Amelia Bonow:
Hello and welcome everybody. We're happy to see you. We're going to let folks arrive for a moment where we get started.

Hi everybody. I used to wait five minutes before we get started, but I think that most people that arrive are generally here at the top of the hour and many watch after the fact. So I'm just going to get started. Plus, if you're here, you have likely heard this spiel from me before. Hello everyone and welcome. Whoop. I just kicked the garbage can and the cat got scared. Hi everybody. I'm Amelia and I use she/her pronouns and I am the executive director of Shout Your Abortion, which is a nationwide organization working to normalize abortion and elevate paths to access regardless of legality. We make resources, campaigns, and media intended to arm existing activists, create new ones, and foster collective participation in abortion access all over the country.

SYA just had our 2026 planning retreat, and one of the things that we talked about, of course, you always got to revisit the mission. And we continue to notice that our mission that I just read does not feel like it adequately represents our international collaborations and how much that has become a priority in our work and how much our hearts and minds are just in constant conversation with people all over the world. So stay tuned for what may be an expanded mission statement at some point.

So if you're here, you probably know that Abortion Academy is a monthly webinar series where we speak to one of our brilliant colleagues who takes a deeper dive into their area of expertise. And these sessions are for anybody who's looking to deepen their knowledge, connect the dots between issues happening at the regional, national, and international levels, or just get some fresh ideas to take back into your community. And we've sort of been alternating local, I mean, US-based activists with what we call our study abroad series, where we speak to someone who's working on access internationally as we are today with our friend, Suzanne. So just housekeeping stuff. Audience members will be off camera and muted for security reasons, but you will be able to ask questions in the chat throughout the session. Suzanne's going to speak to us for 30 or 45 minutes maybe, and then we'll have a Q&A, and Suzanne and I will chat.

We do have live Spanish translation available. If you go down to the bottom of your Zoom bar and you click the globe that says interpretation, and you can choose to listen in the language of your choice. Also, today we'll be having our first ever flip translation where our translators will be translating for English speakers, a video that Suzanne's going to play that's in Spanish. So be prepared, English speakers, to go find that globe and toggle it to English if you'd like to listen in English. So today we're really excited to hear from activist and physician Suzanne Veldhuis, a feminist, activist, physician, and researcher originally from the Netherlands who's been living in Chiapas, Mexico since 2013. And for the last decade, decade plus, Suzanne has worked on projects related to sexual and reproductive health and access to safe abortion, both in Mexico and internationally. Suzanne serves as advocacy and research coordinator and physician at Women on Web, beloved Women on Web, and is also the co-founder of the Network of Pro-Choice Physicians Mexico.

And she specializes in self-managed abortion models and their articulation with the medical sector. So today, Suzanne's going to be sharing some of her groundbreaking research and work with

acompañantes and pro-choice physicians in Mexico. And acompañantes, is the name for groups of activists who accompany pregnant people through their abortions outside of clinical settings, and they do so by creating a safe, holistic, and destigmatizing method of care. So Suzanne's going to be talking to us about why it is vital to center the accompaniment model in the work of expanding access to self-managed abortion, and also how acompañantes and these activists and doctors can potentially work together to build a better system of care.

We're really excited to hear from Suzanne today, and we love to talk to people who are inside of the medical system and researchers who are interested in demedicalization, which if you're not familiar with that term, I'm sure Suzanne will talk about it, but it's basically just this idea that, I mean, as applied to abortion, it's this idea that abortion in the United States, for example, is profoundly overmedicalized, and most people have an understanding of abortion that it is something that needs to happen in a medical setting, a person requires medical support in order for abortion to be safe, and that ultimately research doesn't reflect that.

Research reflects that abortion pills are safe and effective, whether they're used in medical settings or outside of them, and whether or not a person has formal medical support, I.E., is talking to a doctor during the process of their abortion or not. So the more that we, I think, understand the ways that these medications can be, the more that we decouple them from a medical understanding, the more we liberate ourselves to understand paths to community care and support, and to build this new world that we want to live in together. So with that, I'm excited to hand it over to Suzanne.

Suzanne Veldhuis:
Hey, thank you so much for this lovely introduction. I'm super happy to be here. I love Shout Your Abortion. I've been following you for a very long time, and it's been lovely to have had some contact over the years and doing some stuff together. And I'm really, really happy to be here to talk about my work and my activism and my research. So it's all connected for me. It's different ways of working on the same thing. So this won't be a super academic talk, but there will be some academic stuff coming through at some points. So I'm going to share my screen. I guess you can see this now, but let me know.

So I'll be talking about the abortion component movement in Latin America and Mexico, but also as you already mentioned, discussing possible interactions and collaborations between pro-choice physicians and activists, acompañantes, which was the topic of my PhD dissertation, which I finished last year. And it's also very much something that interests me as a person, as I am a physician who is moving both kind of spaces. So this is why I always start with a short, you already read my biography, but I think it's always really important to understand who's talking and why they're talking about this topic. So I'm a doctor, but I'm also an activist since before I was a doctor. I'm also a researcher since a couple of years, and I'm also a mother. This is a photo of my daughter eight years ago when we were at the abortion manifestation for almost, I think about 10 years, a little bit less than 10 years now.
I've been friends with a lot of acompañantess in Mexico and have been supporting them as their ally doctor to go to with any questions or anything I can support them with. And showing you here these two photos, it shows both parts of the spectrum, which on one hand is one of the first, it was the first national encounter in Mexico, Autonomous Abortion acompañantes in 2018, I think it was. And the other one is a photo of the first meeting of the National Doctors Network we started a couple of years ago. For

me, working in abortion care and then getting to know acompañantes, that changed everything for me. It changed my way of looking at abortion, changed my way I looked at medicine and my own role in abortion care, but also in healthcare in general. And I've been wanting or have been exploring these other ways of seeing and thinking about things also through research.
So I have always these different hats, like my researcher hat, my activist hat, my doctor's hat, just I'm your friend hat. So this comes back throughout the presentation at some points. So just a little bit of history. I'm sure most people are aware of this, but we are able to talk about self-management because of the existence of abortion pills. As Amelia mentioned, abortion obviously has always, always existed, but when biomedicine or modern medicine evolved, started to exist and then evolved abortion just as any other health issue came under medical control. So it was defined as a medical issue and also therefore treated as something that needed to be under medical supervision, medical control. And because all, let's say, or most traditional knowledges about possible safe ways of having abortions were lost or criminalized or suppressed over the last couple of hundreds of years, the only methods that existed were surgical methods and you needed a doctor for those.

And that meant that people depended on medical staff, on legal systems to be able to access safe-ish methods, let's say. So this all changed when abortion pills were discovered. Misoprostol was originally, or is still also a gastric medication. It came on a market in Brazil and both pharmacy workers and women and pregnant people found out it could be used as well to induce a miscarriage. They started using it like that, and that was picked up really quickly by the medical establishment with a lot of worry about what's going on here? Why are people doing this? This is very dangerous. But it kickstarted both a trajectory of medical research and use and the widespread, the spreading of this knowledge throughout communities. At the end of the '80s, there was also another medication, mifepristone registered in France was discovered in a lab, not because they looked for an abortion medication, but because they found something that had that as effect as well.

And then there was these two trajectories. The one that was within the formal health system, the development of medication abortion with mifepristone and misoprostol, sort of the gold standard, which was unattainable for anyone outside of formal health systems and misoprostol, which was readily available in most parts of the world and started to be used widely across Latin America. In the end, both medications ended up on the WHO essential drug list. And in the 2000s and 2010s, all of this enormous range of different models of supporting people or helping people to access these abortion medication, mostly misoprostol only in Latin America and across the world. So in 2005, Women on Web was founded as the first international online abortion service. In 2008 was the first Safe Abortion hotline that was founded in Latin America, and that model was quickly replicated across other countries. And those merged or became parallel to what we now call the accompaniment model and groups that provide accompaniment across the continent.

So acompañantes are feminist activists who accompany individuals who have medication abortions outside of clinical settings. And it's models because there is no one specific model that's the... Yeah, I'll come back to that. So when we talk about self-managed abortion, I just wanted to briefly discuss the definition because it's been used for lots of different things. Nowadays, we mostly use the term when we mean abortions that take place without clinical supervision. So outside of formal health systems, without any provider involvement, self-sourced, self-administrated, and we call that self-managed abortion. But if

you read, if you look at the literature, but also the way sometimes, for example, doctors talk about it, they mean different things with self-management. So they may be talking about self-management as part of clinical care. For example, someone who has an in clinic visit but then goes home and self-manages their abortion at home and then goes back to the clinic for a checkup, for example, that's like a self-management aspect within clinical care.

So that's why you could also talk about self-management as existing across this huge range from relatively very clinical and medicalized with medical and clinical supervision to what in Latin America we call autonomous abortion or [foreign language 00:16:43], where the person themselves, the people themselves use the medication without any person, without any clinical oversight. And that can be alone or for example, within acompañantes. So what I can speak to is the holistic, what we call the holistic accompaniment model in Mexico. It's where I did my research, it's where I live, it's where I have been working with acompañantes for the last 10 years. And just to explain a little bit, what does that work like? People always wonder, what does that look like in practice? So first of all, it's good to know that acompañantes are volunteers mostly. It's not their jobs. It's something they do as political action from their political or feminist stance. And the steps are actually really easy. This is different than in some other countries. There are differences between acompañantes, between collectives. There are acompañantesthat work alone. There are those that are in a group.

There are those that are form part of an NGO, but mostly contact is remotely, virtually, by phone. Someone passes a number by WhatsApp or Signal or by email or by social media. And it's people asking, "I need an abortion. How can I get one?" So the acompañantes provide information. They provide information like what are the options? Exploring what someone needs. And this counseling is usually virtually, but depending on the situation and the acompañantes, where the person is, some also do this in person. The provision of medication is within brackets because they do obviously for people, the worry is mostly, how do I get the pills?

Here in Mexico, it's not that complicated, because most pharmacies sell the misoprostol without prescription. So we are in a super privileged position, but there are settings in which that is not possible. For example, here in the south of Mexico, near the coast is a very, very conservative communities where there may be one pharmacy in a small village, and then it's impossible for that person to go to the pharmacy asking for abortion pills, for misoprostol, which everybody knows are abortion pills because it would be very dangerous on a social level to do so.
So there are lots of different situations and acompañantes provide information to make sure people can get the pills and they can also help procure the pills. The accompaniment of the whole process is this before, during, and after, until it ends. When the person needs it to end, it can end the moment the person takes place. It can end even before, it can end months later, depending on what the person needs. Mostly virtual, but in some circumstances, especially if it's more later in pregnancy, it can also be in person. And there is this follow-up always based on the needs on the person. Important is that the acompañante does also often provide information on if people need access to health services, how to access those. We know that most, or almost everyone who is criminalized or prosecuted for abortion has been denounced, or I don't know how to say that English, by medical personnel or by health workers, or by people working in the health system.

So part of what the acompañantes do is help prevent this possible criminalization. Oh, sorry, going to the next slide. And this is a little bit like a long list of characteristics of what makes the accompaniment model the accompaniment model. Now these are some logos. They're already old. Lots of groups have new logos. In the meantime, of some of the collectives here in Mexico, there are hundreds. Every state, every municipality has their collective, and they all have their own way of working, but they have some overarching characteristics, which is that it's person-centered. And that doesn't mean what it sometimes means when we talk about person-centeredness in health services. There usually means you treat the people nice and you don't discriminate and stigmatize them, but here person-centered means the accompaniment is adapted completely to what the person wants and needs. So it can be completely different from one to another person.

It's also completely situated. So that means that it takes into account the needs, the possibilities, the circumstances, the desire of the person who's being accompanied. And the horizontality of it, besides that there is no provider like client or patient relationship is also in recognizing or acknowledging that both parties, so to say, have their own expert knowledge. So in that sense, the acompañantes is just another person who happens to have information about abortion pills and is willing to share it. And the person needing the abortion is an expert on her or their own life, their own body, their own circumstances. And this exchange of information makes what acompañante is. It's based on trust, there's no asking about reasons, it's respecting autonomy, which also sometimes means respecting that people make decisions you may think are not good for them, but respecting autonomy is also respecting that people can and need to decide about their own lives and their bodies.
Placing the feelings at the center. So the emotional accompaniment is a very central part of the model. So this doesn't mean that acompañantes are psychologists and give therapy. It just means that there is... They often say the physical part, that's the easy part. The medical, the how to take the pills and what are the physical effects. That's not what's complicated. What's complicated for people because they are in situations where abortion is stigmatized, where they may be criminalized, where they have to do it alone, where they cannot talk to anyone else, where they feel guilty. They may be Catholics and think they go to hell. This whole set of feelings around abortion, usually not about the abortion itself, but the circumstances that makes that this emotional accompaniment is so important. The flexibility, it has to do with the situatedness and the person-centeredness. Destigmatization is also a very important part, and this is where the political, how do you say it? The politicalness of the model comes into place.

It's changing these ideas about what abortion is, if it's good or bad, or all of these stigmatizing ideas people have that make them feel worse during the process. So it's like this work with them to re-signify, maybe in some occasions, their abortion, to make it maybe sometimes even transform it into positive experience. It's deeply political. I've mentioned the prevention of criminalization. Often the acompañantes also provide economic support, for example, by supporting someone who needs an ultrasound or by donating the pills and then ensure safety in talking about safety in something that goes beyond the physical safety.

So it's providing stigma-free information, it's collaboration with health professionals to make sure that people can access the care if they need it or they want it, and things like ensuring there's no coercion. And all of this together is a way of expressing feminist ethics of care. So what the accompaniment model is based on, the idea that we can do this even where abortion is not legal, because this started when

abortion was still extremely restricted in Mexico and in other Latin American countries, is this idea, and this is also something like a discourse that was created that providing information and accompanying someone is legal even where abortion is not.

And I put in a little asterisk there because that's a big difference with the US, because the anti-rights groups have also paid attention, and that's why now you have, in some states, these laws that do not go after the person having abortion, but after the person who's providing information or just accompaniment or being aware of the abortion someone's having. So that's a significant difference between these settings. This is also depends on different countries. So I wanted to show you two short clips from a documentary, which is called [foreign language 00:26:48] that's Between Us, the Historical Memory of Abortion Accompaniers in Mexico. It was made in a pandemic by one of the larger, well, not larger, but an important collective called-

Suzanne Veldhuis:
... Larger, well, not larger, but an important collective called Libre Aborta Chiapas, they are from the South, where I live, and they visited different activists, acompañantes in different parts in Mexico to talk to them about what is accompaniment. I just wanted to show you two short clips. So this is the part where we go from Spanish to English. So if someone needs to go to the translation card, this is the moment. It's like half a minute and the other one is like a minute. There we go. What happened there? Sorry.

[documentary plays. Check links on SYA website to watch]

Suzanne Veldhuis:
Sorry. So those are ... I love this documentary. Sorry for the quality. It's terrible. It's better ... The original version, I think we're going to share the link. You can find it on YouTube. I love this documentary so much. First, half of them are really close friends of mine and I just love seeing them sometimes from other parts of the country. And what I like so much about it is that they're so happy. Abortion doesn't have to be a tragedy. And accompanying is also not something done out of sacrifice. It's something that is done with love. And it can be love for a stranger. One acompañante in one interview I did, she said, "It's like becoming someone's best friend for an hour," and that's totally fine. And then having that connection with someone, with a total stranger to support, and that also is like a reward to you. So that's also the horizontal part.

For me, when I got to know the acompañantes, this is what changed my view. I was working in an abortion clinic and I was convinced I was being a very nice doctor and providing very nice care. And then I got to know them and just thought this is much better than what I'm doing in the clinic. I'm doing my best, but there's also only so much I can do within these rigid frameworks of a health service. And what they are doing is so much more. And if I had to have an abortion, I would definitely go with them before going to a clinic. So that made me reflect on what is actually the role of doctors, what should be the role of doctors, what can we learn from them? Talking about quality of care. So that set off my path.

I also wanted to mention that this direct action is also a way of creating knowledge. And these are just some examples of on the left side, those are the first manuals on how ... The one with the rainbow is the

first manual on how to have an abortion with pills from Argentina, I think it was 2009 it came out. And then about second trimester abortions, there's another one. There is different guidelines. There's about how to accompany to empower. There's the systematization of accompaniments, which specifically the Socorristas in Argentina did, which was very important, instrumental in the legalization of abortion.

And then all of these encounters, meetings, exchanges of information, this constant getting better at what you're doing as an acompañante. And it's not just sometimes there's [inaudible 00:33:49]. It's just middle-class students who have nothing better to do in the cities, but abortion accompaniment also happens in Indigenous communities. So these two photos below here are from Zapatista, which is a political Indigenous movement in the south of Mexico who have their own autonomous clinics where traditional midwives and community health workers use misoprostol, mifepristone, et cetera.

On the right, some academic articles that were ... These investigations or these researches were done in collaboration with global north researchers, with global south accompaniment groups on a horizontal way of collaborating and participatory research. And one of the most important studies on self-managed abortion and accompaniment, it's called the SAFE Study by Ibis Reproductive Health was created this way, was showing that self-managed abortion is super safe and super effective, something that activists and women and pregnant people in Latin America already knew for a very long time, but you need to prove these things.

So then we come to the second part, which is, so what about collaborations between acompañantes and pro-choice physicians? Why should we want this? And I think there's a lot, lot, a lot of things like possible, positive outcomes such as I think the first thing that comes to mind is to have more options and to have better access to safe abortion and to have better care, higher quality of care. Because if you collaborate, people can choose whatever they want. There are people who prefer to have a vacuum aspiration in a hospital. There is people who do not want to speak to anyone, just want to buy the pills, have the abortion, get it over with. And there's people who want to self-manage their abortion, but feel safer if they can go for checkup with a doctor afterwards, even though it's not strictly necessary.

So for all of this, if there is collaboration between the activist who accompany these people and the physicians ... I'm talking about pro-choice physicians because I'm not even going to discuss all of the conscientious objectors and the physicians that treat people horribly. That's a whole other group. Of course, we would love to have collaborations with everyone, but let's start with the physician that at least are pro-abortion.

So you can imagine all of these options that are just available to people and you can access without any problem, you can have exactly the abortion care you want, you need, but there's other positive outcomes as well or possible effects. So talking about demedicalization. For me, it has worked like that. Becoming in contact with acompañantes has taught me a lot about my own non-central role as a doctor and understanding that medicalization is, first of all, unnecessary. And second of all, an important barrier to access. So this movement towards the demedicalization for doctors.

But then there is always this exchange of information, so learning from each other, because at one point I was very much into demedicalization and doing all my research, finding evidence that backed that up

to have these arguments with doctors. But then the acompañantes said, "Can you please give us a training on the medicalization because it's really helpful for us to know that what we are doing is the right thing."

So there's this back and forth, also in advocacy, combining and strengthening advocacy, because you have more views on the topic, not just from one side, but from all sides. In some spaces, it really helps to have a doctor because doctors have this role in society where they are supposed to have the knowledge. And if a doctor says it, people will believe it. If an activist says it, they won't. So it's like playing with those different roles in different spaces and know that you can back each other up overall just makes the movement stronger and de-stigmatize abortion, and it can also mean mutual care. So being there for each other and know you can count on each other. So there's so much good that could come out of this.

So how possible is this? So this was my question for the last couple of years, and I will just share some of the things I looked at in my study. Obviously, this was in Mexico, it was with a specific group of acompañantes in three parts of the country here in the South in Chiapas, Baja California, which is a northern frontier state as well, and in Mexico City and with doctors from the Pro Choice Doctors Network. And there were several questions I had to ... I thought I need to answer before I can answer this question. How possible is this? Because there are some fundamental differences between those two groups. So here's where it becomes a little bit academic and then we move away from here. So bear with me.

Basically, physicians and acompañantes, they come from two different worlds, and those two different worlds, what makes it so difficult is that they're really contradictory. Physicians are trained in hegemonic biomedicine. Biomedicine is called hegemonic because it's the dominant version of medicine across the globe, and every doctor everywhere in the world is trained under this scheme of thought. And biomedicine is not a neutral science. Science is never neutral, but this is definitely not a neutral science. It was developed or it developed in Europe around the time capitalism came up. That's not a coincidence. It's biologistic and individualistic, which means that it turns every health process or even social processes into a physical thing. It's all biology. So social, cultural aspects, economic aspects. They're not at first taken into account.

It's medicalized. So that means placing all of these social issues under medical control and definition. It's paternalistic, it's androcentric, heteronormative classist and colonialist. And this means that this doesn't ... When I say this to doctors, they get up on their high horses really fast because everybody says, "No, but I'm not." No, you might not be, but the system you were trained in definitely is. The white male cis hetero middle-class body is considered normal, the standard. This is also why all medication studies are only on male bodies, young-ish male bodies. No, it's also not old and not young people. And everybody else is a deviation of this normal. This is why it's so important to have gender perspective in health, but also a class perspective, de-colonial perspective, et cetera, et cetera.

So you are trained under this way of looking at healthcare. It also means other knowledges and other models of care are subordinated. So they're always considered less. Traditional medicine, acupuncture, any other type of knowledge, activist feminist knowledge is considered less. And the medical studying to

become a doctor is a very long study, as you may know, and it takes place under high levels of hierarchy, violence, and the lack of possibility of challenging these ideas. So what happens during this training is that as a person, you start identifying with this way of thinking. There is a lot of studies on why doctors, for example, in Mexico on obstetric violence, and then researchers looked at like, so why do doctors become violent? And it has to do with the way they are trained. There are obviously more authoritarian and less authoritarian versions of training during medical careers, but overall, this is them, the common ground.

So what happens is that you develop as a doctor, what is called authoritarian medical habitus. And habitus is that something, it becomes your normal. So this is the way you think and analyze the world. So that means that when you say abortion to a doctor, the doctor says, even if they're pro-choice, "Yeah, that's a health issue. It's a health issue. And to be safe, it needs to be under my control because then I can ensure the safety for those people." And this is the best version scenario.

And this is totally contradictory to where the acompañantes come from. They are feminist activists who form part of what author [inaudible 00:44:48] calls autonomous health movement, which is defined by ... It's not specific to abortions, also for example, around HIV and needle use, like self-use. It's also another example for an autonomous health movement, but it applies to self-managed abortion as well, which is the community use and control over health processes that were before or are dominated and controlled by the medical establishment, by direct, in this case, feminist action.

Another key characteristic is this demedicalization, which challenges that control of the medical profession over this process and fights or shifts by doing so, these power relationships. And there's also this willingness or this practice of working on the edge or outside of the law. This translates in the acompañantes model, which I showed you. And for acompañantes, abortion is political. Yeah, it's also health thing, but it's mostly political.

So the question I had was like, "But what about pro-choice physicians? Aren't they nicer people?" Or maybe they have moved away from this hegemonic medical model, which would make it easier to find common ground with acompañantes, no? So that's the first thing I looked at, a little bit of a weird table or a graphic, I will explain. What I did was, so I interviewed doctors and I interviewed acompañantes and had them describe how they provide or accompany abortion care, and then check those descriptions on a long list of characteristics for these basic contradictory characteristics of both worlds, if that makes sense. So on the one hand, it's horizontal from demedicalization to medicalization, because it's not a binary thing either. Demedicalization, medicalization, it's a range. You can demedicalize or medicalize on lots of different levels and lots of different ways by the way you act, but also where you are, who you are, et cetera. And then on the vertical, align is more autonomy, horizontality to the corner, and then more up is more control and more verticality.

So here is a fictional person, which will be the most hegemonic medical doctor scoring high on everything that is controlled, verticality and medicalization. And here will be total autonomy, total demedicalization. So all of the ones with A are acompañantes and all the ones with Ms are doctors. So the acompañantes are grouped here and it makes sense because demedicalization and autonomy is a key characteristic of their model. So that is clear in most of their descriptions, but there are also

acompañantes that do like their control a little bit more and do medicalize a little bit more because in the end also, we were all born and raised in society where the only model of care we know is this authoritarian medical model. So we also replicate sometimes, even if we don't want to.

And then with the doctors, it's really interesting to see there's a range. They're definitely not in this corner, like the super hegemonic medicine model. They're moving away from it, which makes me very happy. And there's a couple who are even really close to the acompañantes. Where people are at depends sometimes not just on their own wishes and thoughts and political views, but also on, for example, where they work. If people work in the newly stated public abortion services in Mexico, they feel like they have much more opportunity to provide care that aligns more with their values.

But if they work in a general emergency room where all of their colleagues are conscientious objectors and anti-abortion, and they suffer a lot of violence for being pro-abortion, or the institution puts all of these rules and regulations ... They have very little space to enact another model. [inaudible 00:49:45] who have their private clinic have more flexibility. So there's all of these different ... Doctors have, and that's something that became very clear, they have less flexibility to do whatever they want because they work within the formal health system and the doctors that are close to acompañantes are actually doctors that do accompaniments outside of their work as doctors. So that's why they're able to move towards there.

On the other hand, not all of them have ideas that align with, for example, the acompañantes model. So that was my next question. What do they actually think about each other? I'm sorry, there was a typo. So with pro-choice physicians, again, there's this range. There are those that move more towards demedicalization and acceptance of self-management and others who really struggle with that because it goes against this habitus. It goes against everything they have ever been taught. It's really difficult to break from that. So the funny thing is most of these pro-choice physicians say, "Yeah, we trust in self-management. We think it's totally safe." They all have experience with it. It's super common. So they have all seen patients who've had self-managed abortions and they all agreed, "Yeah, they never have complications. It's super safe."

But I say, "But still, I think it's better with medical supervision," because that for me is like the habitus kicking in. And you see that in this state, in this testimony, she says, "To me, self-management is a double-edged sword. While it can be a very good idea, very good option, it could lead to complications, although we know those cases are few, but I do feel that if not closely, there should be some medical supervision." So there's this tension between I'm a feminist and I want self-management and autonomy is great, but medical supervision, it would be better.
They also conceive self-managed abortion as they totally understand it exists now, but they do have this vision of, yeah, but when we have clinical services everywhere and it's legal, then it won't be necessary. Best thing is with the doctor.

And then there is most of the doctors I interviewed, and these are pro-choice doctors who from part of pro-choice physician networks, or they're the most progressive of the progressive doctors in Mexico, most of them didn't know that acompañantes exist. And the ones that did, they mostly described them as, "Yeah, it's really great what they do. They can help me in a sense that I can provide the service and

then they can accompany them throughout the abortion." As complementary and not as a valid alternative option, for example, and they clearly describe abortion as medical.

For acompañantes, the main issue, they don't trust doctors and they don't trust the medical system, and that is because they have had so many bad experiences. Healthcare in general is not great here in Mexico. There's a lot of violence. And then when talking, there's even obstetric violence when you deliver, when you have a birth, imagine with abortion, there's a lot of stigmas, discrimination, there's violence in the health services, and they also mentioned this lack of knowledge of doctors. I say there is this discrepancy between doctors pretending to know it all, but we are actually the experts on abortion care. And the doctors do admit that they weren't trained on abortion in the medical training, but they say, "Yeah, I wasn't trained, but still I think it's safer with me because I'm a doctor and I know about these things." So there's like this, for me again, is the habitus kicking in. They also, acompañantes also described the ...

Suzanne Veldhuis:
They also [foreign language 00:54:02], also describe these kind of power dynamics and knowledge hierarchies. They feel very frustrated about doctors owning abortion knowledge while they and pregnant people, women having abortions are the actual experts on self-management, and they don't see them as themselves as central. So they say, "We are just another option. We don't want everybody to have self-administered abortion. We just want everybody to have the abortion they want and they need, and we can be part of that to make that happen." And they mentioned they do see value in collaboration, but not in integration. So that we do not want to be part of the health system because that would limit us in our actions, and for them, abortion is deeply political as I already said. In this testimony, she describes these knowledge hierarchies. She says that doctors are not trusting women's words, not taking into account their whole being as human beings.

It's a terrible abuse, and doctors have always believed that they have all the knowledge and experience in the world and all the power to do whatever they want with women's bodies. I think what comes next, I saw this video this morning. I thought it was hilarious because it goes right into this, what I'm describing right now. There is now at this moment, a conference in Bangkok on abortion care, and it's a very medical conference, but there are also activists present, and this is what happens when doctors are talking about self-managed abortion. Yeah, so I just wanted to add this because I thought it was hilarious. It's precisely, this is what happens. Self-managed abortion is something that activists and pregnant people have been accumulating experience and knowledge over the last 30 years.
It's relatively new that it's been discussed in medical circles, and then when it does, it's immediately appropriated and placed again, under medical control. So the activist is like, "Oh my God, look at them." So you see there is a gap between those two worlds. That is not easy to close because it's very understandable that the gap exists. However, there are examples of activist physician interactions. So I tracked a little bit here in Mexico, the type of interaction that exists, basically ranging from starting short punctual interactions where there's some sort of first contact. It's also because there didn't used to be almost any contact between the [foreign language 00:57:26] and physicians in Mexico, very little, more on an individual level.

But since legalization has been happening over the last couple of years in different states, accompaniment groups have tried to seek out the health services to try to set up referrals, and to also monitor and make sure the services are actually providing services and high quality of care. So it is this approachment. Then there's a next level, which is references and this is the reference of cases by [foreign language 00:58:03] to physicians. So this is very common throughout Latin America. So many groups have identified, "This is a physician I can send someone to, they will not treat them bad. They will not overcharge them. They can do the checkup." This is like their go to physician, and then there are more close collaborations that are alliances where there are multiple of these mutual benefits going around, can be resolving doubts, the bilateral referral of cases. So not just [foreign language 00:58:39] to physicians, but also physicians to [foreign language 00:58:42].

Mutual support, obtain medications, the invitations to participate in events in more advocacy or trainings, and there is this version where it is to be here to have an allied doctor, which are relationships that are much more close based on trust and recognizing each other as allied activists who share families political stance. So in that group, very small group, these differences are fading away, but it's more the exception than the rule. So I'm almost done.
One part of my research for my PhD was besides trying to figure out all of these where are we at and where are the differences and what do we need maybe to cross those gaps was a workshop, developed a workshop methodology. It's available as a small booklet, both in English and in Spanish or online in PDF, and the workshop methodology was developed both for research, but also as an intervention, because one of the things I noted from the interviews was that basically they don't know each other. The [foreign language 01:00:11] have an idea, very correct idea about the medical profession in general, but actually no very little pro-choice physicians, and the physicians, they don't know any [foreign language 01:00:24]. So I thought first step is they have to get to know each other. So it's much easier or it's much more difficult to hate someone if it's an actual person.

And I'm sure there are common grounds, but let's see what happens. So we did these workshops, getting together, the doctors and the [foreign language 01:00:47], and some really interesting things happened. There was a total claim that they were all interested in building alliances because they have common goals. They're all there and doing this work voluntary or part of your job because they want people to be able to have safe, and quality, and nice, and loving abortions. That's not the issue. The issue is that they have different ideas of what that is and how to get there, but they all understood, they were all motivated to find ways to work together.

And they connected, it's a bit sad, some hand, but they connected on recognizing that in other parts of their lives, they are not different. So in this workshop, we're all cis women that participated. So all people who have had suffered gender-based violence throughout their lives, in their works, in their careers, and they recognized each other in that. We're different on that level, but we are also all people who suffer from the same patriarchal system that we are trying to fight in some way. So there was this awareness and mutual recognition that came out of the workshop. The clear obstacles to working together was they all mentioned not knowing each other. If you don't know each other, you keep your prejudices and your ideas and you don't move away from them. They're coming from the two worlds. For the [foreign language 01:02:38], it's what they call this false superiority of physicians and the lack of overall knowledge without recognizing our [foreign language 01:02:47] expertise and also unfulfilled

expectations in the sense that when collaborations happen, it doesn't mean that they're immediately perfect and nice and everybody does what the other expects. It's difficult.

And then on the other hand, what our facilitators is getting to know each other, communication, openness, willingness, patience, horizontality are very important. This mutual recognition of everybody has their role. We need all of us. It's not one role that is the most important or the one that cannot lack. We are all important and the ones that are in the center are the people having the abortion. So if that idea is clear, that really facilitates collaborations, working on prejudices, and noted very clearly shared feminist political stance. So it's like another way, more positive way than mutual recognition in having experienced violence, a more positive way of recognizing each other in a shared political stance. The main obstacle is the medical authoritarian habitus because that is what dictates the thoughts and the actions of doctors, and it's very difficult to break away from that because it's a process of constant self-evaluation, redefining, seeing things from another point of view.

So that requires a lot of deconstructive work, but it helps to have the same objective, and also one of the conclusions was the aim or the ideal is to have these synergies where everybody is just nourishing each other and everything just becomes these amazing multifaceted collaborations. That'd be great, but there is also this acceptance of that may be far away, but having more concrete collaborations on specific points, that is already a start and more than what we used to have and from these collaborations, new things can develop. So yeah, that was it. Are there any questions? This says we have been aborting since immemorable times and we'll keep doing so. Thank you, I'll stop sharing.

Michelle Veras [SYA]:
Thank you so much, Suzanne. Amelia I think dropped off. So I'm just going to take a question from the Q&A. I'm not sure if you can see that, but I'll read it out. So I've noticed confusion around the term demedicalization, especially since SMA involves medication. Have you encountered this and how can we make the concept clearer and more accessible?

Suzanne Veldhuis:
Yeah, that's super common. So doctors always freak out when you talk about demedicalization. It's like, "What? This medicine not useful anymore?" No, that's not what we're saying. Demedicalization, for me, it always helps to think about it as a range. You can be a demedicalized person, like an activist, and do very medicalized stuff. Say you have to have an ultrasound before the abortion and after the abortion, you can only take the medication while you're on the phone with me, and that is a demedicalized person, accompanying a demedicalized process, but medicalizing stuff at the same time, and at the same time, doctors can have demedicalized models of care or ways of providing abortion care. So to me, that makes a lot of sense. So that's why it won't be 100% demedicalized because it's medication we're using. It's produced by the pharmaceutical industry.

In some settings, you need a prescription. It's the only way to get it. So there are things that you can't demedicalize. There are things you can. Depends on where you are. If you're in a hospital, yeah, there's only so much you can do, but there is a lot you can do to demedicalize. Yeah, I don't know if that answers your question. There is a very nice research article, which I think is very accessible and explains it really well. It's by Drew Hoffman about demedicalization, medicalization, and she says it can happen at

different level on a personal level, hospital kind of level, and then also on macro on a nation, international level, and then on different ranges in identities. So the actor can be demedicalized or more medicalized, but also in practices and in discourse, because the words you use, medicalization is also placing things on our medical discourse. So it's like talking about uteruses instead of wounds or I don't know. I find English in general uses a lot of very medicalized terms for everything.

Michelle Veras:
Yes, absolutely.

Suzanne Veldhuis:
Yeah, but the way you speak about things can be more or less medicalized or demedicalized.

Amelia Bonow:
Can you guys see me and hear me?

Michelle Veras:
Yes, we can see and hear you.

Amelia Bonow:
Hi, sorry that happened. I don't know, am I still working?

Michelle Veras:
Yeah. Yes, you're good. So there's one question in the Q&A. I don't know if you can see that. I'm happy to read it.

Amelia Bonow:
Yes.

Michelle Veras:
Okay, so someone is asking how can American activists help bridge the connections between doctors and activists here in the US?

Suzanne Veldhuis:
Yeah, so I think the first step is getting people in the same room, and what I found is that it's sort of an unfair situation in where activists are required to have a lot of patients because they are often, and this is not to talk bad about doctors, but doctors are not usually political people, so they don't get to abortion from a political point of view. They start working it because it's healthcare and because yeah, they think it's important people have access, but activists come to it as a political issue. So they're often much further ahead in their thinking about things, and so getting people in the same room, but in a way that you don't reproduce these hierarchies. So for example, that's why these conferences are always awful because it's always these doctors speaking on the high stands and activists in the stands listening and being frustrated.

That's not a good space. What was really nice in the workshops we did was they worked together around defining what is safety and what is quality of care, and then to see that they have a lot of ideas in common and a lot of things that also are different, but understanding where you're coming from, and it doesn't require this notion of knowledge. What we also did were social dramas. So we did some acting where the doctors were asked to act out an accompaniment scene and the [foreign language 01:11:44] were asked to act out like a doctor scene and that placing yourself in someone else's shoes, it seems so simple, but it really works. So that really created that awareness. So I think these kind of spaces where you can work together on a task where no one feels not recognized in their role, but it's not easy, but I think that's the first step, to get together, and do stuff together, and start seeing each other as people, persons, individuals, and find this common ground.

Amelia Bonow:
It's the first step in doing everything we have to do to survive the future, I think.

Suzanne Veldhuis:
Yes, totally. Yeah.

Amelia Bonow:
Thank you for that incredible presentation, Suzanne. That was really just articulated so much, so many themes that I think that SYA is obsessed with and you did it really beautifully. I'm curious, in the chart where it's the dots, where is your dot?

Suzanne Veldhuis:
I didn't put myself in there. It's also interesting for me, I do not call myself an [foreign language 01:13:23] because I feel I cannot be because I'm a doctor.

Amelia Bonow:
You can't unknow what you know.

Suzanne Veldhuis:
Yes, but also I cannot undo my role in society. I can be an [foreign language 01:13:35] if the other person doesn't know I'm a doctor, then it might work, but the moment they know I'm a doctor, they are going to assume that everything I say is totally correct and right and amazing, and the whole horizontality disappears the moment I assume my doctor hat.

Amelia Bonow:
Yeah.

Suzanne Veldhuis:
And that is because the interaction changes. So I do sometimes accompany people, but I'm a doctor who does accompaniments outside of formal health settings.

Amelia Bonow:
Yeah.

Suzanne Veldhuis:
So I cannot undo my identity, and I think that's fine. I'm a doctor with my feet in both worlds, and it's the privilege I have and the role, I feel like that can be my role to talk to activists about yeah, I know doctors can be difficult, but you have to understand where they come from and why they think the way they do, and yeah, just sometimes also very frustrated, but that doesn't help change them.

Amelia Bonow:
Yeah, totally.

Suzanne Veldhuis:
And then on the other hand, I can talk to doctors about self-managed abortion, about [foreign language 01:14:52], and they will listen to me at least while they would never listen to maybe an activist talking about it. So I can leverage that role in different spaces. So yeah, but I sometimes wonder, I'm not working in clinical services at this moment. I sometimes wonder what if I were to go back to the consultation room, what would my consultation look like?

Amelia Bonow:
Yeah, totally.

Suzanne Veldhuis:
Because I don't want to do it anymore the way I-

Amelia Bonow:
Right. I mean this is so interesting. It's answering a lot of the questions that I had about how you split the world yourself, and yeah, I guess because so much of it is sort of rooted in positionality to use a jargon-y word, I can see how you would feel like you couldn't go back or something, or it would be very difficult. I wonder also, I mean I'm assuming that doctors get mad at you. People have such emotional defensive reactions to this. Are you seen as a rabble rouser who's a traitor to your profession?

Suzanne Veldhuis:
Probably.

Amelia Bonow:
Yeah.

Suzanne Veldhuis:
I don't know. I've never been told so to my face, but I know there are people that I'm sure they don't like me very much or I don't really care. Yeah, how to say? Yeah, I don't know. I'm generally nice to people.

Amelia Bonow:
Yeah. So I wanted to ask, oftentimes in Abortion Academy, I find myself, I don't know, it's like in no way that I want to play devil's advocate, but I feel like often I'm listening to really smart people talk in a way so that I can be more prepared to talk to people who are less on the level that I am, and so a question

that I have is when doctors are making points that are like look, a hierarchy is bad or the hierarchy within the medical system is bad. There's medical racism, damage is done there, but some medicalization is good, or maybe they say to you like, "If you want to do things in a non-hierarchical way, that's totally good, but at the end of the day, sometimes a person is hemorrhaging and it's a good thing that you understand hemorrhage." How do you answer what you see as the most kind of evolved form of resistance to demedicalization?

Suzanne Veldhuis:
Yeah. Well, that's the whole thing. It's not deleting medicine, it's just about let go of control. Why should you decide on what abortion care looks like for someone? I think abortion is the easiest thing because it's just so easy to have an abortion. There are medical things that are a lot more complicated and where it would be very much more difficult to see how you could take away the control from the doctors, but abortion is so easy to-

Amelia Bonow:
The doctors took control from us.

Suzanne Veldhuis:
Yes, yeah.

Amelia Bonow:
The fact that they're so insistent that it is in the medical purview is a historical.

Suzanne Veldhuis:
Yes, totally and it's funny, how to say this without being rude. So where I live here in San Cristóbal de las Casas, there's a lot of more alternative thinking, hippie-ish kind of thing going around, and there's a lot of rejection of medicalization or medical services in general.

Amelia Bonow:
There's lots of crystals and shit.

Suzanne Veldhuis:
Yes, totally and stuff. Yeah, and I totally understand that because the medical services are extremely violent. I worked one year in a public hospital and I broke in a million pieces, and what am I going to do with my life? Because my political view doesn't let me work in private services, but I'm not able to survive in public services because I'm witnessing so much violence, malpractice, discrimination, racism.

Amelia Bonow:
Specifically against indigenous people?

Suzanne Veldhuis:
Yes, totally, but also women in general. Terrible. So I understand this rejection completely anywhere in the world because the system, there are places where it is better and nicer and there's less impunity, but it all has the same thing.

Amelia Bonow:
It's all on that spectrum.

Suzanne Veldhuis:
Yeah, but then there's people that say, "So everything, all medical services are bad, medicine is terrible. Let's go back to the traditional indigenous knowledge of delivery and birth." Yeah, that's very important, but at the same time, that is not something that is the same as 500 years ago. There has been 500 years of disposition of knowledge, of this...

Suzanne Veldhuis:
... ago. There has been 500 years of disposition of knowledge, of destruction of communities, et cetera, et cetera. Which doesn't mean that the parteras, the midwives aren't still super important to their communities. A lot of knowledge, they do. But at the same time, Chiapas has the highest rate of maternal mortality of the country.

Amelia Bonow:
Wow, that's surprising.

Suzanne Veldhuis:
They're meant to die all the time because health services are not accessed or are not accessible. It's not their fault. It's the fault of the health services. But there is this, "Yeah, we do need..." I'm very happy antibiotics exists. I'm also super happy that vacuum aspiration exists and that we have all these applications to detain hemorrhages. And that if someone wants to have a dilatation evacuation for a second trimester abortion, that they can get one. That's the thing. It's not one or the other. We need all options, but we need that people who have the abortion are the ones that decide how and where and when and with whom and under what conditions. And yeah, so let go of that control and just do your work, which is being there for people and offering good quality care when they want or need it. So that's my ...

Amelia Bonow:
Yeah, perfect. No, that's really... I wanted to ask about... I went to San Crist ages ago, probably 20 years ago now, but it definitely is still in my heart as it's just one of those... It is a magical place. You see how it's become this nexus of vibes because it's just real. I wanted to ask about the Zapatista community healthcare, autonomous healthcare, and how your experience has been of that. And I also am curious, I'm surprised to hear that it's the highest maternal mortality in the country. And I'm wondering if you can say what your speculations are as to why or your enlightened data-driven observations.

Suzanne Veldhuis:
Of course. So the maternal mortality is not in autonomous Zapatista communities because they have a maternal mortality of almost zero while they are-

Amelia Bonow:
Oh, my God.

Suzanne Veldhuis:
Yes. While they have no doctors, it's all community health workers and they are the most remote, poor, all of what you imagine villages impossible. So that's not the issue.

Amelia Bonow:
If that's not proof of concept, I don't know what is.

Suzanne Veldhuis:
So actually my first steps towards questioning my role as a doctor happened in a Zapatista community. Before I started working on abortion stuff, I worked as a trainer of sexual reproductive health for community health workers. So they were all girls. They were super young. They were between 14 and 24 in the Zapatista community. And I was always teaching stuff and, "What am I doing here? They know so much more than me." Because I know stuff from medicine that is useful in a hospital, but not there. And I remember one day there was this woman who came and she wanted an abortion, and I was like, "Oh, okay, so what are you going to do?" And they were like, "Oh, we'll give her misoprostol." I was like, "Oh, really?" And I asked her, "So what does the Junta, the local Zapatista government, what do they think about that? Do you have rules or is there a law?" And she was like, the health workers are like, "What do you mean, ask the Junta? Why do you think we need to ask her? This is a woman's stuff. It's women's stuff. We deal with this our own. Why would we ask?" And I thought that was so hilarious.I was like, "Oh yeah, you're so right. There I come with my way of looking."

Amelia Bonow:
I mean, there's so much projection in the way we show up and help other people, and we cannot ever delete our own personal-

Suzanne Veldhuis:
Yeah, where you come from.

Amelia Bonow:
Yeah, where you come from. And I mean, I think that another, the flip side of that, I think I could see it being difficult to be an activist, whether you're full on claiming the mantle of acompañantes or you're just doing abortion support somewhere in the states. Say you're working at a helpline. I could see it being very difficult if you are a person who has had profoundly damaging experiences in the medical system to stop yourself from projecting that onto another person. And I could see that being very problematic as well. Although I think that the doctors projecting onto people like, "You don't know shit. There's no reason why you would understand. Your body or your feelings about this are irrelevant." I think that's a much larger structural problem, obviously, and one that has life and death consequences all the time that we see.

But I think that as activists, as we look at building this better new world that I love to hear you say that, it makes my heart feel so... I feel so empowered every time we hear from a brilliant person who is like, "No, not only are we going to be okay, we're going to be better." And it makes me cry every time, which is something that people are probably aware of at this point. But what I was going to say is I think that it's

so important for us as we do this work to check our own projections all the time so that we're not just doing the same shit in a different way and constantly centering the abortion seeker, centering the person. And that might mean that they are someone who is profoundly anxious about not consulting with a medical professional. You know what I mean?

Suzanne Veldhuis:
Yep. Yeah, no, I completely agree. I think I keep repeating it in every space I am, abortion is so safe. You can do so many things wrong and it will still be safe. It's really difficult to not have a safe abortion, and it's like it's not abortion, it's a lack of access to a health service when you need them. That's the issue with abortion health.

Amelia Bonow:
Yes.

Suzanne Veldhuis:
And then even those, when do you need health services, almost no one needs health services, very little people. So I'm also not worried about that. But what I really like about the acompañantes, or at least I'm also a bit biased because I think I know the nicest ones... I'm not sure. I'm sure the acompañantes world is also an entire world with a lot of different ideas and stuff and ways of working. But through the beginning years, there were so many of these encounters and get togethers where there is this active rethinking of, "What are we doing?" And as doctors, we're not used to do that. We're not used to doing that. As a doctor, you are trained and then you-

Amelia Bonow:
Yeah. Your whole thing is building a level of knowledge that-

Suzanne Veldhuis:
Working technical stuff.

Amelia Bonow:
Yeah. Building a level of knowledge that puts you above people as opposed to the opposite.

Suzanne Veldhuis:
Yeah. But nobody ever goes into a consultation room with you to see-

Amelia Bonow:
"What do you think?" Yeah.

Suzanne Veldhuis:
I think doctors rarely reflect on their own actions beyond the technical part.

Amelia Bonow:
Oh, yeah, totally.

Suzanne Veldhuis:
And then... Because we're not taught to do that. We're taught the technical part is the only part that matters. And the acompañantes, this whole reflective process is part of the political process of being in acompañantes. It's political, so it's all the time. Their protocols are not the same as they were five years ago. They have changed, they've developed, evaluated, they're critical, these collectives where it's three, four, five, and they come together every week to discuss their acompañantes and, "What was it and what did you feel and what this-"

Amelia Bonow:
They're evolving. Yeah.

Suzanne Veldhuis:
And it's this self-criticism or evaluation also trying to incorporate self-care, not as a personal individual thing, but as a collective care practice, or there's this whole... And I'm not saying all acompañantes do this, but I do know that the idea of a lot of collectives is to have this ongoing process of reflection. And I think it's really unique. And I think that's something we can really learn from them as health professionals.

Amelia Bonow:
Yeah. Yeah, absolutely. I mean, it's the equivalent of consultation or whatever that a therapist would do where they talk to other therapists about the cases are challenging them.

Suzanne Veldhuis:
Yeah. And I know that some places, some doctors have these group... And here in Mexico, I don't really know that. I know the Netherlands where I'm from, where family doctors do have these inter-vision groups sometimes, but those are the exceptions. And it's still often about technical stuff.

Amelia Bonow:
Yeah. Yeah. I was going to ask relatedly, you said something during your presentation about how the person's feelings are really paramount in an acompañante situation, and to a medical provider that's outside of their purview. The feelings are not on the table. And I think that it often gets lost, the fact that feelings are not frivolous in this situation, and that negative emotional experiences lead to much worse health outcomes.

Suzanne Veldhuis:
Yes.

Amelia Bonow:
And I'm wondering if you could just expound on that a little bit.

Suzanne Veldhuis:
Yeah. I think different things. So first, feelings are so important because abortion is not a neutral process. So as I said, all of the feelings people feel around an abortion are usually not about the decision to have an abortion. Most people are sure they want an abortion. And we know also from research that people

do not regret having abortions and having the abortion itself doesn't lead to any negative mental health outcomes, but all of the other stuff, the stigma and guilt and the fear because we're taught abortion is dangerous because that has always also been the argument of the pro-choice movement for a very long time. "Abortion's super dangerous. That's why it needs to be legal and ethical." So that is sort of not helping our case, our own case now, because people think it's so dangerous.

So having all of that fear... So first of all, we know that on a physical level, feeling afraid leads to feeling more pain. So people will literally suffer more during the process physically, but it also means that people, if they do need healthcare, are too afraid to go and seek it. So that's why we have people who suffer abortion complications because they're too afraid to go. And if they go, they are treated terribly. So they were right to be afraid. So I think that is... So a lot of the work that acompañantes do is around that, making sure people do not feel guilty, do not feel afraid, that they can just live through the process the way they need, feel supported and just... Yeah, it's part of life. It's part of so many people's lives.

Amelia Bonow:
Someone in the video.

Suzanne Veldhuis:
And as for doctors, I think for doctors, it's difficult because the care is shaped differently in the sense that if you have a 10-minute consultation with someone or even half an hour, yeah, it's not the same as having a continuous conversation with someone over the course of five days. And that also doesn't fit in what medical practice is right now. And that's why what I said, I don't know how it would be if I would go back to clinical care, because I know that in the way medical care is shaped, you can't dedicate that much time to one person.

Amelia Bonow:
No, it's like capitalist anything else where it's just... My father had a stroke a few weeks ago and he's okay, but we were in the hospital and we saw a couple of nurses who were great, but the first doctor who we saw, it had not even been diagnosed as a stroke yet, but he was having all of the telltale stroke symptoms. And this guy was straight up... He was adamant that he did not have time to pull up my dad's chart. And my dad has had, at this point, heart stuff. He's had stroke stuff. He's on a whole bunch of different meds. And the guy was just interrogating my freaked out 74-year-old parents and being like, "When was the last incident? I don't have time. I don't have time to even open the computer." And it was just... I don't even know what to say about it, but I think that it is just a compression that makes everything worse that we see all over capitalist anything else, except it's like people's lives.

Suzanne Veldhuis:
Production.

Amelia Bonow:
Yeah, it's production. It's just like, "We got to hit the numbers," or whatever. And that is the opposite energy of your best friend for a day that's like, "I am here, I'm in it with you. I am in it with you, whatever. If you want to talk the whole time, if you don't want to talk at all," just meeting someone where they are and just being present in the experience with them, it's such a beautiful luxury that we don't experience

very much in capitalism because everything feels like... Yeah, it's really, really... I'm sure that people have experiences with acompañantes that they're like... And I hear this honestly... I love abortion providers. I specifically, that's why it rides really hard for independent abortion providers in the United States, and they're some of the most incredible, values-driven, radical people that I know.

And often they will talk about... And they practice a real patient-centered kind of care. The best abortion clinics in the United States are really, really patient-centered. And I think that there is a lot of overlap in the sort of ethos that you describe. And I think that probably... I know that they have experiences with people, and I'm sure that acompañante networks have experiences with people where the person is like, "I have never felt seen like this before. I have never felt listened to in a medical situation," which I reject the idea that abortion is a medical situation, but I'm sure that with accompaniment networks that people sometimes get the feedback of just not only was this not bad, but this relationship is amazing.

Suzanne Veldhuis:
That is actually something that a lot of people theorize around that precisely... A lot of acompañantes become acompañantes because they have an acompañante, because, "Oh my God, I can do this for someone else." You don't need to be an expert. It's just being there for someone. And that's also the idea behind it. You want to democratize this knowledge, so everybody can accompany everybody. People have to go to a stranger. It's possible if you want to, but you can also ask your neighbor or your mom or your sister or your friend. And if there's no stigma, then you can ask anyone and it's so easy, you can look up-

Amelia Bonow:
That's the world. Let's do it.

Suzanne Veldhuis:
That's what we want. That's what we want.

Amelia Bonow:
Let's make it happen.

Suzanne Veldhuis:
I totally hear you. I know so many also really nice doctors that provide lovely medical care. And it's not the same as the acompañante, but it's also... Does it have to be?

Amelia Bonow:
Yeah, no.

Suzanne Veldhuis:
When we think about different roles and different... Not everybody needs an acompañante, like 48 hours.

Amelia Bonow:
Yeah, totally.

Suzanne Veldhuis:
There's lots of people who just want to receive the information and the pills and be treated nice. That's totally fine.

Amelia Bonow:
I mean, I think that's something I really appreciated about your approach is you're not trying to say that this is the way it should be for everyone. And that's the difference between you and other doctors is they are doing that.

Suzanne Veldhuis:
Yeah. And some activists as well, there are some activists-

Amelia Bonow:
Yeah, no, for sure.

Suzanne Veldhuis:
There's so much rejection of the medical system, this is the best thing. The thing is we are not the persons to decide someone-

Amelia Bonow:
That's the whole thing.

Suzanne Veldhuis:
Someone having an abortion is expert on their lives and will know what they need. Yeah, so it should just all be available. And so I think that's also what you said before, I think doctors don't need to feel threatened by anything like this. And there's also this whole aspect of the financing of clinics and... But okay, take away that then and still...

Amelia Bonow:
It's inseparable though from their reaction, I think.

Suzanne Veldhuis:
Yeah. Yeah, I think so. And in the end, there's plenty of abortions to go around.

Amelia Bonow:
Yeah. Yeah.

Suzanne Veldhuis:
So keep having abortions.

Amelia Bonow:
Totally.

Suzanne Veldhuis:

And that's not bad. It's part of life. Yeah, I really want for people to also be able to go to a clinic and then meet a nice doctor will treat you really well. And I always think... I also had recently experience in the public hospital here where I accompanied my mother-in-law, and she had chest pain and wasn't heart, but we're still looking. And then this doctor, he just made us wait an hour. If she had an heart attack, she would be dead right now. And then made the EKG and said, "No, the EKG is fine." I asked them, "Could you maybe examine her?"

Amelia Bonow:
Check her out? Yeah.

Suzanne Veldhuis:
"Kind of put a stethoscope on her and talk to her instead of to me?" And then there's always this argument like, "Yeah, there's no time, there's so much pressure." Yeah, the emergency room was crazy, but all of these things take you so little time. It's very easy to be nice to people and-

Amelia Bonow:
Oh, my god.

Suzanne Veldhuis:
... just to look them in the eye.

Amelia Bonow:
It's free. It's free. It's easy. It's better for everyone.

Suzanne Veldhuis:
And you make people feel so much nicer. I always thought that that was the lovely thing about being a doctor is that people appreciate it so much.

Amelia Bonow:
Oh, my god. Oh, yeah.

Suzanne Veldhuis:
I always said the most narcissistic job in the world because people are so grateful all the time.

Amelia Bonow:
Oh, my god. Yeah. After that shitty doctor, we had the best doctor experience and it was just like you feel saved by the good ones. Emotionally, your experience is so transformed by someone looking at you and listening to you and taking time because it's so rare.

Suzanne Veldhuis:
Yeah. And as a doctor, you have that power.

Amelia Bonow:
Yeah, so much power.

Suzanne Veldhuis:
Even if you don't want it. No, you have that power with what you say, with what you do, with how you treat people. You have so much power, and then with great power comes great responsibility.

Amelia Bonow:
Yeah. Spider-Man knows that.

Suzanne Veldhuis:
Terrible. Yeah.

Amelia Bonow:
Suzanne, this has been such a pleasure. I can't believe that we went this long, but no, this was so amazing. It's really just like... It's an honor to be in this movement with you and listen to your research, which was so accessibly presented also. Appreciate that. And of course, given the subject matter, of course it would be, but it's always really cool when academic research is presented that way. And yeah, it's just an honor and a privilege. And you just made us all smarter and more empowered.

Suzanne Veldhuis:
Thank you so much. That's lovely. This is my favorite topic. As I said, I can talk about this for days, so I'm really happy to be here and glad that I can-

Amelia Bonow:
Thank you for spending the time with us and thank you everybody for being here. We hope that you enjoyed yourselves and everybody keep taking care of yourself in this fucked up world and we're sending love to all. Thank you, Suzanne.

Suzanne Veldhuis:
You too. Bye.