP?
8. Which negative feelings have you experienced after VTP (depression, anxiety, guilt)?
9. Some days–months after your experience, do you think that you are part of this group of women who affirm having suffered from a psychological point of view?

Appendix C

Focus groups at *Geneva University Hospitals* (Switzerland). Main topics considered:

1. Role of internal and interpersonal communication at the Gynecology Department.
2. Internal procedures between the Gynecology Department and the Family Planning Unit.
3. Influence of the call center's initiatives on patients' perceptions and behaviors.
4. Nurses' skills in communication, legal issues, and emotional intelligence and the impact on patients' decisions.
5. Patients' perceptions about the hospital's practices concerning VTP.

Focus group at *Lausanne University Hospital* (Switzerland). Main topics considered:

1. Role of internal and interpersonal communication and its influence on patients' satisfaction with VTP.
2. Health professionals' skills in communication, emotional intelligence, and legal issues and their effects on internal procedures.
3. Patients' perceptions about their own autonomy and freedom.
4. Internal procedures at the hospital: Gynecology Department, call center, administration.
5. Patients' social influence: family, friends, social pressure, etc.

Deep interview with one of the Heads of the Department of Gynecology at *Geneva University Hospitals* (Switzerland). Main topics considered:

1. Nurses' roles in VTP care.
2. Internal communication processes among doctors, nurses, and patients.
3. Influence of management decisions on medical practices concerning VTP.
4. Patients' autonomy and freedom.
5. Healthcare workers' skills in communication, emotional intelligence, and legal issues related to VTP.

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