Abortion Providers' Experiences with Stigmatization in Different Work Roles, Clinics and Clinic Types

BY

MOLLY K. MURPHY
B.A., University of Wisconsin-Madison, 2004
M.P.H., Emory University, 2008

THESIS

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Defense Committee:

Nadine Peacock, Chair and Advisor
Arden Handler, Community Health Sciences
Joan Kennelly, Community Health Sciences
Sadia Haider, University of Chicago
Melissa Kottke, Emory University

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APSS Abortion Provider Stigmatization Survey

IRB Institutional Review Board

NAF National Abortion Federation

SUMMARY

Abortion providers are vulnerable to stigmatization and harassment because of their work. This stigmatization ultimately impacts the availability of abortion care overall. A recent quantitative study demonstrated that stigma is experienced differently by abortion providers in freestanding clinics than by those in hospital-based clinics, but qualitative inquiry is required to illuminate the specific processes and resources that impact providers' experiences of stigma in different contexts.

This study explored the meaning of abortion provision work to providers, how providers experience and manage stigmatization of their work, and how these experiences and stigma management strategies differ for providers in various work roles, clinics and clinic settings. Ashforth and Kreiner's theory of "Dirty Work", which seeks to explain how stigmatized workers maintain positive work role identities, was the conceptual framework for this inquiry.

The mixed methods study design featured qualitative observation of clinic settings, in-depth interviews with providers, and quantitative surveys of abortion providers' experiences of work-related stigma. The study sample included abortion providers (n=31) from two freestanding and two hospital-based clinics that provide surgical abortions. Findings from the study illustrate the aspects of abortion provision stigma that affect all providers, as well as those that are unique to specific work roles, clinics and clinic settings. This detailed understanding of contextual influences on abortion provision stigma will facilitate supporting providers in the ways that are relevant for the contexts in which they work.

I. INTRODUCTION

Abortion is one of the most common surgical procedures performed on women of reproductive age (DeFrances & Hall, 2007). In 2011, 1.1 million U.S. women had abortions (Jones & Jerman, 2014a). Since the 1973 Roe vs. Wade U.S. Supreme Court decision that legalized abortion nationally, polls on abortion have consistently indicated that a majority of Americans want abortion to remain legal (Joffe, 2009). Yet despite persistent need for abortion and popular desire to keep it legal, abortion is highly stigmatized.

In his seminal work on stigma, Goffman defined stigma as an attribute that "is incongruous with our stereotype of what a given type of individual should be" and reduces the individual who bears it "from a whole and usual person to a tainted, discounted one" (p. 3, 1963). Stigma negatively impacts abortion providers in the workplace and professional circles, making it a human resource issue with important implications for continued access to abortion for all. A recent study of abortion providers' professional quality of life and experiences with stigmatization found that providers working in hospital-based clinics had lower stigma experience scores than did providers working in stand-alone clinics (Martin et al., 2014). The study's quantitative approach did not allow for in-depth exploration of how the contexts of freestanding versus hospital-based clinics impact providers' experiences of stigma differently. It also did not indicate how stigma experiences may vary based on work role or by clinic; these as yet unexplored aspects of abortion provision stigma were the focus of the current study.

A. Intellectual Puzzle and Research Questions

Mason (2002) suggests that all qualitative research should be constructed around an intellectual puzzle and should attempt to produce some kind of explanation of that puzzle. Intellectual puzzles contain ontological and epistemological assumptions; in this study, the ontological entities of interest are abortion providers' *perceptions* of the *social* and *personal processes* that impact their experience and management of stigma. Epistemology concerns a theory of knowledge, or what would constitute evidence about the social reality under investigation. My epistemological assumption was that the subjective understandings that inform abortion providers' qualitative and quantitative reports on experiences with stigma constitute valid evidence of the phenomenon. My intellectual puzzle was partly mechanical and partly comparative in that I was interested in learning how stigma is experienced and managed (i.e. the mechanics of abortion provision stigma for providers) as well as how providers' experiences with stigma compared across clinic types.

To explore abortion providers' experiences with and management of work-related stigma, I conducted in-depth interviews and quantitative survey assessment of providers' experiences with stigmatization in addition to nonreactive observation of the two freestanding and hospital-based clinics involved in the study. A variety of work roles involved in the provision of abortion care were included in my use of the term "abortion providers", including medical assistants, clinic administrators, nurses, physicians, social workers and so on. Ashforth and Kreiner's theory of "Dirty Work" (1999) assumes an occupational group level of analysis and served as the conceptual framework for this inquiry. "Dirty Work" seeks to explain how people who engage in "dirty work"---

occupations regarded by some as disgusting or immoral, such as abortion provision---construct positive work role identities in the face of stigma. The following research questions were explored:

1. What does abortion provision work mean to abortion providers?
    a. What do abortion providers feel are the defining features of their work?
    b. How do abortion providers feel about the defining features of their work?
2. How do abortion providers experience stigmatization of their work?
    a. Where and when is stigma salient for abortion providers? How does it manifest?
    b. When abortion providers experience stigmatization of their work, how do they feel it impacts them?
3. How do abortion providers respond to stigmatization of their work?
    a. What ideologies are important to abortion providers' management of stigma?
    b. What actions are important to abortion providers' experiences and management of stigma?
4. How is the experience and management of abortion provision stigma similar or different based on providers' work role, clinic, and clinic type?

B. Study Implications

This study advanced scientific knowledge about abortion stigma, which is "under-researched and under-theorized" (Norris et al., 2011, p. S49), and abortion *provision* stigma, specifically, in the following four ways. First, individual constructs of "Dirty Work" have been used in previous studies of abortion provision stigma, but the model as

a whole has never been used as the conceptual framework for such inquiry. The full integration of "Dirty Work" and its attendant constructs into this study's design, data collection and data analysis allowed for meaningful exploration of this model's relevance for the management of abortion provision stigma. Second, research on abortion provision stigma is at its inception and the few studies that exist rely largely on data from participants in an intervention intended to alleviate abortion provision stigma. This study expanded knowledge about abortion provision stigma to unstudied groups of abortion providers, and ones that were not already involved in stigma management interventions. Third, the occupational group level of analysis informed by in-depth individual interviews allowed for rich personal accounts that, when aggregated, comprised complex, nuanced portraits of how abortion provision stigma plays out in different occupational groups. Simultaneous exploration of within-group differences illuminated the roots and edges of abortion provision stigma, sharpening our understanding of the concept itself. Finally, the most important implication of this study is how its findings can be used to develop meaningful support for providers so that they can maintain positive identities and continue this important work, even as stigmatization of abortion care persists.

II. BACKGROUND AND SIGNIFICANCE

A. Abortion in the United States

By the age of 45, more than half of all women in the U.S. will have experienced an unintended pregnancy, and three in ten will have had an abortion (Finer & Zolna, 2014). Women's reasons for choosing abortion are complex and diverse, but some common themes can be consistently observed. In a mixed methods study of women's reasons for choosing abortion, nearly three-quarters of study participants indicated that they could not afford to have a child at that time, and large proportions of participants described their reasons for abortion in terms of their responsibilities to their dependents, issues with their partner and their own unreadiness to parent (Finer et al., 2005). Participants in this study emphasized their purposeful examination of the moral aspects of their decision, sometimes describing abortion as sinful or wrong, and other times explaining that abortion is a responsible choice or the "right thing" to do.

Supporters of abortion often assert that there are no absolutes in terms of "better" or "worse" reasons for an abortion. Entertaining such determinations engages a discourse that is ethically problematic and undermines the fact that abortion is a basic part of reproductive healthcare and a critical component of reproductive justice. However, not all people share these views, and this level of abstraction does not account for the complicated influences that moral judgments of abortion have on support for abortion. For example, a study of attitudes on abortion found that majorities of Americans simultaneously say that abortion is morally wrong (52%) but that it should be legal in all or most cases (56%) and at least some health care professionals in their communities should provide abortions (58%) (Jones et al., 2011). The complex moral position of

abortion in public discourse has meant that abortion care is constantly under attack, even as need for abortion and apparent commitment to its availability persist.

In the 1973 *Roe vs. Wade* ruling, the U.S. Supreme Court affirmed women's constitutionally protected right to have an abortion in the early stages of pregnancy. Unfortunately, the right to abortion does not entail access to abortion for many women due to various structural impediments to abortion access and pervasive stigmatization of abortion. In 2011, 89% of U.S. counties lacked an abortion clinic and 39% of all American women lived in those counties (Jones & Jerman, 2014a). Where clinics do exist, they are often targets of antiabortion antagonism that affects both patients and providers; 82% of all abortion clinics in the U.S. experienced at least one form of antiabortion harassment in 2011 (Jones & Jerman, 2014b).

Training in abortion has become an increasingly isolating and burdensome professional route for physicians. It is more typical that obstetrics and gynecology residency programs require residents to "opt in" to abortion training in their elective rotation time than that residents must "opt out" of routine abortion training if they so choose (Freedman, 2010). Of those trained to provide abortions, approximately half of physicians ultimately decide not to do so, due to institutional barriers and strain on collegial relationships (Freedman et al., 2010; Steinauer et al., 2008). Those who continue providing abortions after training demonstrate a high degree of ideological commitment to the work (Steinauer et al., 2008). We do not yet know the extent to which the effects of stigma deter non-physicians from joining the abortion-providing workforce, but recent studies have demonstrated that a variety of work roles involved in abortion care are subject to the deleterious effects of abortion provision stigma (Harris et al., 2011;

Martin et al., 2014; Martin et al., 2014; O'Donnell et al., 2011). Thus, as access to abortion is eroded through various tactics, a small group of dedicated individuals are left responsible for the bulk of abortion care in the U.S.

B. Abortion Provision Stigma as a Public Health Issue

A critical function of society's simultaneous demand and lack of support for abortion care is that those who provide this care are highly stigmatized. Abortion provision stigma merits the attention of public health research, advocacy and intervention because it produces undue stress and professional burnout for providers as well as structural impediments to increasing the abortion providing workforce and access to abortion for all women. Stigmatization of abortion work is both born of and sustains power imbalances that harm women. Understanding abortion provision stigma and strategies of resistance to it is therefore a social justice issue with important implications for women's health.

C. Stigma Overview

In his seminal work on stigma, Goffman defines it as an attribute that "is incongruous with our stereotype of what a given type of individual should be" and reduces the individual who bears it "from a whole and usual person to a tainted, discounted one" (p. 3, 1963). Although still relevant, Goffman's initial theorizing on stigma offered only vague definitions of stigma and focused primarily on individual experiences of being stigmatized. Perhaps owing to its loose original definition, the concept of stigma has morphed and inflated and is now frequently used to refer not to a personal attribute in itself (as Goffman described it), but to a constellation of social attitudes and processes that create the meaning and impact of various types of stigma.

For example, the *fact* of being an abortion provider would be a stigma in Goffman's view, but current usage of the term "stigma" also refers to the collective social construction of what being an abortion provider means about an individual.

Unbound by clear conceptual limits, the meanings of "stigma" have proliferated, but the stigmatized individual remains the primary focus of analyses of stigma. Only recently have theories of stigma acknowledged the roles of various processes and actors in the construction of stigma. In the foundational "Conceptualizing Stigma", Link and Phelan (2001) suggest that stigmatization of any group or individual results from co-occurrence of five processes: labeling, stereotyping, separation, status loss, and discrimination. They argue that that negative impact of stigmatization cannot be achieved---even if all five processes occur at once in a given context---in the absence of a power imbalance that does not favor the stigmatized. Thus stigmatization is a "persistent predicament" per Link and Phelan in that it both results in and is born of unequal distribution of power.

Philosophically, Link and Phelan's work rejects the notion that stigma is an inherent existential state that simply is, and that cannot be changed. Conceptualizing stigma as an unfortunate but inevitable truth of the social world is conducive to fatalistic and victim-blaming logic about people who are stigmatized---if they are able, stigmatized individuals can quit what they are doing to invite stigma, conceal the stigmatizing attribute, or just endure the harmful effects of stigma. In contrast, when stigma is understood as the result of processes enacted by people and dependent on power, active resistance to stigma and its associated harms emerges as a possibility.

D. Abortion Stigma

In "Conceptualizing Abortion Stigma", Kumar and colleagues (2009) elaborated on the work of Link and Phelan by outlining the ways abortion stigma is produced through framing discourses as well as structural, organizational, community and individual factors. The authors propose that while claims to "universality" of abortion stigma are untenable, the act of procuring an abortion makes women vulnerable to stigma because it violates traditional notions of femininity, which dictate that women are perpetually fertile, inevitability mothers and innately nurturing. Abortion providers and other supporters of abortion are referenced in Kumar and colleagues' model, but the focus of abortion stigma in their view is the woman who seeks to terminate a pregnancy.

In 2012, a group of researchers, practitioners and advocates participated in the Bellagio Expert Group Meeting to develop a learning agenda and conceptual framework to guide research and programmatic efforts on abortion stigma. The framework they developed closely mirrors that of Kumar and colleagues, but some assumptions of the model are unique and worth noting. First, the model holds that abortion stigma has geographic and temporal dimensions, and manifests itself differently in different contexts. Second, the model recognizes that stigma intersects with stereotyping and prejudice, but has distinct components uniquely its own, as well. Last and incredibly important, the model holds that not all negative reactions to abortion are stigma (Hessini, 2014). In a commentary following "Conceptualizing Abortion Stigma", Kumar (2013) also cautioned, "everything is not abortion stigma". Research on abortion stigma should bound and localize conceptualizations of stigma so that the concept does not become so encompassing that it is meaningless, impossible to measure or conducive to fatalistic

attitudes about overcoming stigma. Recent empirical inquiries into the nature of and responses to abortion provision stigma are useful in this regard.

E. Abortion Provision Stigma as a Human Resource Issue

To date, much of the research on abortion stigma has centered on women who procure abortions. Stigmatization of abortion providers has received less attention by comparison (Harris et al., 2011), but innovative research and interventions on abortion provision stigma are underway. If women who have abortions violate feminine ideals of sexuality, fertility and nurturing (Kumar et al., 2009), those who provide women with abortions are implicated in the transgression of these ideals. This is abortion provision stigma at its most basic level.

In their reconceptualization of abortion stigma's constituents, causes and consequences, Norris and colleagues (2011) identified abortion providers as one of three groups that are affected by abortion stigma (women who have had abortions and supporters of women who have had abortions comprised the other two groups). Unlike women who obtain abortions, providers have continual engagement with the stigmatizing behavior---it is their daily work. This means that abortion stigma is uniquely close at hand for providers and may be consistently integrated into the identities of abortion clinic staff (Harris, 2008; Norris et al., 2011).

Stigma is produced by over-simplifying complex situations such that false or negative stereotypes of the stigmatized can be created and held up as justification for the stigma itself. Abortion opponents frame abortion as murder, thereby excluding abortion from legitimate reproductive healthcare and rhetorically establishing the image of the abortion provider as one who subverts basic norms of healthcare provision. Purposefully

left out of this frame, of course, is any information that competes with the false stereotype, like the fact that abortion is a healthy, responsible choice for many female patients in the care of abortion providers. Harris and colleagues have described this predicament for abortion providers as the "legitimacy paradox", wherein providers exist in public discourse as "dangerous, deviant or illegitimate practitioners, despite the fact that they have provided safe abortion care to many millions of U.S. women since Roe vs. Wade" (Harris et al., 2012, p. 11). The mainstream medical community has tacitly endorsed negative stereotypes of abortion providers via their acceptance of abortion care being marginalized into freestanding clinics, where most abortions now take place (Jones & Kooistra, 2011).

Initially championed by feminist activists and practitioners, freestanding clinics were a positive development in abortion care in many ways. Costs associated with abortion procedures were lower in freestanding clinics than in hospital settings, clinics had the ability to hire staff members who were explicitly supportive of abortion, and clinics amassed impressive safety records (Joffe, 2014). However, the institutional marginalization of abortion care validates abortion stigma and makes the clinic itself a stigmatized place for providers and patients, alike (Norris et al., 2011).

Empirical inquiry into abortion provision stigma is nascent but hypothesized effects on individual providers include stress, professional difficulties with anti-abortion colleagues, fears about disclosing one's work to others and burnout (Norris et al., 2011). Psychological consequences of stigmatization include shame, isolation and loss of self-esteem (Major & O'Brien, 2005; Major & Gramzow, 1999). At its most extreme, abortion provision stigma has manifested as violence, including 11 murders, 26 attempted

murders, 42 clinic bombings, and 185 arson and other kinds of attacks on clinics since 1977 (National Abortion Federation, 2015). At a structural level, anticipated and experienced stigma influences providers' willingness to provide abortion services and therefore has an aggregate, negative impact on the availability of abortion care in the U.S. (Freedman, 2010; Norris et al., 2011).

F. Providers' Experience with Abortion Provision Stigma

Of the four published empirical studies that explore abortion provision stigma in the U.S., three are based on data from the Providers Share Workshop, which is a six-session workshop in which abortion providers (i.e. anyone with direct daily involvement in abortion care) meet to explore their experiences and try to mitigate the effects of work-related stigma with the aid of an experienced group facilitator (Harris et al., 2011). Workshop topics include the meaning of abortion work, memorable stories from abortion work, abortion and identity, abortion politics and strategies for self-care (Martin et al., 2014). A quantitative tool to assess abortion provision stigma, the Abortion Provider Stigma Survey (APSS), was developed to assess change in Providers Share Workshop participants' experiences of stigma over the course of the intervention. Survey results indicated that while they have high levels of pride in abortion work, providers perceived their work to be marginalized within the medical community and disapproved of by society, in general. Providers' overall stigmatization scores did not change from the baseline assessment to completion of the workshop (Martin et al., 2014).

In addition to the APSS scores, focus group data from the Providers Share Workshop indicated that stigma negatively impacts providers in the workplace and in professional circles (Harris et al., 2011). Workshop participants felt that silence and

selective disclosure about abortion work were helpful in dealing with stigma, but the sustained burden of these tactics led to professional burn-out and high staff turnover rates. Another qualitative study of resistance to abortion provision stigma found that of all the techniques providers used to manage stigma, the most successful was the development of communities of support comprised of others performing this work (O'Donnell et al., 2011). Thus supportive social interactions in the workplace are likely important to successful management of stigma, but may not be available to those who need them most.

The most recent study from the Providers Share Workshop assessed changes in abortion provision stigma over time and explored how stigma is related to professional quality of life (Martin et al., 2014). Workshop participants experienced fewer negative effects of stigma over time, but participants who worked in freestanding clinics had consistently higher stigma scores than their counterparts in hospital-based clinics. While the immediate context of the clinic, including supportive workgroups, appears to be important to providers' experience of stigmatization, this study was not equipped to explore the contextual differences that may account for these different experiences of stigma in hospital-based versus freestanding clinics.

The processes through which stigmatized workers construct and maintain positive identities are the focus of Ashforth and Kreiner's theory of "Dirty Work" (1999). Central constructs of "Dirty Work" have been referenced in previous studies of abortion provision stigma (Harris et al., 2011; Martin et al., 2014; O'Donnell et al., 2011). "Dirty Work" comes from the management literature and is a middle-range theory that assumes an occupational group level of analysis; in the current study, the occupational group is

comprised of the abortion providing workgroup within each freestanding or hospital-based clinic. "Dirty Work" focuses on stigma management mechanisms that are likely to be shared by members of a given occupational group rather than on idiosyncratic or organization-level strategies for resisting stigma. This focus is based on an assumption that salient stigmatization of an occupation fosters strong occupational cultures wherein workers share "deeply held systems of values, beliefs and norms" with associated ideologies and processes of weighing outsiders' perceptions of their work. The theory's focus on stigma management processes and use of an occupational group level of analysis make it an excellent framework for this exploratory comparison of abortion providers' experiences and management of stigma in freestanding hospital-based clinics.

G. Conceptual Framework: Ashforth and Kreiner's Theory of "Dirty Work"

"Dirty work" refers to occupations regarded by some as disgusting or immoral, such as abortion provision. "Dirt" and "cleanliness" in work are socially constructed to be antithetical and threatening to one another. To protect "clean" parts of society from the taint inherent in the "dirt" of dirty work, societies disavow those who perform dirty work while simultaneously supporting the demand for these occupations (Hughes, 1962). This paradoxical relationship is evident in the simultaneous vilification of abortion providers and persistent need for abortion services in the U.S.

Social identity theory suggests that individuals seek positive self-definitions, which are importantly shaped by occupational identities----the set of central and distinctive characteristics that typify a line of work (Van Maanen & Barley, 1984; Albert & Whetten, 1985). When an individual's occupational identity is stigmatized, social validation of his or her positive self-definition becomes problematic. With their theory of

"Dirty Work", Ashforth and Kreiner (1999) aimed to explain how members of stigmatized occupations secure positive self-definitions when society demands their services yet seems regretful about the very existence of their occupation. The theory does not have an official name and will be referred to hereafter simply as Dirty Work. The outcome of the stigma management processes postulated in Dirty Work is "work role identification", which refers to stigmatized workers' ability to see themselves as good people despite doing stigmatized work or, more ideally, good people doing *good* work. Ashforth and Kreiner propose that work role identification is a function of the relationships between salience of occupational stigma, occupational culture strength, social weighting and occupational ideologies (Figure 1).

Ashforth and Kreiner postulate a negative association between salience of occupational stigma and work role identity, such that workers will experience weaker identification with their work role when stigmatization of their occupation is more conspicuous. Salience of stigma has a positive association with occupational culture, which refers to the within-group cohesion of workers within a given occupation. Of relevance to the abortion provision, occupational cultures are made stronger by demographic clustering (e.g., abortion provision work is performed by mostly politically liberal, female workers), high task interdependencies, collective socialization and isolation of the occupational group from other groups. A threat to occupational group strength that may be relevant for the field of abortion provision is high employee turnover, which inhibits group formation.

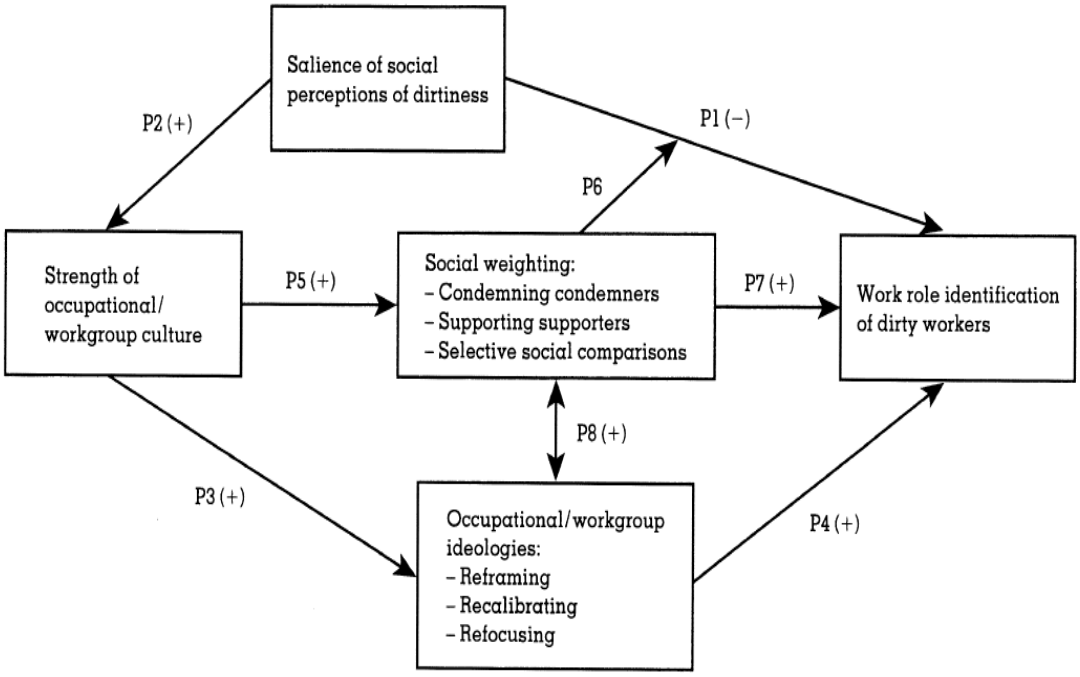

Figure 1: Dirty Work conceptual framework

People in stigmatized occupations use the processes of reframing, recalibrating and refocusing to construct occupational ideologies that are conducive to positive work role identification. Reframing is used to transform the meaning of a stigmatized occupation (e.g., abortion is a normal, important part of reproductive healthcare). Recalibrating involves modifying the perceived magnitude and/or valence of a given aspect of dirty work (e.g., women are often relieved, not traumatized, by their abortion). Refocusing shifts attention from the "dirty" aspects of the work to less stigmatized features of the occupation (e.g., abortion providers offer emotional support to women in need of it). These processes are not mutually exclusive, although reframing is singular in

its “power to transform the very meaning of the work itself” (Ashforth & Kreiner, 1999, p.423).

Social weighting refers to ways that members of dirty work occupations make sense of their work role in relation to how it is understood by outsiders to the occupation. Processes of social weighting include condemning the condemners (e.g., endorsing the idea that those who do not support abortion do not support women), supporting the supporters (e.g., viewing abortion provision as a critical component of reproductive rights), and selective social comparisons (e.g., asserting that those who counsel patients on abortion but do not perform the procedure are on higher moral ground than providers who perform the abortion procedure). Ashforth and Kreiner propose that stronger occupational cultures and ideologies are associated with greater use of social weighting processes. They also postulate a reciprocal, positive relationship between social weighting and processes of occupational ideology. Social weighting is positively associated with work role identification and moderates the association between the salience of occupational stigma and work role identification. Processes of social weighting may make members of dirty work occupations more likely to identify with their work role even where social stigmatization of that work is salient.

III. METHODS

A. Mixed Methods Research

The central premise of mixed methods research is that "the use of quantitative and qualitative approaches, in combination, provides a better understanding of research problems than either approach alone" (Creswell & Plano Clark, 2007, p. 5). When executed thoughtfully, mixed methods designs enhance the strengths and offset the weaknesses inherent in both quantitative and qualitative research, helping researchers gain a more comprehensive understanding of the phenomenon of interest. Creswell and Plano Clark encourage researchers to engage in mixed methods research only if they can identify at least "one clear reason" why the approach serves their intellectual puzzle. Bryman's (2006) typology of reasons outlines several reasons for mixing methods that are of relevance to this study. The primary reasons are that mixing methods will allow for 1) *sampling* for one data collection activity based on data gained through another data collection method and source, 2) *triangulation* of data types, 3) *completeness* of the account of abortion providers' experiences of stigmatization, 4) *explanation* of quantitative results in light of qualitative data and vice versa, 5) *illustration* of quantitative findings through qualitative data and 6) a *diversity of views* among the researchers' interpretation of qualitative data and the quantitative reports directly from study participants. While "mixed methods" research often refers to mixing qualitative and quantitative data for various purposes, this study will also mix two different qualitative data types (outlined in Figure 2 below).

B. Convergent Parallel Design

In a convergent parallel mixed methods design, researchers implement the quantitative and qualitative strands of a study at roughly the same time, keeping the strands independent during analysis and eventually mixing the results during overall interpretation. In this final interpretation stage, the researcher explores how the various sets of data converge, diverge, relate to each other and/or combine to explain the phenomenon of interest. The purpose of this design is "to obtain different but complementary data on the same topic" (Morse, 1991, p. 122). Initially conceptualized as a triangulation tool, convergent parallel design is now used for purposes other than those strictly pertaining to corroboration of results (Creswell & Plano Clark, 2011). In this study, convergent design is used to organize collection of different types of data on abortion provision stigma for a more complete understanding of the phenomenon.

Quantitative and qualitative methods can have relatively greater, less or equal priority in mixed methods studies. Due to the exploratory nature of the research questions, the primary focus of this study is on the qualitative data collected via interviews, and I will take what Mason (2006) describes as a "qualitatively-driven" approach to mixing methods. This approach highlights the ways that mixing methods fits with a "qualitative logic of comparison", which works by seeking to understand "the distinctive dynamics, mechanics and peculiarity of each case *holistically* and then to make comparisons at the level of analysis" (Mason, p. 16). In this study, this means considering all available data about providers to understand their individual experiences with and management of stigma, then making comparisons with other providers experiences, and eventually comparing across groups of providers at the occupational

group level. A qualitatively-driven approach to mixed methods research does not require that interpretation of various data types converges into single corroborated result. Instead, the approach holds that all explanations are constructions and therefore more than one can be valid.

The methods crosswalk tables found in Appendix A describe how I conceptualized the coordination of constructs, data sources and instrument questions. Some constructs were explored through only one data collection method or instrument question, while others were informed by multiple methods and questions. The purposes and procedures associated with the various sources of data for this study are discussed below.

C. Study Activities

Study procedures were divided into two phases. In Phase 1, I identified all clinics located in the city where the study took place that provide surgical abortions and conducted brief structured interviews with administrators at each of these clinics. Phase 1 was not a study within a larger study; the purpose of Phase 1 activities was for clinic administrators to provide me with information that was used to develop a rigorous sampling and recruitment strategy for data collection activities in Phase 2.

Using the data collected in Phase 1, I selected two freestanding and two hospital-based abortion clinics that served as recruitment and data collection sites for Phase 2. In Phase 2, I explored my research questions through nonreactive observation of the clinics' physical environments, in-depth qualitative interviews with abortion providers, and quantitative surveys of abortion providers' experiences with work-related stigma.

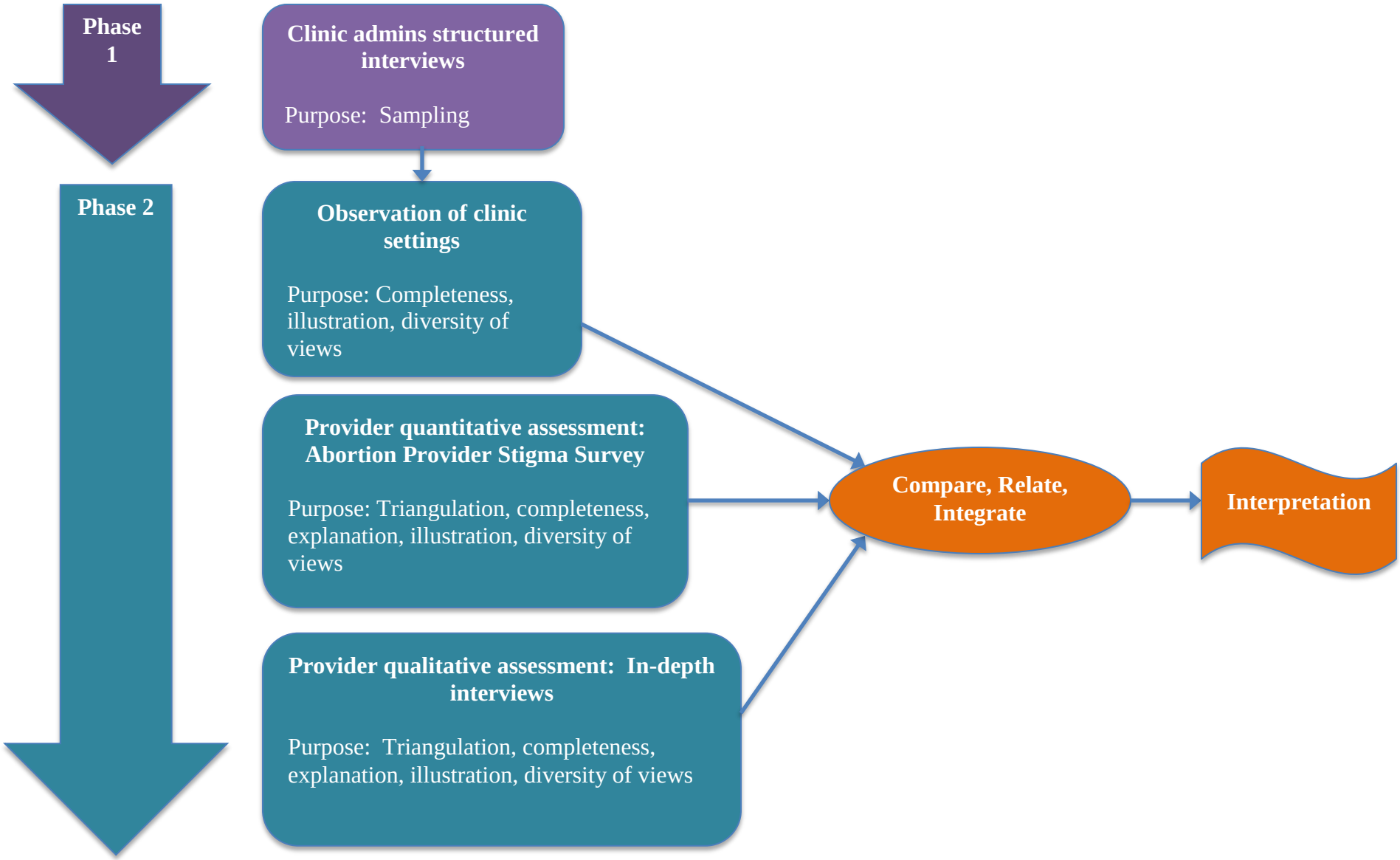

Figure 2: Study phases, data sources and data purposes for convergent mixed methods design.

1. Phase 1: Identification and selection of clinic recruitment sites

An aim of this study was to compare the stigma experiences of abortion providing workgroups in freestanding clinics with those of workgroups in hospital-based clinics. Abortion stigma affects patients and providers of surgical as well as medical abortions, but surgical abortions are the focus of anti-choice activism and targeted regulation of abortion provider laws. Because surgical abortions are more highly stigmatized than medical abortions, only clinics that provide surgical abortions were considered for data collection and recruitment sites for this study. A sampling frame of the clinics that provide surgical abortions was required to select clinics for observation and recruitment of providers to participate in interviews and surveys. No comprehensive list of clinics meeting these criteria exists. To identify all possible clinics of this nature, I procured a list of clinics affiliated with the National Abortion Federation (NAF). I was informed by a NAF staff member that this list may not be comprehensive, so I expanded it by searching for abortion clinics online, using a variety of search engines and terms. This resulted in a list of thirteen clinics in the metropolitan area. Of these clinics, one was no longer open for business and four did not meet the criteria of providing surgical abortions in the city. The eight remaining clinics met the criteria for participant recruitment and data collection sites for this study.

To limit confounding and facilitate comparison of providers' experiences across clinic settings, I attempted to match freestanding clinics with hospital-based clinics that were similar to each other on features that could impact each clinic workgroup's experience and management of stigma. These features included: clinic volume, number and type of staff members, involvement in abortion advocacy, and availability of

formalized support for dealing with work-related stress or stigmatization. To develop a sampling frame of abortion providers to recruit for participation in in-depth interviews and quantitative survey assessments, I needed to know which staff roles were involved in abortion care at each clinic. None of this information was publicly available, so I created a brief standardized interview guide on these topics to be administered to clinic administrators at each of the eight abortion clinics in the city. The interview guide can be found in Appendix B.

Once University of Illinois at Chicago's IRB determined that collecting data on the aforementioned topics did not constitute human subjects research, I began cold-calling and emailing each clinic, keeping a log of my interactions with staff members at each clinic. When my attempts to reach anyone at a given clinic failed, I called upon my colleagues' contacts and networks to help me gain access. I successfully completed interviews with a clinic administrator or medical director at five of the eight clinics in the city, all of whom initially indicated on behalf of their clinic workgroup that they would consider participating in Phase 2 of this research. One of those five administrators later indicated that her clinic would not be able to participate any further in the study, resulting in a total of four clinics with two freestanding and two hospital-based clinics represented in the final pool of clinics willing and eligible to participate in Phase 2. The two hospital-based clinics were Hospital Clinic A and Hospital Clinic B. The two freestanding clinics were Freestanding Clinic A and Freestanding Clinic B.

2. Phase 2: Mixed methods inquiry into abortion providers' experiences with and management of stigmatization

The data that informed my inquiry into abortion providers' experiences with and management of work-related stigma were 1) nonreactive observational data of the clinics' physical organization and contents, 2) in-depth interview data collected in interviews with abortion providers, and 3) quantitative survey data on abortion providers' perceptions of and experiences with work-related stigma. The samples for the quantitative surveys and in-depth interviews were the same (n=31); providers who consented to participate in interviews also completed the quantitative assessments of abortion provision stigma prior to or following their interview, on the day of the interview. Observational data was collected independent from survey and interview data.

D. Nonreactive Observation of Clinic Settings

1. Data collection and analysis

Physical organization of the clinic space and messages about abortion within and outside the clinic may impact abortion providers' experience of stigmatization (Norris et al., 2011). To document the physical aspects of each clinic that may influence the ways that the abortion providing occupation groups understand their work and experience stigmatization, I conducted nonreactive observation including a clinic tour at each clinic (n=4) for approximately one hour at each site. Nonreactive observation entails collecting data without interacting or reacting visibly with participants in the observation setting (Ulin et al., 2005). Observational data consisted of detailed field notes on each clinic's immediate surroundings, interior, safety infrastructure (e.g., metal detectors, protective glass), and salient messages about reproductive health and abortion,

specifically. These data provided important background information about each clinic that contextualizes findings from interview and survey data. The observational field notes guide can be found in Appendix B.

2. Protection of research subjects

The focus of observation activities was on physical aspects of each clinic and messages therein, not on the activities of people in those settings. Therefore, it did not constitute human subjects research and did not require documentation of informed consent for IRB approval (this was confirmed by a member of the University of Illinois at Chicago's IRB). I requested permission to conduct nonreactive observation from the clinic administrator at each site, provided he or she with the observational field notes guide I used and arranged to conduct the observation at a time that would not be disruptive to clinic staff or patients at each site. In this paper, I have completely omitted all results involving nonreactive observation data in order to protect study participants. When presenting this study's findings at conferences or in publications, I will try not to include any information from observational data that would allow an audience member or reader to identify any of the clinics involved in the study.

E. In-depth Interviews with Abortion Providers

Because I am interested in subjective meanings, detailed description of processes that are not readily observable, and rich description of personal experiences, in-depth interviews are an appropriate mode of gathering data from providers (Weiss, 1994). Interviews allow for improvisational tailoring of data collection to unexpected but important ideas, on-the-spot clarification of concepts and mutuality in the construction of knowledge. These aspects of the methodology are particularly beneficial to the study of

abortion provision stigma, as little is currently known about it and its attendant concepts can be unwieldy and complex.

Interviews elicit data that can help outsiders identify with the interview respondent, if only briefly, by "presenting events as the respondent experienced them, in the respondent's words, with the respondent's imagery" (Weiss, 1994, p. 10). Essentially, good interview data can humanize interviewees. They are conducive to empathy and help bridge understandings of how people act, think and feel, and why they do so. If stigma silences, marginalizes and dehumanizes abortion providers, then interviews are a uniquely appropriate method to begin understanding how to counter abortion provision stigma.

Consistent with "Dirty Work" theory, this study assumes an occupational level of analysis, but collecting data at the level of the abortion providing workgroup could have undermined important study aims. Research on abortion provision stigma has indicated that providers' experiences with and management of stigma may negatively implicate their abortion providing coworkers (Harris et al., 2011). For example, a medical assistant may indicate that she feels positively about her role in abortion care but would feel bad about performing the abortion procedure. Asking providers to share such experiences in a group setting could have precluded forthright responses or exposed providers to negative attitudes and reactions from coworkers. In-depth interviews were conducive to exploring individual stigma experiences but still allowed for identifying experiences and stigma management tactics shared by the workgroup as a whole.

1. Sampling and recruitment

“Purposeful” or “purposive” sampling is used when there is a particular purpose that study participants should serve and the people who can serve that purpose comprise a relatively small or hard-to-find population (Bernard & Ryan, 2010). In this study, participants need to be able to speak to personal experiences with and perceptions of abortion provision stigma. The power of purposeful sampling comes from selecting “information-rich cases” that can facilitate in-depth understanding (Patton, 2002, p. 46).

To identify information-rich cases and develop a purposeful sampling strategy that could be applied consistently across the four clinic sites, irrespective of differences in staff structure and size, clinic administrators were asked in Phase 1 to identify the four provider types within each clinic that are “most involved” with abortion care. These roles vary by clinic. For example, one clinic administrator explained that physicians, reproductive health associates, sedation providers and recovery room staff constituted the four work roles “most involved” in abortion care at their clinic. At another clinic, medical assistants, physicians, nurses and a clinic administrator were the four roles identified as “most involved” in abortion care.

I conducted purposeful sampling and recruitment of staff members at each clinic that fell within one of the four work roles “most involved” in abortion care until no more providers indicated interest in participating in the study. Clinic administrators invited eligible providers to participate in the study on my behalf via a recruitment script created and signed by me. The recruitment announcement was shared through emails and at staff meetings. It included a description of the study, eligibility criteria and the risks and benefits of participation. Upon conducting interviews, I learned that in addition to the

planned recruitment strategies, several participants had written to their coworkers after their interviews and encouraged those who had not yet participated to do so via internal email chains.

At Freestanding Clinic A, the clinic administrator shared the invitation to participate in the study with staff at the downtown site I had intended as a recruitment site as well as staff at another site within the Freestanding Clinic A organization but located in a suburb outside the city. This constituted a departure from the sampling and recruitment plan, but I decided to include those interested in participating at this second site because they worked within the same organization as the downtown site, several staff members worked at both sites and there is high consistency across sites within the Freestanding Clinic A organization. Participants from both sites are collectively referred to as those from Freestanding Clinic A.

Providers who were interested in participating in the study contacted me via phone or email, when I screened them for eligibility and scheduled them for interviews. Eligibility to participate was established by the provider verifying that he or she occupies one of the roles previously identified as "most involved" in abortion care at their clinic. IRB approval was obtained in June of 2015 and recruitment began immediately after, producing a final sample of 31 participants by December of 2015.

2. Data collection procedures

The interview guide was sufficiently flexible to incorporate questions that emerged in the immediate context of the interview and sufficiently standardized to facilitate comparisons across participants. The guide is found in Appendix B and a table depicting the relationship of study constructs to interview guide questions is found in

Appendix A. Two abortion providers not involved in the study as participants reviewed the guide for clarity and face validity. The guide was then modified to enhance fitness between study aims and topics included in the guide. These modifications centered on clarifying terminology that would be most familiar to participants. While the guide was not formally changed past this point, the best way to ask questions in the guide became apparent after the first three to five interviews, so I adopted those approaches for the duration of data collection. For example, when asked what reaction they have to the statement "abortion is stigmatized", some participants took that to mean I was suggesting abortion *should* be stigmatized. I intended the prompt to elicit the extent to which they perceive abortion *is* stigmatized, irrespective of whether or not it *should* be stigmatized. Making slight modifications to hedge against this sort of confusion is normal and necessary in interview research.

Interviews were conducted in a private room at the location and time of the participant's choice. Length of interviews ranged from 45 to 122 minutes with an average duration of 83 minutes. All interviews were audio recorded by me and transcribed by a professional transcriptionist within two weeks of being conducted. Participants provided their informed consent to take part in the study and were compensated with $20.00 for their time.

At the end of the informed consent document, participants were asked to indicate whether they would like to review a case summary of their interview, highlight anything that they are not comfortable with having reported and add anything they feel is important but neglected to say during the interview. The intent of the case summary review process was to enhance validity of the data and added an extra layer of protection

for research participants. Due to delays in transcription and coding, the 17 participants who requested their case summaries for review did not receive them until approximately a year and a half after their interviews. This timing probably limited participants' ability to recall interview content to verify the validity of my summary. However, it did still provide participants with an additional opportunity to review the main points of their interview based on my interpretation and add any thoughts they felt were important. At the time of this writing, no one had returned case summaries with any elaborations or request for modifications.

3. Data analysis procedures

The tools used to analyze the interview data included coding, memo-writing, creating concept maps and critical discussion of analytic themes. The process of coding involves "taking data apart, and defining and labeling what those data are about" (Charmaz, 2000, p. 342). Codebooks can be thought of as organized sets of themes and concepts that are observable in transcript data. In this study, codebook development was informed by a priori constructs (see Construct-Definition table in Appendix A) drawn from the interview guide, a review of the research literature and constructs of Ashforth and Kreiner's theory of "Dirty Work" (1999), in addition to emergent ideas grounded in the interview data. I aimed for a comprehensive yet parsimonious guide that provided clear definitions and conditions of use for each code.

In qualitative research, data collection and analysis are not discrete, successive stages. Analytic ideas occur constantly throughout data collection. Good field notes and immediate documentation of those ideas can shape subsequent data collection procedures

and analysis of data. The following case example about "Anti's" provides a detailed description of how data collection informed analysis and vice versa, throughout the study.

Language is important to abortion stigma. The terms we use can indicate the "side" we are on, and language itself can be stigmatizing (e.g. the literal meaning of "pro-life" is general and inherently positive, yet the social meaning of this term really means anti-choice and is specific to abortion). During an interview with a medical assistant from Freestanding Clinic A, I noticed that she consistently referred to protesters and anti-choice activists as "Anti's". I wondered if this was a term that other abortion providers used as common shorthand for protesters, or if this term might be popular only among Freestanding Clinic A's staff because they have regular, vocal, well-organized protesters. It also could have just been an innocuous turn of phrase this participant occasionally used. I documented these questions in my field notes and in subsequent interviews, I paid close attention to who used the term "Anti's" and asked participants about it when it didn't come up without prompting. I learned that it was, in fact, a very common term among Freestanding Clinic A staff but wasn't used by providers at other clinics. Participants agreed with my speculation that the term was born of constant discussion of "Anti's" at Freestanding Clinic A given the persistent, aggressive protesting of their clinics. When developing a codebook, I made "Trapped/Tricked by Anti's" a code so that I could track the places in interviews where concern about being tricked by Anti's came up, allowing me to assess who was really using this term and what were the related circumstances. This is one example of how data collection and analysis can occur simultaneously and are symbiotic in this study as well as in qualitative research in general.

I took field notes during interviews, but most of my field notes come from "brain dumps" where I would rapidly record notes immediately after each interview. These field notes comprised the first documented source of ideas for codes and analysis. Once interviews were transcribed, I listened to the original interview audio for each interview to verify the associated transcription, taking notes throughout the audio replay. These notes provided a second source of initial coding and analysis ideas. The third stage of this process consisted of me reading each transcript and taking notes as I did. By this point, some of my notes became more fully developed ideas, like those that I would record in memos in Dedoose 7.0.23, the qualitative data management program used to code data.

The first draft of the codebook was based on index codes for interview topics and emergent codes based on my initial notes from interviewing, listening to transcripts, reading transcripts and discussing themes with my second coder and partner in analysis. The second coder had experience in qualitative research methods and was interested in learning more about analysis, specifically. We met to discuss analysis for two hours each week over 15 weeks in the Spring of 2016.

As the second coder acquainted himself with the study data by reading eight interview transcripts, I coded three interviews with the first draft of my codebook, adding new codes as needed. I then met with the second coder to discuss the codebook and modify code definitions for maximum clarity and potential for consistency in how each of us would apply them, separately. I selected four transcripts to be coded by both the second coder and me, aiming for a subset that would represent diverse roles, clinics and topics covered in the interviews so that the full range of codes might be used and tested.

We repeated the following process for each of the four transcripts: I coded each

transcript first, creating blocked segments of text where the second coder could see that I had applied some code(s) but not which one(s), the second coder would code the same transcript, then we would meet in person, review the entire double-coded transcript with each other, calculate the percent agreement between coders in our code applications, and modify the codebook as needed based on discrepancies in how we had applied codes.

This process was painstaking but essential for modifying codes and advancing analysis. For example, I initially had two separate code families (a main code with associated codes comprising a thematic subgroup among all codes) for "Stigma Impact/Why it matters" and "Stigma Evidence/How we see it".

Prior to coding, I thought of these as separate but related concepts. Upon reviewing discrepant application of codes between the second coder and me, it was clear that these concepts were indistinguishable in the ways that participants discussed them. The second coder would consistently label sections that I had labeled "Stigma Impact/Why it Matters" as "Stigma Evidence/How do we see it". We agreed that these code definitions were not sufficiently distinct for us to know how each would be applied uniquely and since we consistently applied both codes to the same section, the codes should be merged. In terms of furthering analysis, our discussion of how the codes had been applied helped us articulate an important idea about stigmatization: evidence of stigma *is* its impact. Stigma is made real through its consequences.

We repeated the process outlined above for each of the four transcripts selected for double coding, starting with the one that I thought would be most straightforward to code and escalating to the most complex interview of the four. As we reviewed discrepancies in our code applications, we calculated percent agreement between coders

for each transcript. Unsurprisingly, our percent agreement scores decreased across interview transcripts as they went from simplest to most difficult to code; from the first to the last transcript, the percent agreement between coders was 93.92%, 88.61%, 83.33% and 78.45%.

Calculating percent agreement was a means for the second coder and me to spot check our application of codes and ensure that we were not applying codes in dramatically different ways. Qualitatively reviewing coded transcripts as a team and discussing discrepancy in code applications was most meaningful for establishing validity and reliability in coding, but triangulating these quantitative and qualitative assessments of inter-coder reliability resulted in a strong codebook and a structured, thorough approach to analysis. A final version of the codebook can be found in Appendix D.

In addition to coding, memo-writing, and construction of conceptual maps throughout analysis were central to identification of emergent themes and relationships grounded by the interview data. Memo-writing is the "pivotal intermediate step between data collection and writing drafts of papers" through which I developed my ideas, fine-tuned subsequent data-gathering and engaged in critical reflexivity (Charmaz, 2000, p. 162).

I constructed instrumentation, coding, and analytic memos in Dedoose and attached them to relevant excerpted data. I used instrumentation memos to flag areas of a transcript that indicate new lines of inquiry to be pursued in subsequent data collection. Instrumentation memos were used as a sort of self-check on the interviewing techniques I used and a way to suggest useful approaches for future interviews. As the following

example memo will demonstrate, ideas about how to ask interview questions differently were often analytic questions as much as instrumentation issues.

> *Instrumentation Memo Title: Figure out better word for 'I don't want to see that' phenomenon*
> *You need to figure out a better, more neutral way to express this thing where participants say they don't want to see products of conception or hear about what's happening at "that end of the bed"…some describe it as "grotesque" or "difficult" aspects of abortion care, but all of those words are themselves stigmatizing. Can't use them, they undermine the purpose of the question. What's the difference between moral superiority with anything dealing with the fetus, or discomfort with seeing products of conception? Don't want to outright imply it's a moral position, too leading. "Opting out"?*

The second coder and I created coding memos when questions about code definitions or issues with code applications came up in the process of coding a transcript. I collated these memos and we discussed them in our weekly analysis meeting. The following is an example of a coding memo.

> *Coding Memo Title: "LGBTQ being 'out' comparison to providers being 'out'"*
> *Advocate types discuss this relatively frequently. Don't think the analogy works, but should we make a code for it?*

The process of coding demands that one is immersed in the data, considering the importance of each idea expressed therein on its own, as well as in the context of other data, codes and themes. This level of engagement with the data prompts important analytic ideas and questions; analytic memos attached to excerpted data allow for immediate documentation of those thoughts in situ. While instrumentation and coding memos dealt with the mechanics of data collection and coding, analytic memos were used to document my thoughts on the meaning and interrelationships of data excerpts, codes, and themes. The following is transcript text and the analytic memo that was attached to it.

Transcript Text

"They're like, 'isn't this great, we provide care for poor women!' And it's like, no, it's not that great, because you wouldn't send your sister there, to these places that give subpar care…like, is that really what we're satisfied with in an urban, industrialized, liberal city? But no one within the abortion community is going to say anything because there is so much angst from the outside that you don't need angst from within."

Analytic Memo Title: "So much angst from the outside…"

Wow. This participant speaks much more openly, and just more, period, about criticism of how we provide abortion care and names specific institutions and individuals and is really, really critical of them in specific terms. Yet, this "so much angst" quote is important, because she understands that through all of her frustrations, that these are still her comrades, her peers, the people doing the work that she is doing. Granted, in a way she sees as very different than what she does, and insufficient for her standards, but still, her team.

It's always been hard to be pro-choice and be critical at all of abortion care or providers because there's so much at stake and the situation is so precarious. Especially now, with our current political climate and hatred for providers. But we need to find a way to talk about these things and share views in a respectful way so that we can continue to improve care and access on our own terms. We can't be so hobbled by anti-abortion action, legislation and attitudes that we diminish the quality of care being provided, citing the constraints of anti-abortion people as fully responsible for the priorities and standards of the abortion providing workforce.

Throughout data collection and analysis, I also continuously developed and modified concept maps illustrating relationships between themes in the data. I checked the validity of the relationships proposed in the concept maps by identifying the codes that would be relevant to the concept map constructs, pulling the excerpts associated with those codes and deciding if the relationships depicted in the concept maps were borne out by the excerpted data. If the relationship was not supported, I modified the concept map or attempted to uncover other possible explanations for the observed relationships. Analytic memos and concept maps were indispensable in moving qualitative data interpretation and analysis beyond coding.

F. Quantitative Assessments of Abortion Provision Stigma: The Abortion Provider Stigma Survey

The Abortion Provider Stigma Survey (APSS) was used to conduct a quantitative assessment of interview participants' experience with abortion provision stigma. The APSS is a 35-item measure that was developed by Martin and colleagues (Martin et al., 2014) to assess providers' exposure and responses to stigma in varying contexts such as in their clinics, within the larger medical field and in their personal lives. Permission to use the APSS in this study was obtained from Dr. Lisa Martin in March of 2015.

A factor analysis conducted by the scale's creators identified five subscales of the APSS: disclosure management, internalized states, judgment, social support and discrimination (Table I). Response options in the APSS ask participants to indicate whether they have experienced the proposition of each item all of the time, often, sometimes, rarely, or never. Psychometric tests of the scale and its subscales have demonstrated high internal consistency (α=0.92; KMO=0.90), which suggests that all of the items in the scale are in fact measuring the latent variable of stigma. In terms of external validity, the APSS scale and subscales were positively correlated in the expected directions with the Psychological Distress, Emotional Exhuastion and Depersonalization subscales of the Maslach Burnout Inventory (MBI), and inversely correlated with the Personal Accomplishment subscale of the MBI (Martin et al., 2014). -

TABLE I

ABORTION PROVIDER STIGMATIZATION SURVEY SUBSCALES

APSS Subscale	Example Subscale Item
Disclosure Management (10 items)	I avoid telling people what I do for a living.
Internalized States (10 items)	I am proud that I work in abortion care.
Judgment (7 items)	I feel other health care workers question my professional skills when they learn I work in abortion care.
Social Support (4 items)	I can talk to close friends or family about a hard day at work.
Discrimination (4 items)	I have been physically threatened or attacked as a result of working in abortion care.

1. Sampling and recruitment

As explained previously, the in-depth interview sample and the APSS sample were one and the same. When participants were recruited to participate in in-depth interviews, it was explained to them that they would also complete a brief quantitative assessment (the APSS) on the day of the interview.

2. Data collection and analysis procedures

The APSS was compiled with a brief set of participant background questions pertinent to the study (e.g. age, education, tenure at current clinic), and administered via hard copy to all participants on the day of their interview. Completing the APSS took each participant approximately10 minutes. Survey responses were

entered into a password protected Excel spreadsheet, and APSS composite and subscale scores were calculated for each participant, clinic workgroup and emergent subgroup of participants indicated by the qualitative data. Participants' APSS scores were examined alongside interview data for purposes of triangulation, contextualizing these quantitative data and integrating qualitative with quantitative views of work satisfaction and abortion provision stigma experiences.

As I prepared the APSS forms to be reviewed by the IRB and completed by participants, I accidentally omitted one APSS item from the internal states subscale: "by providing abortions, I am making a positive contribution to society." I did not realize my oversight until I was almost done with data collection and it was practically and ethically impossible to contact all previously enrolled participants to have them complete the missing item. All participants in the study did receive the same APSS, however, which means that internal comparisons made within the study sample are still valid. External comparisons to other study samples' composite APSS scores would be invalid but currently, the only other reported sample of providers who completed the APSS was that used for the factor analysis in creation of the scale (Martin et al., 2014). Composite scores for the APSS as administered in this study could range from 34 - 170, with higher scores indicating greater experiences of stigmatization.

G. Reflexivity: My Relationship to My Research

Reflexivity is a process of "continual internal dialogue and critical self-evaluation as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015, p. 220). It means that a researcher

must continuously acknowledge, critique and document the ways that who they are and what they do affects what they learn about the world they are studying.

Reflexivity is not meant to be an apology for subjectivity, nor an academic navel-gazing exercise for the researcher's own benefit. It is associated primarily with qualitative research but would enhance the quality and trustworthiness of any research. Abruptly removing the researcher from the process of discovery at the point of disseminating findings feels illogical and dishonest to me. It also denies others the opportunity to understand and judge important elements of the context that informed the inquiry.

More than a vague commitment to "being honest" or "self-critical" in research, rigorous reflexivity for me includes keeping a research journal that functions as an "audit trail" on my thoughts, reactions and decisions throughout the research process. This starts with a free list of assumptions that I document at the very start of developing questions about a topic I want to research. I do not edit the list as I write it or afterwards, and push myself to create a richly varied list, including ideas that are "a given", as those are often reflective of my most fundamental suppositions. The assumption list sets the stage for subsequent reflexive notes that I add to and review throughout the research process. I use the first person and my personal thoughts and reactions in these notes, as well as in memos I create as I code, and in presentation of study findings and methods.

The emic/etic balance of my position in this study was fluid, which worked to my benefit. Sometimes my position in this study was emic---that of an insider---as participants knew me to be pro-choice and a sort of "insider" or at least "vetted outsider" to the abortion and family planning community. Other times, I had an etic perspective---

that of an outsider (Eppley, 2006). I explained to all participants that I was neither a clinician nor an abortion provider. Both positions enhanced my ability to learn from participants. As an insider, I was trusted with information that participants did not normally discuss with anyone who does not work in abortion care. As an outsider, I received rich detail about participants' experiences, as they did not assume I would have had the same experiences. They understood their role to be that of the "expert" in the interview, which is ideal for eliciting rich data from in-depth interviews.

Typical aspects of self that are attended to in being reflexive include social position (e.g. gender, age, race, sexual orientation), personal experiences, and political or professional commitments (Berger, 2015). Of relevance to this study, I am a white, straight, feminist, cis-gender female with no children, though I look forward to being a parent someday. I grew up in an upper middle-class home in a working class town. Our immediate family was explicitly political and liberal.

My parents were raised in stereotypically Irish Catholic homes in terms of their parents' commitment to Catholic rules prohibiting contraception and abortion. My mother is one of nine children and my father is one of twelve. Despite believing that Catholicism's rules about contraception are harmful to women and families, I love my enormous family and my life has been shaped by it in many ways, mostly for my benefit, I think.

For the most part, Catholicism did not survive my parents' generation in our extended family, but my siblings and I went to Catholic grade school. It is fair to say that we were exposed to, but far from indoctrinated in, traditional Catholic teachings,

particularly where controversial issues like contraception, abortion, homosexuality, and divorce were concerned.

I do not remember being a believer but I think Catholicism shaped how I view the world when it comes to abortion, in that I learned early through my parents' criticism of the church that the morality of things like abortion are open to thought and discussion, no authority is unequivocally right and I should pay attention to what I think matters.

Being pro-choice is socially normative in my professional circles and among my friends. I have worked at Planned Parenthood, am very committed to reproductive justice and have many friends who have been abortion patients or are abortion providers. My connection to the family planning community from previous work facilitated my acceptance in the local abortion-providing community, and was crucial to successful recruitment of participants in this study.

In general, I think I am received as a funny, warm, non-judgmental person to people I meet. People open up to me quickly in interviews and are very generous with what they are willing to share with me. This is a fortuitous quality for a qualitative researcher and I try to treat it with respect and not exploit it.

I want my work in this particular study as well as throughout my career to support women's health as a social justice issue. I am also committed to the integrity of my research and presenting the truth of any situation that I study, as I interpret it through my data.

H. Social and Political Context of Data Collection and Analysis

The number of legislative restrictions on abortion in the U.S. proliferated greatly in the period from 2010 to 2015. The Guttmacher Institute (2016) reported that during

that time, states adopted 288 new legislative restrictions on abortion, which is nearly as many restrictions as were adopted in all of the fifteen years preceding 2010, combined. Fifty-seven restrictions were made law in 2015, the year in which I proposed this study and began collecting data. The 2015 restrictions focused on waiting periods for abortion, medication abortion, abortion after the first trimester and Targeted Regulation of Abortion Providers. In addition to their impact on abortion access, these laws were important reflections of social norms and attitudes. The escalating restrictions on abortion leading up to 2015 reflected passivity on behalf of pro-choice voters and momentum among anti-choice activists. In this social context, the release of misleading, inflammatory videos featuring abortion providers had profound impact.

In July of 2015, an anti-abortion group released several video recordings that they had surreptitiously made of Planned Parenthood doctors discussing donation of fetal tissue in blunt, clinical terms with a representative of the anti-abortion group, who was posing as a researcher. The impact of the videos was widespread and harmful to Planned Parenthood as well as abortion providers everywhere, despite the fact that the doctors featured in the videos did not say or do anything illegal and believed that they were discussing the donation of fetal tissue for stem cell research with a legitimate researcher. The creators of the videos were later charged with 15 felonies by the State of California, but by that point, significant damage was already done. Pro-choice advocates were unsettled by the doctors' frank, unapologetic discussion of fetal tissue and anti-choice advocates were outraged.

The National Abortion Federation (NAF) has tracked threats, harassment and violence against abortion providers for approximately 40 years. Immediately following

the release of the first video, they observed an unprecedented increase in death threats, hate speech, online harassment, arson, and attempted murder of abortion providers. In 2014, there was one incident of a death threat to an abortion provider. In 2015, there were 94. In all of 2014, there were 91 documented incidents of hate speech and threats to providers online. During one six-week span of the fall of 2015, there were 25,839 such incidents. After each video was released, social media, blogs and news outlet comment sections online were flooded with derisions of abortion providers as "evil" and "murderers", including death threats to specific providers and an offer to "pay ten large to whoever kills [particular abortion doctor]. Anyone. Go for it." Abortion clinics in Illinois, Washington, California and Louisiana were victims of arson within the three months of an anti-abortion extremist encouraging arson online: "One person setting fire to an abortion clinic will not do anything, but thousands setting fire to an abortion clinic will speak volumes." With the assistance of an outside security firm, NAF was able to identify some of the individuals making online threats, encouragement for arson and offers to pay for the murder of abortion providers, and those individuals are now being prosecuted (National Abortion Federation, 2016).

On Thanksgiving weekend in November of 2015, an anti-abortion extremist attacked a Planned Parenthood clinic in Colorado, engaging in a 5-hour long standoff with police. The clinic was part of the same Planned Parenthood regional affiliate as the clinic featured in the inflammatory videos. Before he was apprehended, the attacker killed 2 civilians and 1 police officer, and wounded 9 other people.

Several news outlets reported that the attacker made a reference to the videos in a rambling, largely incoherent interview with police, but this detail is unnecessary to

establish the link between the Planned Parenthood videos and the violence and harassment of providers that followed. The first group of videos was released on July 15, 2015. I conducted my first interview with a provider the following week.

IV. RESULTS OVERVIEW

A. Roadmap for Presentation of Results

The findings of this study and their implications are presented throughout Chapters V - X. Mason (2002, p. 177) asserts that qualitative research produces social explanations comprised of "arguments" based on the researcher's data and their interpretation of it. Results for this study are comprised of interpretive, narrative and reflexive arguments, wherein I illustrate how my interpretations of the data are appropriately nuanced, valid and shaped by my critique of my own ideas. Discussion of these interpretations and their implications is woven throughout the presentation of the results (i.e. Results and Discussion sections do not follow a traditional scientific paper format). Some important data, themes and explanations have been omitted from this paper in service of protecting study participants, but will be included in future publications after I conduct more thorough member-checking and vetting of the concepts.

The meaning of abortion work to study participants is addressed first, as it was in interview data analysis. I assumed that learning how participants thought of their work would be important context for understanding how they experienced stigmatization because of it, so I sequenced my analysis of research questions and presentation of findings accordingly. I focused first on an individual level of analysis and comparison so that I would not miss important aspects of abortion work meaning that would have been obscured by aggregating supposedly similar people into pre-defined groups, like their work role or clinic setting. This analysis indicated that participants made sense of their work through its relation to their identities, feelings and definitions of the purpose of abortion work. During this stage of analysis, I identified two thematically defined groups

of participants in terms of their perceptions of the defining features of their work: utilitarian types and advocate types. Those groups are explained in Chapter V and are referenced throughout the entire discussion of study findings.

Discussion of stigmatization and quantitative APSS scores in Chapter V is limited to describing differences between utilitarian types and advocate types. In-depth descriptions of themes pertinent for each clinic are found in Chapter VII while more general descriptions of the clinics are included here in Chapter V.

Interview and APSS findings reported in Chapters VI - X resulted from applying first an individual level of comparison, then by work role, clinic and clinic setting. Chapter VI addresses the experiences with stigma that were common to all participants' experiences. Distinctions that indicated unique experiences of stigma by group membership are covered in the subsequent chapters. Participants had discrepant experiences with stigma by clinic (Chapter VII), clinic type (Chapter VIII), and physicians versus non-physicians (Chapter IX). Discussion of results concludes with Chapter X, which covers the implications of the study findings for supporting abortion providers in dealing with stigmatization.

Throughout all subsequent chapters and sections, I will use the word "participants" or work-role specific terms like "physicians" to refer to findings from this study, in particular. "Providers" will be used to assert something that is true for all providers, including those not involved in this study.

B. Description of the Study Sample

A variety of work roles and length of involvement in abortion care were represented in the final sample of 31 participants from the two freestanding and two

hospital-based clinics (Table II). All participants and clinics have been given aliases and I have omitted as much identifying information as possible in order to protect participants and their clinics. I collected information about participants' education, amount of hours worked per week, tenure in abortion care, age, gender and number of abortion clinics participants have worked at, but I elected not to present all of this information here in the description of the study sample. Instead, I included this information throughout results only when it was relevant context for a particular anecdote or participant quote.

TABLE II

DESCRIPTION OF STUDY SAMPLE

Clinic (n=4)	**Participant (n=31)**	**Work Role**
Hospital Clinic A Total abortion staff (n=8) Study sample (n=8)	Ms. Summer Ms. Banks Ms. De Silva Ms. Bryant Nurse Castillo Dr. Francis Dr. Nydegger Dr. Rostami	Surgical Coordinator Social Worker Medical Assistant Medical Assistant Nurse Physician Physician Physician
Hospital Clinic B Total abortion staff (n=6) Study sample (n=5)	Nurse Kerr Dr. Schaeffer Dr. Barnes Dr. Kendrick Dr. Campbell	Nurse Physician Physician Physician Physician
Freestanding Clinic A Total abortion staff (n=24) Study sample (n=12)	Ms. Lappley Ms. Duvall Ms. Murray Ms. Doss Ms. Dougherty Nurse Lopez Nurse O'Hara Nurse Kirby Dr. Sullivan Dr. Rouse Dr. Rivers Dr. Simpson	Call Center Manager Medical Assistant Medical Assistant Social Worker Social Worker Nurse Advanced Practice Nurse Advanced Practice Nurse Physician Physician Physician Physician
Freestanding Clinic B Total abortion staff (n=32) Study sample (n=6)	Ms. Orlowski Ms. Mulroy Ms. Quinn Nurse Merrick Nurse Dahl Dr. Eisler	Patient Representative Patient Representative Patient Representative Nurse Anesthetist Recovery Room Nurse Physician

V. THE MEANING OF ABORTION WORK TO PROVIDERS

> *"I always wanted to be some sort of agent of change, that's how I view myself---like I'm this person who is put into your life for this very moment, and I've been able to support this process for you and help get you to the point that you want to be, and then I step out of your life, because I was the bridge that helped you at that time. That's always what I've wanted to do and that's what I feel like I do here."*
>
> - Ms. Doss, Social Worker, Freestanding Clinic A

The responsibilities of abortion work and the meaning derived from it were unique to each participant, but they generally felt very proud and fulfilled by their work. Participants' collective understanding of their work's meaning can be described in terms of their perspectives on (A) how being involved in abortion care fit with participants' identities; (B) how abortion work made participants feel; and (C) what participants considered to be the defining features of their work.

In the subsequent sections, I will use the word "participants" or work-role specific terms like "physicians" to refer to findings from this study, in particular. "Providers" will be used to assert something that is true for all providers, including those not involved in this study.

A. Abortion care and provider identities: Who here is an "abortion provider"?

In the absence of a political or cultural consensus on what abortion really is or why it matters, choices in language have especially important consequences. Use of certain terms and references signal group membership (i.e. pro- or anti-choice), generational differences (i.e. "we're not going back to the back alleys"), degree of clinical experience with abortion and level of comfort with discussing abortion. Analyzing participants' deliberate choices and reactions to abortion terminology allowed me to explore their conceptualization of their work. When encouraged to articulate why

particular terms resonate with them while others did not, participants moved beyond generalizations about abortion work and identified the specific ideas and experiences that were meaningful to them. To explore how their work fits into their sense of self, I asked all participants in this study how they felt about the term "abortion provider" as applied to each of them, personally.

Physicians and non-physicians alike associated the word "abortion provider" predominantly with the physicians who perform surgical abortions, but most non-physicians were not opposed to or offended by the idea of being an "abortion provider". Many participants advocated a more encompassing use of the term as they analyzed the distribution of labor in an abortion procedure, during which medical assistants and nurses often spend much more time with the patient than does the physician. As they considered the term and its implications, participants sometimes surprised themselves by concluding that medical assistants and nurses may be as much of an "abortion provider" as physicians.

> "*I think in a narrow way, I guess I think of it as the doctor or the person that's actually doing the suction curettage procedure. But since you're asking the question, it does make me realize that you know, a large portion of what we do [at the clinic], you know, physicians are just doing the small piece of the actual, you know, five minute suction curettage.*"
>
> - Dr. Eisler, Freestanding Clinic B

> "*I would say that term does apply to me, because I'm pretty much involved from beginning to end, you know. I do call patients to make appointments, I do address whatever questions they have regarding the type of abortion they're having. I do talk to them about financial things, and once they get here I do vital them. Then I assist in their procedure, and then I discharge them. So I'm like, very involved. The only thing I don't do is I don't actually do the actual physical abortion. I'm just in the room assisting, you know but other than that, that's the only thing I don't do. Everything else, I do.*"
>
> - Ms. De Silva, Medical Assistant, Hospital Clinic A

Two nurses, Nurse Merrick from Freestanding Clinic B and Nurse Lopez from Freestanding Clinic A, rejected outright the label of "abortion provider" as applied to them. Each explained that she did not think of herself as an "abortion provider", emphasizing that her role is to be "at the head of the bed, not the foot of the bed" or that she is "not the one who actually does [the abortion]."

In contrast to the many participants who felt that the term was accurate if incomplete in light of their many responsibilities, Nurses Merrick and Lopez did not feel that the term was appropriate at all for their roles and were emphatic about distancing themselves from it. Nurse Merrick pointed out that the term invites stigmatization that she did not feel her role in abortion care merited, so she preferred to avoid it altogether. This categorical rejection of being identified as an "abortion provider" was a sharp contrast to other participants. Most who did not typically think of themselves as an "abortion provider" treated the prompt to do so as a sort of thought experiment where they tried on the term and identified ways in which it was true or not. Nurses Merrick and Lopez's refusal to even consider the term as applicable for themselves suggested that their desire to distance themselves from "the one who actually does [the abortion]" was not just to avoid stigmatization. They appeared to personally rely on this separation from abortion in order to feel that their work was represented fairly.

In contrast, many participants felt being an "abortion provider" was a badge of honor. Some wanted to make it sound more compassion-centric but still abortion-explicit, offering alternatives such as "abortion caregiver" or "abortion doctor." Ms. Murray, a medical assistant at Freestanding Clinic A, felt flattered and inspired by the term in reference to herself, but also unworthy of the label:

> "*This maybe sounds weird, but I feel like [being called an 'abortion provider'] is something to which I would aspire and at this point, I feel like a small peon in the journey to providing abortion. So I mean, if everybody would want to call me that, as long as they are being nice about it and not denigrating me, I would definitely take it.*"

An important caveat to Ms. Murray's enthusiasm for being called an "abortion provider" was that it not be used against her. Abortion providers are by no means the only, and usually not even the most vocal, group of people who shape the public perception of what it means to be an abortion provider. Ideas from people outside the field regularly contradict but still preempt abortion providers' realities.

> *"Working in this field, it doesn't matter what you do in that office, anyone that doesn't like what you do, you're still the enemy. Even though I am not actually the one doing D & Es and D & Cs, any of the 'actual' abortion providers, if you will, that's still 'what I do'…they see all of us as the same, you know I'm just as 'bad' as the physician, just the fact that I work there. Even the woman that's at the front desk! It doesn't matter. I could see [physicians] having an issue with the term, "abortion provider" being applied to my role, but I mean I'm still called a murderer or whatever. So yeah, I think it's appropriate."*
>
> - Ms. Mulroy, Patient Representative, Freestanding Clinic B

All participants expressed frustration with the fact that the nuances to abortion care were lost on those who oppose it. In Ms. Mulroy's case, identifying as an "abortion provider" had as much to do with deriding the ignorance of anti-choice advocates as it did with demonstrating solidarity with her colleagues.

Monolithic views of abortion providers were not limited to those who oppose abortion; participants spoke at length about how anyone not involved in abortion care did not really understand the work that they do or why they do it. Presumably, providers would not subject themselves to the judgment and misunderstanding that abortion care invites if the benefits of this work did not outweigh the costs. Exploring what

participants got out of abortion care revealed important facets of the meaning of abortion care to providers.

B. Pride, fulfillment and the hidden implications of caring: How abortion work makes providers feel

Abortion providers are caregivers. Their work requires their time, energy and intellect in addition to more visceral demands like assuaging patients' fears, acknowledging hard truths, bonding with patients or being frustrated with them. Receiving a paycheck (often a meager one in abortion care) does not make up for those debts of self. Helping someone in need has to be sufficiently satisfying in its own right to justify what it requires of caregivers. This was abundantly true for the experiences of participants in this study. The satisfaction that they got from their work was directly linked to giving of themselves in order to connect with patients and take care of them. Participants' overall sense of pride and fulfillment in their work resulted from a commingling of: (1) their sense of responsibility to patients; (2) their sense of self; and (3) their sense of purpose and mission where abortion is concerned (Figure 3).

1. Responsibility to patients

Like caregivers of all types, abortion providers prioritize the needs of their patients above their own physical, mental, and emotional exhaustion. Abortion patients' needs are often shaped by stigmatization of abortion, so participants were sometimes responsible for helping patients feel okay about their decision to have an abortion.

> *"When I think of the patients that I meet, who are terrified when they come in---and this has been throughout all the years that I've worked in abortion services---they come in, they're so shut down and then you get them on that exam table and you're in a one-on-one with them and that whole barrier breaks down if they have*

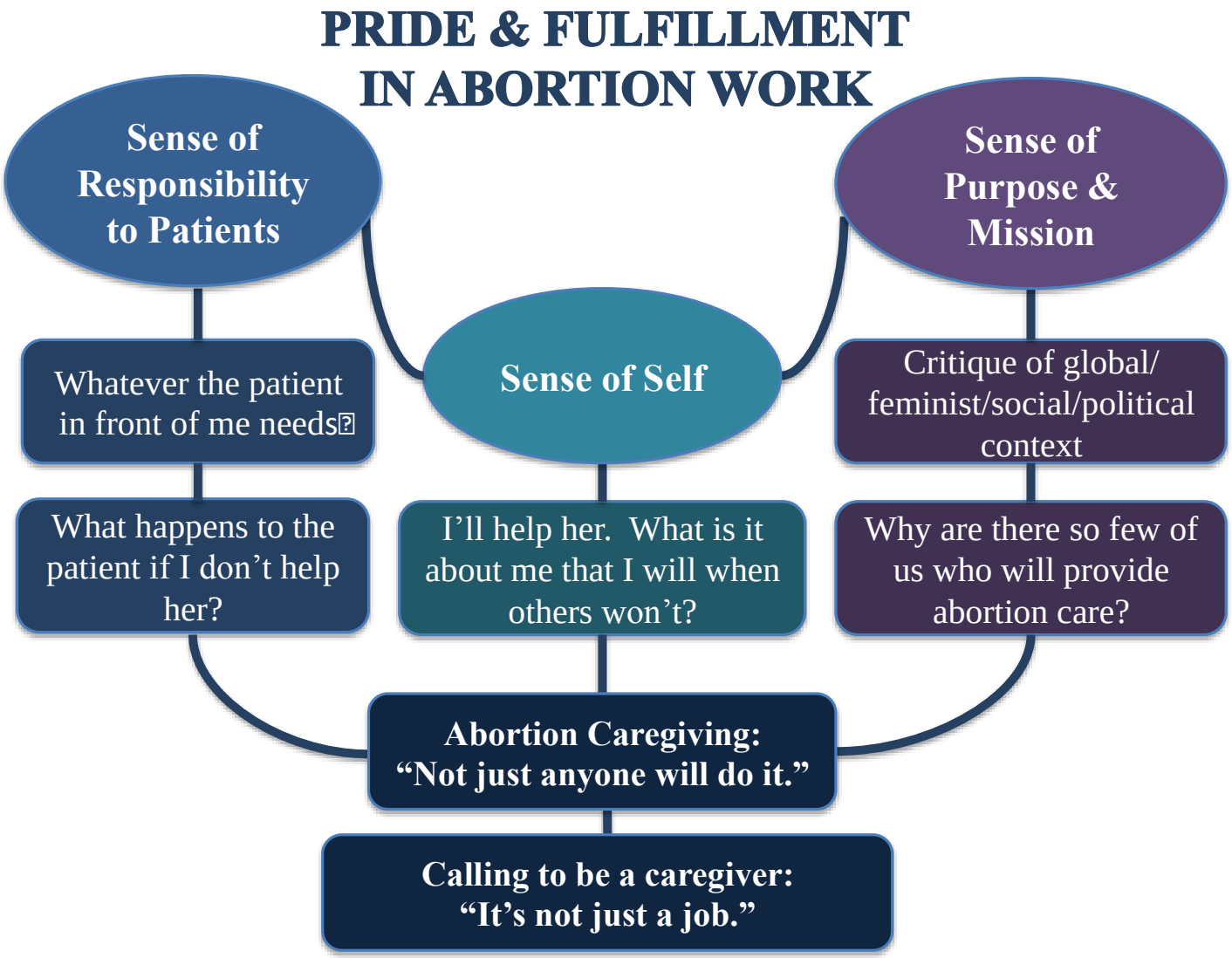

Figure 3: Pathways to pride and fulfillment in abortion work for participants.

> *that pissed off, mad at the world thing. It's like 'look, this is what's going on.' And there may be tears, there may be expression of anger, regardless, I'm there with that woman, one-on-one. I'm listening to her, letting her know that this is okay, that we're going to take care of her, that no matter what her friends think, it doesn't matter. Nobody is walking in her shoes but her. And that's the passion, that's my gratifying moment, every single time that I get to talk with these patients and give them my support and my love, hugs, whatever they need. To let them know that this is okay. It's really okay. And between her and I, we make it okay."*
>
> - Nurse Kerr, Hospital Clinic B

As her description shows, Nurse Kerr is very generous and open with patients, with whatever emotional support they need. The gratification that she got out of helping patients "feel okay" about their decision was equally as satisfying as her empathy for those patients would have been heart-breaking, if she could not help them. With each other, she and her patients are able to "make it okay."

2. <u>Sense of self</u>

All healthcare professionals are vulnerable to burnout, given the many demands of their work. Most are lauded for their efforts on behalf of their patients but this is rarely the case for abortion providers. While public appreciation may not make up for the physical and emotional tolls of caregiving, it is vastly preferable to the judgment, harassment and outright vitriol that meet abortion providers when *they* take care of *their* patients. Abortion stigma entails a doubling down on the demands of being a caregiver for those involved in abortion care. In addition to their caregiving responsibilities, providers have to have a strong sense of self where their work is concerned.

> "*Doing this job, you have to really know yourself and know where you stand on these issues, because if you don't, the pressure is crippling. There's too much against you to not be strong in your convictions."*
>
> - Nurse Kirby, Nurse Practitioner, Freestanding Clinic A

The fact that not just anyone could or would take care of abortion patients gave participants a unique pride in their work and motivation to counter stigmatized notions

of abortion care through their own examples. Many participants indicated that abortion care and helping those who "really, really need" it produced an "alignment" between the mission of their work and their sense of who they are and what matters to them.

> *"I think that it just gives me a sense of calm knowing that I'm doing something about a situation that otherwise drives me so nuts and I'm doing something in a field that so many people won't do…it makes me feel a little stronger or more passionate that I'm providing a service that other people are, I don't know, they wimp out on or something…it makes me feel more in line with my convictions. Even though it's brought up a lot of moral questions and stress, it also helps me be more in line with what I originally thought that I wanted to do…even in high school when people talked about contraception or abortion or whatever, I would get all riled up and I'd want to do something. So the idea, now, of being able to enact some sort of actual difference in that field and act on an emotion that I've felt for my entire life, it just it helps me become a little more in line with the person that I want to be."*
>
> - Dr. Kendrick, Hospital Clinic B

Being an abortion provider can bring providers a "sense of calm", making them feel motivated, productive and strong in the face of opposition to abortion. That very opposition, however, also means that they are regularly called upon to articulate to themselves and others why their work is important, good and necessary.

Dr. Kendrick was early in her career as an abortion provider and was having a hard time with aspects of abortion that she did not anticipate that she would struggle with, prior to her family planning fellowship. After a particularly difficult but interesting day working a weekend shift at a freestanding abortion clinic, Dr. Kendrick wanted to do what she always did when she had something new or exciting to report: talk to her mom and her boyfriend about it. She realized she did not feel comfortable talking with her loved ones about her day providing abortions and a cascade of questions ensued, all of which are very normal and common to abortion-providing physicians, particularly early in their careers. Dr. Kendrick's questions included: "If it's not bad, why do I feel bad

talking about it? Am I actually uncomfortable, or am I just tired? If I had delivered babies all day, I would have had no problem talking to my mom or my boyfriend about that---am I protecting them or protecting myself from talking about a day full of abortions?"

These could be hard questions to ask yourself if, like Dr. Kendrick, you felt your sense of self was tied to a sense of mission where abortion is concerned. Understanding why abortion is stigmatized entails asking why so few people will provide abortions---what is it about abortion that is so objectionable to so many? Understanding one's own compulsion to provide abortion care means exploring "what it is about me that I am willing to do it when others are not?"

These questions are more subtle functions of abortion stigma than public conflicts about abortion, but are no less taxing on providers. Exploring personal beliefs and abstract ethical ideas in service of one's job can be burdensome, but it affords providers the opportunity to live out their convictions on a daily basis. Through abortion work, providers are able to connect who they think they are with what they feel is important.

> *"I work until midnight on Friday night [at a hospital where abortions are not provided] and then I have to be at work at Lakeland Women's at eight in the morning on Saturdays, so I drag my butt out of bed and it sucks and I'm like 'oh my God, why do I work here, I'm up so early, this is the Saturday I could have had off!' And then the minute I step in Freestanding Clinic A I'm like, I'm here, I'm so happy, I love everybody here, like 'what can I do to help' and it's just, it just makes me feel complete, really. If I just worked at the hospital, in that crazy little rich white suburb, I would go insane. I feel like abortion connects me to the work that I need to do, so that's what I need to do with my life."*
>
> - Ms. Doss, Social Worker, Freestanding Clinic A

3. <u>Sense of purpose and mission</u>

Providers' commitment to abortion as a mission met with opposition is the third component of their pride and fulfillment in abortion work. Experience with anti-choice advocates and awareness of abortion as a contentious political issue added a "knight in shining armor" dimension to participants' caregiving.

> "*Well, I wouldn't have to deal with protestors everyday if I didn't work here…I wouldn't have to be as cognizant of things like security, safety, things like that. Part of me thinks that it might be boring honestly because I'm very, very invested in what I do and suppose I probably could get that elsewhere but it doesn't have the same type of weight, as far as my investment in it…there is a different charge. Abortion services polarize people and I get to be an advocate. I get to be, well this is kind of a little bit ridiculous, but I get to be the knight in shining armor and I get to stand up for what I think is right and I don't even have to be in front of anyone to do it. I get to be behind the scenes but still advocating for change. So, parts of it would be better [if I had a job uninvolved with abortion], I suppose you could say, but I don't know how much weight it would have anymore. Because I feel like what I do has a lot of weight, whereas if I was just running a call center that, I don't know, was like shipping out orders for auto parts or something like that, who cares*?"
>
> - Ms. Lappley, Call Center Manager, Freestanding Clinic A

Every participant had personal experience with stigmatization of themselves, their patients and their work. The impact of these situations on participants' lives were sometimes relatively innocuous, like when Dr. Schaeffer arrived at Freestanding Clinic B for a weekend shift and protesters screamed at her, "they murder babies in there! They'll kill your baby!" Dr. Schaeffer, who is young and who, like all providers in freestanding clinics, cannot wear scrubs to work for her own safety, probably looked like many of Freestanding Clinic B patients. On this particular day, she rolled her eyes and gestured to the two large boxes of Krispy Kreme donuts she was bringing to share with the staff and drily asked the protesters, "Do you honestly think I'm bringing two dozen donuts to my abortion?"

Most of the time, however, the impact of anti-abortion advocates cannot be diffused by sarcastically deriding protesters (although that is a big part of providers' commiseration with each other). Participants described keeping their work secret from family members, being physically attacked, experiencing professional discrimination in the larger medical field, being sued for malpractice and being stalked by members of anti-abortion groups, all because of their involvement in abortion care. This begged the question, how did they deal with antagonism regularly and remain steadfast in their commitment to their work?

> *"[The negativity] gets you more motivated…it's frustrating and it's like 'okay great, more legislation against abortion providers'…but it just makes it obvious what our challenges are and that we need to keep moving forward and not…not let it get us down, not let it accomplish what it's supposed to, which is intimidation, right? So it's actually more motivating. It's frustrating but motivating."*
>
> - Dr. Rostami, Hospital Clinic A

The persistence and organization of the anti-choice movement has drawn clear lines between "sides" where abortion is concerned. "Hysterectomy providers" or "cesarean section providers" do not exist in the public consciousness in the way that "abortion providers" do because there is no opposition to these aspects of women's reproductive healthcare. Opposition to abortion has made it so that abortion providers cannot exist as a loosely affiliated group of professionals within a particular field---to continue their work, they have had to bond together and demonstrate strong commitment to defense of their patients and their work. In this sense, it is no surprise that abortion providers expect antagonism, are frustrated by it, but ultimately feel even more committed to providing abortion care than if it were not stigmatized.

C. Defining features of abortion work: Utilitarian and advocate types' perspectives

All participants in this study cared deeply about their work and felt it was not "just a job like any other." The particular *aspect* of their work that participants felt most connected to differentiated thematically along "advocate" and "utilitarian" type lines, as identified by four distinguishing characteristics. These include: how participants felt about abortion in the context of their other responsibilities, how they thought they would feel upon leaving abortion work, the language that they used to describe choice and its implications, and perceptions of who is impacted by their work (Table III).

To verify that there were in fact two thematically different groups and then determine which group participants belonged to, I pulled all interview excerpts associated with codes relevant to the distinguishing characteristics and analyzed the interview content. This analysis confirmed that participants' perceptions of the defining features of their work cohered around utilitarian (n=8) and advocate (n=23) type subgroups. All physicians were advocate types but non-physicians were represented in both advocate and utilitarian type subgroups. The mix of utilitarian and advocate types also varied by clinic workgroup (Table IV). At Hospital Clinic A, non-physicians were utilitarian types and physicians were advocate types. At Hospital Clinic B, all participants were advocate types. At Freestanding Clinic A, just one participant, a nurse, was a utilitarian type. At Freestanding Clinic B two non-physicians were utilitarian types and a mix of physicians and non-physicians were advocate types.

TABLE III

CHARACTERISTICS OF UTILITARIAN AND ADVOCATE TYPES

Distinguishing Characteristic	Utilitarian Types (n=8)	Advocate Types (n=23)
Abortion in the context of other responsibilities	• Abortion does not loom larger than any other reproductive health responsibilities.	• Abortion is singularly important to perceptions of the meaning and importance of their work.

Views on ending involvement with abortion care	• Can imagine ending abortion work, doubt that they would miss it.
	• Cannot imagine being uninvolved in patient care.
	• Anticipate feeling incomplete if they were no longer a caregiver.
		• Cannot imagine leaving abortion work unless:
		  • Increased threat to safety
		  • Criminalization of abortion provision
		  • Retirement
		• Anticipate guilt, sadness, and boredom upon leaving abortion work.
		• Insist that they will always "stay involved somehow" with abortion.

Language used to describe choice and its implications	• Patient-centric language.
	• Individual patient-focused logic to justify the right to choose:
	  o "You never know what her reasons are, you're not in her shoes."
	• Less effusive supportive of abortion, specifically, than of the right to choose:
	  o "I probably wouldn't have one but I think it's good that there are safe ways to get an abortion."
		• Rights-centric language.
		• Choice as a feminist and political issue affecting expansive social groups (i.e. women, not any one particular woman and her decision).
		• Preemptive rejection of how many abortions is too many for one woman and good or bad reasons to choose abortion.
		• Refer to abortion opponents as "anti-choice" not "pro-life".

Perceptions of how and to whom their work is important	• Locate importance of their role in the interpersonal support they provide to patients.	• Perceive that their role is important in their immediate interactions with patients and as part of a social and political battle with radiating impact.

TABLE IV

UTILITARIAN AND ADVOCATE TYPES BY CLINIC AND WORK ROLE

Clinic	Participant	Work Role
Utilitarian Types (n=8)		
Hospital Clinic A (n=5)	Ms. Summer	Surgical Coordinator
	Ms. Bryant	Medical Assistant
	Ms. De Silva	Medical Assistant
	Ms. Banks	Social Worker
	Nurse Castillo	Nurse
Freestanding Clinic A (n=1)	Nurse Lopez	Nurse
Freestanding Clinic B (n=2)	Ms. Orlowski	Phone Admitter
	Nurse Merrick	Nurse Anesthetist
Advocate Types (n=23)		
Hospital Clinic A (n=3)	Dr. Francis	Physician
	Dr. Nydegger	Physician
	Dr. Rostami	Physician
Hospital Clinic B (n=5)	Nurse Kerr	Nurse
	Dr. Barnes	Physician
	Dr. Kendrick	Physician
	Dr. Schaeffer	Physician
	Dr. Campbell	Physician
Freestanding Clinic A (n=11)	Ms. Murray	Medical Assistant
	Ms. Duvall	Medical Assistant
	Ms. Lappley	Call Center Manager
	Ms. Doss	Social Worker
	Ms. Dougherty	Social Worker
	Nurse Kirby	Advanced Practice Nurse
	Nurse O'Hara	Advanced Practice Nurse
	Dr. Rouse	Physician
	Dr. Rivers	Physician
	Dr. Sullivan	Physician
	Dr. Simpson	Physician
Freestanding Clinic B (n=4)	Ms. Quinn	Patient Representative
	Ms. Mulroy	Patient Representative
	Nurse Dahl	Recovery Room Nurse
	Dr. Eisler	Physician

The fundamental difference between these advocate and utilitarian types was the role that abortion played in their overall sense of their work. For utilitarian types, abortion usually did not provide any unique contribution to their sense of pride and satisfaction in their work.

> "*It's just another procedure that we do, you know, as needed."*
> - Nurse Castillo, Utilitarian Type, Hospital Clinic A

While advocate types leaned into the controversy surrounding abortion, utilitarian types emphatically shifted focus away from the politicized, stigmatized aspects of their work, preferring to highlight their other responsibilities.

> *"I look at it as I'm an anesthesia provider. I never looked at [being involved in abortion care] like something that I can't do religiously or something that I can't do because in my heart it's wrong… I just look at it like I'm an anesthesia provider and that's what I'm here to do, to provide anesthetic."*
> - Nurse Merrick, Utilitarian Type, Nurse Anesthetist, Freestanding Clinic B

Advocate types usually did not spend any more time providing abortions than did utilitarian types, but abortion loomed much larger in their conceptualization of what their job was and why it was important. They were motivated to work in abortion care not despite but *because* of abortion stigma, and took great pride in the fact that they helped women when others would not.

> *"Maybe other people here just work here because like they just have a certification in medical assistance and they were hiring here. But I was like this is like my thing, you know---I took a pay cut and this is my charge…it makes me feel a little bit silly sometimes that this is like an extremely ideological thing for me but it is, yeah…I wanted to be, at least in some small way, in a position where I could help provide abortions. And I know that since I will never go to medical school and never be in the position to actually, like, be a medical provider, that this is about as close as I'm going to get to anything like an abortion provider."*
> - Ms. Murray, Advocate Type, Medical Assistant, Freestanding Clinic A

Advocate types were well versed in abortion's history of political jeopardy and uncertain future. Discussions of abortion access were often emotional and reflected gritty

commitment not just to personally providing abortion care but also to ensuring that abortions are accessible to all women who need them.

> *"We're providing a safe means of health care to women who are not dying because they're having abortions in the back alley. It's just, to me, it's that cut and dry, it's that black and white, there is no gray area. We were in the back alley a long time ago, we're not there now. We have safe means, you know, abortions are safer than giving birth. If you don't like it, don't do it. And quit giving hell to the people that work in abortion services, the doctors that provide that care, that do the procedures---people just need to stop. This is part of our given right to health. And we've come so far in health care but not when it comes to abortion services."*
>
> - Nurse Kerr, Advocate Type, Hospital Clinic B

Utilitarian types were less savvy than advocate types about the political and social history of abortion, but they were very clear on their commitment to choice. When explaining why stigmatization of abortion is harmful, advocate types tended to highlight the safety of abortion and women's rights to abortion as part of reproductive justice. By comparison, utilitarian types shied away from emphasizing abortion as a good or socially just resource, instead focusing on the importance of choice on principle and how on an individual basis, you "never know what she's going through." These explanations were usually couched in what utilitarian types imagined they, personally, would do "if I ever had to make that decision." Here is how one utilitarian type participant described the social importance of the right to choose:

> "*I mean, I'm pro-choice. I don't really follow politics that much, but I really just don't want some random person that I've never known in my life, that doesn't have anything to do with my life, get to say 'you can't do this' because of his beliefs, you know. Like why would that person---a 'him', especially, you know it's not even a woman, a lot of those politicians are men---why would he have a say in it? You know, but other than that, I really…it's more just that it's my job."*
>
> - Ms. De Silva, Utilitarian Type, Medical Assistant, Hospital Clinic A

In terms of pathways to pride and fulfillment in their work, utilitarian types tended to emphasize how their responsibility to their patients and their sense of self was

important, whereas advocate types tended to highlight how their sense of purpose and mission fit with their sense of self where abortion is concerned (Figure 4).

Abortion was so important to advocate types' ideas about their work that when asked to imagine how they would feel if they someday stopped being involved in abortion care, they often required clarification on the question, wondering if I was implying for the hypothetical scenario that they would have stopped because abortion became illegal. The idea of just quitting abortion care without political intervention requiring them to do so did not easily occur to them unprompted. Upon clarification that abortion was still legal in the hypothetical scenario, advocate types offered scenarios they thought would prompt them leaving abortion care including increased threats to their safety or the safety of their families, retirement or the criminalization of abortion provision. They reflected that regardless of the reason for ending involvement in abortion work, doing so would make them feel guilty, empty, sad, helpless and bored. Their consternation about hypothetically leaving abortion care was always capped by assertions that they would still "remain involved somehow."

> *"I don't think I'll ever feel that way again about any other job. You know, I've been doing this one thing for almost 10 years now and I'm really good at it. If you have a second trimester abortion, you want me taking care of you afterwards. And when I leave this job, I'm going to lose that whole thing, and I'll definitely feel a loss for that. The whole culture of abortion care is unique. It has this unique intensity about it because it's controversial, so you've got to know what you believe…I mean, if you're a nurse or medical assistant or whatever, you could be working wherever, you know, and you're working this particular place with these particular patients who are going through this particular thing and it creates something special, you know, that I don't expect to find anywhere else. I will always miss it. I will have to leave it eventually and I'll always miss it."*
>
> - Nurse Dahl, Advocate Type, Recovery Room Nurse, Freestanding Clinic B

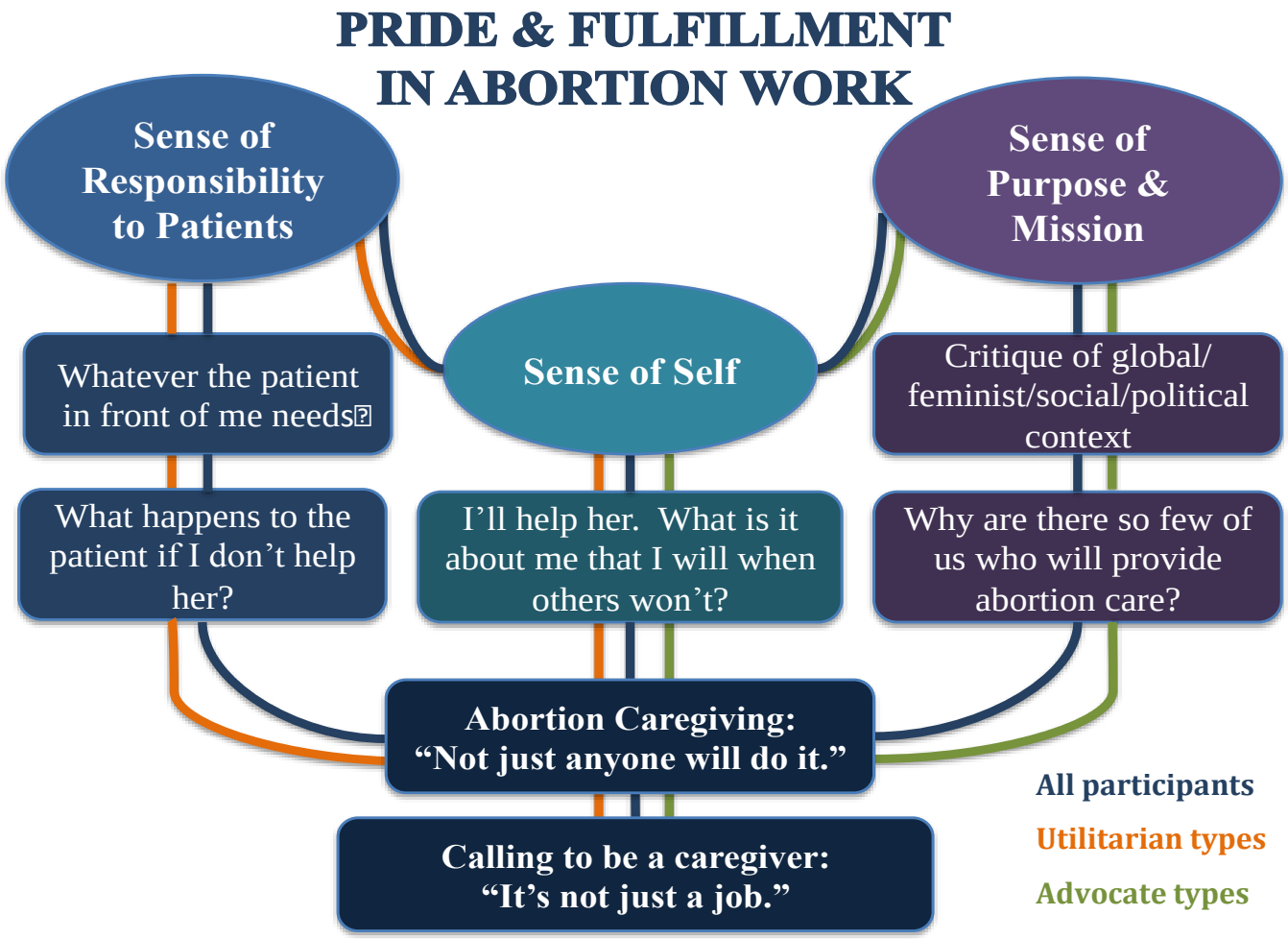

Figure 4: Typical pathways to pride and fulfillment in abortion work for utilitarian and advocate type providers.

Utilitarian types did not express distress at the idea of quitting abortion care, but could not fathom not being a caregiver. Like advocate types imagining how they'd feel upon leaving abortion care, utilitarian types indicated they would feel deeply unfulfilled if they were no longer involved in patient care.

A variety of work roles and clinic affiliations were represented in both utilitarian and advocate groups, and they were not entirely thematically discrete sets. Advocate types would occasionally say things that sounded utilitarian, and vice versa. For example, consider the following explanations from Ms. Bryant (utilitarian type) and Dr. Rostami (advocate type) about why choice is important. Both participants' descriptions follow two utilitarian trends on the subject of women's right to choose: (1) using individual patient-focused logic and their own personal backgrounds to explain the importance of choice; and (2) delineating how abortion is "better than the alternative" for specific women and specific alternatives. Ms. Bryant focused on her friend's dangerous attempt to induce an abortion on her own, and Dr. Rostami discussed the negative implications for families of not providing abortions to women who are not ready or wanting to continue a pregnancy. By comparison, stereotypical advocate descriptions of the importance of choice usually included more unqualified arguments rooted in collective feminist and rights-based goals.

> *"I mean, I'm not the judge, I just think other people shouldn't judge because they really don't know the story. Because I know from experience---not saying something that I experienced myself, but just growing up, I had a friend hiding [a pregnancy] from a parent and she almost died from trying different stuff to get rid of the baby. I just think depending on the situation, I think it's a good thing---I'm not saying it's a good thing that people get abortions because you know whatever, do what you're going to do, but it's a good thing that there are safe measures out there to do them and get rid of, you know, the baby, the pregnancy, if that's what you're trying to do, instead of going down a road of taking pills, going to places that's not legal to do them, stuff like that. So that's how I feel*

about it. I think it's just good that we have safe measures to do them now."
- Ms. Bryant, Utilitarian Type, Medical Assistant, Hospital Clinic A

"Before [becoming a parent] I was like we need to be supportive of women and their rights, and all that, but once you have a kid, you're like oh my God this is the hardest thing you could ever do and we chose to do this! [My husband and I] have resources, we want to do this, and we still feel like we're not doing a good enough job! I mean, that's one of these things like you can't imagine having a child and not…just, an undesired child is pretty much screwed. And so that result is just really sad to me. And me being a parent definitely had a big role in that."
- Dr. Rostami, Advocate Type, Hospital Clinic A

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D. Divergent Experiences with Stigmatization: Utilitarian and Advocate Types

Analyzing within- and across-group differences between utilitarian and advocate types helped sharpen my understanding of how stigma affected providers differentially. No physicians were represented in the utilitarian type group and every clinic had at least one utilitarian type participant with the exception of Hospital Clinic B. The Dirty Work (Ashforth & Kreiner, 1999) framework aligned better with utilitarian types' experiences with and management of stigmatization of their work, but did not fully explain either group's experiences with abortion provision stigma.

The Occupational/Workgroup Ideologies construct of Dirty Work proposes that workers reframe, refocus and recalibrate the stigmatized aspects of their work so that they feel good about it. When proposing this study, I speculated that this construct might be of limited applicability to abortion providers because it assumes that providers start with a negative view of their work and have to engage these ideological processes in order to feel good about it. In reality, many abortion providers start with very positive ideologies about the most stigmatized aspects of their work, rendering reframing, refocusing and recalibrating it irrelevant. This was abundantly true for advocate types.

> *"If abortion were ever mainstream, it would be hard to imagine I'd feel the same about doing my work because there is provably that advocacy piece, that you know, shooting for the underdog."*
>
> - Ms. Dougherty, Advocate Type, Social Worker, Freestanding Clinic A

Utilitarian types, on the other hand, described many instances of using Occupational/Workgroup Ideologies to legitimize their involvement in abortion work to themselves and others (Table V). This fit with other characteristics of utilitarian types, in that they were not enthusiastic about the most stigmatized aspect of their work (i.e. abortion) and preferred to think of themselves simply as caregivers who would provide whatever the patient in front of them needs.

TABLE V

UTILITARIAN TYPES' USE OF OCCUPATION/WORKGROUP IDEOLOGIES

Occupational/Workgroup Ideology & Definition	**Utilitarian Type Illustrative Quote**
Reframing: Changing the meaning of the stigmatized work.	*"They think it's about killing, and it's not."* - Ms. De Silva, Medical Assistant, Hospital Clinic A
Refocusing: Shifting focus to less stigmatized aspects of the work.	*"Abortion is only like 4% of what we do here."* - Nurse Lopez, Freestanding Clinic A
Recalibrating: Changing the magnitude/valence of the stigmatized aspects of the work.	*"[The procedure] isn't hours…it's only like 4 or 5 minutes, really."* - Nurse Castillo, Hospital Clinic A

Results of the APSS indicated that utilitarian types experienced greater stigmatization than advocate types on each of the five subscale domains as well as overall APSS composite scores (Table VI). In fact, the discrepancy between utilitarian and advocate types' average composite scores was the largest difference of any two groups within the sample compared to one another (e.g. physicians vs. non-physicians, freestanding vs. hospital based participants). The coherence between the qualitative, thematic descriptions of utilitarian and advocate types and the quantitative scaled assessments of each group's experiences with stigmatization supports the validity of these groups as distinct, importantly different subgroups within the sample.

TABLE VI

ABORTION PROVIDER STIGMATIZATION SCALE SCORES FOR UTILITARIAN AND ADVOCATE TYPES

APSS Sub- and Composite Scales	**Utilitarian Types (n=7)**	**Advocate Types (n=24)**
Disclosure Mgmt. Subscale Group Avg.	30.86	24.83
Internal States Subscale Group Avg.	18.57	17.21
Judgment Subscale Group Avg.	18.71	16.29
Social Support Subscale Group Avg.	10.71	7.88
Discrimination Subscale Group Avg.	5.29	6.17
Composite Group Avg., Range	84.14, (71 – 111)	72.38, (50 – 97)

Utilitarian types' higher APSS scores and greater utilization of reframing, recalibrating and refocusing the stigmatized aspects suggests that, as a group, utilitarian types felt more stigmatized than advocate types. Advocate types saw themselves as part of a mission or a "side" in a fight that had historic and political dimensions, shaping healthcare for women and our collective understanding of the role and rights of women in society. It is no wonder that conceptualizing their work this way would protect advocate types from being harmed by stigma---it starts with an assumption of opposition to their cause, is equal parts grandiose and arguably true, and implies the support of a whole movement behind each provider. Confronted with overt, direct stigmatization, advocate types might assert the social importance of abortion or summarily dismiss the stigmatizing viewpoint as ignorant and narrow-minded. By comparison, utilitarian types might be more likely to rely on their self-defined truths of their work, like explaining that they are just trying to take care of their patient, whatever she needs, or that you never know what someone else is going through. "You are wrong, sexist, ignorant and politically aligned with fear-mongers" is a very different tool to at your disposal than, "I'm doing my job" when confronting judgment. In this sense, utilitarian types' greater experience with stigmatization is understandable.

All participants, irrespective of utilitarian or advocate group designation, were committed to providing excellent patient care and to protecting women's right to access abortion services. And all participants experienced stigmatization of their work.

VI. IMPACT OF STIGMA ON ALL PARTICIPANTS

> *"You're carrying the divisions that exist in our country in your life, in your person. We're just very divided and that means I'm either a hero or a devil, depending on what you already believe. It doesn't really have to do with me, personally. It's about this much bigger divide."*
>
> - Nurse Dahl, Advocate Type, Recovery Room Nurse, Freestanding Clinic B

An aim of this study was to explore stigmatization of abortion providers and gain a nuanced picture of how it affects people differently and what type of support is most meaningful to a diverse group of providers. Some themes were unique to particular clinics, clinic settings or work roles, but others were common to all participants.

Themes that participants explicitly identified as evidence of stigmatization in their lives included strongly felt vicarious stigma on behalf of patients and managing disclosure of work role details to others. Implicit themes of stigma that affected all participants included a sense of aloneness and being misunderstood, and within-group discomfort and divisions regarding "who sees what" in terms of fetal tissue and the abortion procedure.

A. <u>Vicarious Stigmatization on Behalf of Patients</u>

> *"Abortion is so demonized by some people that women who have abortions feel like they can't tell people. They feel like bad people because they're having an abortion. And I don't think abortion doctors feel like bad people because we're abortion doctors… like I don't get emotional about it, for the most part, it's not internal. The stigma for patients is much deeper and more complex."*
>
> - Dr. Rouse, Advocate Type, Freestanding Clinic A

All participants were asked to explain how stigmatization of abortion work affects them, and why stigmatization of abortion matters. The effect of abortion stigma on patients was central to all of these discussions, as it was in Dr. Rouse's swift dismissal of her own stigmatization relative to that of patients. In addition to the sympathy that they felt for the shame and silencing of patients, participants expressed outrage, frustration and

exasperation on patients' behalf. This was particularly true when describing harassment from protestors.

> *"We have this one protestor, I can't stand her, she drives me nuts. She gets way too close to our building and every time we get close to calling the cops she ends up---it's like she can read our fricking minds---she ends up disappearing…when you walk outside all you hear is, 'they kill babies in there, don't go in there, they kill babies in there!' And I mean, these women are walking past you everyday, like, shut the fuck up. Like, what are you doing, you know? And then these women come in here crying because if they're not educated about it, or if they're not sure of their choice and then they have this woman screaming that when they're coming in…if I can turn that moment around for that woman, then that sustains me. If I can be that person who has changed somebody's mind about abortion or if I can normalize it for a woman who has never agreed with abortion but if I can validate her feelings and give her the clear understanding that she's making the best choice for herself at this time, and she can take that and [have it] resonate a little bit in the midst of her family telling her that she sucks, you know? Then I'm successful. Then I've done something helpful for that person and that keeps me going.*
>
> - Ms. Doss, Advocate Type, Social Worker, Freestanding Clinic A

Ms. Doss' description of these situations is representative of many participants' responses (particularly advocate types), in terms of her sympathy for patients and anger at those who overtly stigmatize them. However, nothing compared to participants' frustration and sadness about instances in which patients themselves held deeply stigmatized ideas about abortion.

Sometimes patients expressed surprise that participants and other abortion providers were being nice to them, or that the clinic facilities were clean and professional. Other times, patients would assert that they do not "believe in abortion" or ask participants if God would punish them for having an abortion. Participants were confident in the morality of deciding to terminate a pregnancy and the right of every woman to make that decision for herself, but fundamentally, they are caregivers and patients' self-judgment for their decision was heartbreaking for participants. They knew

very well how complex and embedded threads of abortion stigma can be and did anything they could to help their patients come to peace with their decision on their own terms.

> *"I've had countless women say 'I never agreed with abortion.' And there they are on the table. It's like you never do, until this happens. And for whatever reason, this is where you're at. 'I don't believe in it, though.' Well, maybe you do because you're here and it's okay. It makes me feel bad for them that internally, this is what they're thinking and putting themselves through. I'm always going to feel bad for them and I'm always going to encourage them that yes, you are here, things change, and you never know until you're in this situation. I always give that encouragement and that message, absolutely."*
>
> - Nurse Kerr, Advocate Type, Hospital Clinic B

> *"I try to create an atmosphere where people don't feel ashamed of whatever it is they're feeling…if somebody says, 'I'm going to hell', I'm not bashful about saying, 'I don't believe that.' Or if somebody asks me, you know, 'do you think God will forgive me for doing this?' I say, 'I know God will forgive you.' Now, I don't even think women need to be forgiven for having abortions, but if my patient is using that language, I'll mirror it."*
>
> - Nurse Dahl, Advocate Type, Recovery Room Nurse, Freestanding Clinic B

Like Nurses Kerr and Dahl, most participants were generous, granting patients space to voice things that, out of anyone else's mouth, might be dismissed as anti-abortion rhetoric. In interactions between patients and participants, all patient concerns were treated as valid and whenever patients' internalized stigma presented as denigration of abortion work, participants took it in stride.

Dr. Schaeffer stood out among participants as particularly unbothered by aspects of abortion stigma that were problematic for others. She was annoyed and sometimes amused, but not really distressed by protesters for her own sake and described being okay with making people uncomfortable when she disclosed that she was an abortion provider. For many early career abortion physicians, the abortion procedure and involvement with fetal tissue can produce some difficult emotions or challenges to values, and Dr. Schaeffer seemed to manage these with less effort than her peers. Given her rational,

apparently invulnerable approach to abortion care, her response to being stigmatized by her patients was significant:

> *"I find the hardest is when my patients stigmatize me. It's really hard when you come in, you sit down with a woman who is having an abortion for whatever reason---medical fetal indication, whatever---and she says something like 'I can't believe you do this. I mean, how can you do this day after day, all day?' And it's really hard because I think this is when it, like, hits you most---when your patient who you're taking care of and doing the best you can for her in this very, very difficult situation. And I mean, honestly, I just don't really know what to say to that because part of me is like, 'well you're here, and I'm taking care of you, and it is hard for both of us in that sense, but I guess someone has to do it. You need my services right now and this is why I'm here….I can chalk it up to ignorance or narrow-mindedness when it's my friends or it's my relatives, or whoever, people on the street. It's really hard when it's your patient."*
>
> - Dr. Schaeffer, Advocate Type, Hospital Clinic B

This response was actually very consistent with Dr. Schaeffer's measured, unflappable approach to managing stigma. She seemed to have accepted that she would be maligned because of her work and that there was little she could do about that, but the unfairness of that situation was made tolerable for her by knowing that she provides an important service for women. When her patients disrupted that narrative by exemplifying the "ignorance or narrow-mindedness" she expected from loved ones or people on the street, Dr. Schaeffer felt the effects of stigma that her colleagues reported feeling in so many other situations. The reward she anticipated for regularly confronting stigma was that her patients, if no one else, understood why providing abortion is important and good. Unfortunately, stigmatization of abortion is so pervasive that this modest expectation cannot always be met.

B. Selective Disclosure of Abortion Work: "It's the silencing that really angers me."

> *"My other ob/gyn friends don't have to do self-censor. My internal medicine friends don't have to hide the fact that they're cardiologists. But I spend a very*

> *large chunk of the day doing clinical work that I can't really talk about. It's like Fight Club. First rule of Fight Club---you can't talk about Fight Club."*
>
> - Dr. Shaeffer, Advocate Type, Hospital Clinic B

To avoid uncomfortable or unsafe situations, abortion providers selectively disclose information about their work to others. This is referred to as "disclosure management" and was the main strategy participants used to deal with stigmatization. They described how they would "size people up" and determine how much they were willing to share about their work based on their assessment of how the person might respond. Criteria that participants took into account in sizing people up included gender, profession, age, apparent political leanings, and their relationship to the person. Family members of participants' partners were frequently cited as the type of people with whom participants were very cautious about disclosure of abortion work. Participants wanted to be forthright and nurture good relationships with their partners' families, but also had many experiences with harsh judgment and being reduced to being only an abortion provider in others' eyes, once that information is shared.

> *"Okay, here is an example---I dated this guy last year, we went to meet his family for Thanksgiving---lovely family, love them, they're great. But before we were going there, he was talking about how his niece is gay and he was mad at his sister for thinking her daughter is going to hell. She loves her daughter but she's a Christian and has fundamental problems with this, and I had to be like, 'I'm sorry, but you're bringing a Jewish abortion provider to Thanksgiving. Do we need to rethink this plan?'"*
>
> - Dr. Schaeffer, Advocate Type, Hospital Clinic B

Dr. Schaeffer was amused by her boyfriend's apparent obliviousness to the fact that that some people vilify her work, and that his family members were stereotypical of people who are often most stigmatizing of abortion providers. That obliviousness is a privilege not granted to abortion providers, who are constantly made aware of abortion stigma specifically through the need to manage disclosure of their work. Complying with

this need upset participants, as being silent about their work carried the unintended connotation of being ashamed of it.

> *"I don't like not telling people. It's what I do, it's who I am. I feel stigmatized, you know, I feel like everybody else can say what they do. I mean, police officers tell everybody what they do and sometimes they're in controversy, you know? I don't know…it's just everyone is allowed to say what they do for a living and I'm like, 'can I tell this person?' So I don't like that and I sometimes rebel against it by telling lots of people, but then it will backfire on me. Like I told this guy who lives in our neighborhood, and you could just see it really kind of stressed him out, and then I felt bad. I don't want to stress people out. But that's not fair. Why does my job have to stress you out?"*
>
> - Dr. Rouse, Advocate Type, Freestanding Clinic A

Participants felt that they were faced with two equally imperfect, basically unfair options. They could be "out" as a provider, risk stigmatization from others and hopefully help normalize abortion provision through their openness and embracement of that role. Alternatively, they could hide some aspects of their work, avoid some overt stigmatization and sometimes feel guilty about not being a "better advocate" for abortion. Participants felt that in addition to providing abortion care when so many have refused to do it, they were also expected to publicly advocate for abortion and their profession by being "out".

> *"The security concerns of not being too public about being a provider, that plays into my decisions [about what to disclose about work]. And being public or not is a big deal in my job. There are people that would really like for me to be public---you know, marketing people and public relations and policy people and my boss, you know, she would really like for me to be out there…being the medical voice for our organization, and there is just a lot of risk associated with that."*
>
> - Dr. Simpson, Advocate Type, Freestanding Clinic A

Unlike other providers, Nurse Dahl rejected the expectations of providers to be "out" not because she felt that responsibility was unfair or overly burdensome, but because she believed being "out" was pointless in terms of changing others' perceptions of abortion providers. She weighed the merits of careful disclosure management against

what she felt that being "out" could reasonably achieve, in terms of people's potential to be "converted":

> *"I live in two worlds…either I'm around people who think what I do is great, or I'm around people who don't know what I do. So, that's how I make an end run around stigma in my personal life…I just don't think anyone is going to be converted…You can be 'out' as a provider on principle, you know, like 'I'm going to fly my flag' kind of approach but I don't think anyone is going to be converted. Just like I'm not going to be converted. I will never be converted."*
>
> - Nurse Dahl, Advocate Type, Recovery Room Nurse, Freestanding Clinic B

Most participants felt guilty or conflicted about selectively disclosing information about their work. They believed that abortion provision is a good thing and that in an ideal world, all abortion providers should be able to state their occupations "loudly and proudly". Only Nurse Dahl explicitly made the distinction of what being "out" can achieve in practice versus on principle, and her point is valid.

It is very unlikely that if all providers were open about their work that anti-choice advocates would be converted. In absence of something approximating this sort of change in abortion stigma, it is unfair to ask providers to deny themselves the right to make their lives outside work a bit more safe and comfortable. The expectation for providers to be "out" would be more reasonable if pro-choice advocates were similarly "out" in all contexts and explicitly supportive of abortion providers, not just abortion. This is not currently the case. As a result, participants described feeling alone and misunderstood, talked about but not heard, silenced by others and self-censored for their own protection.

C. Condemners, Supporters and Abortion Providers: Feeling Alone and Misunderstood in Abortion Work

> *"The extent to which people who know nothing about pregnancy have an opinion about abortion is funny. And dangerous."*
>
> - Dr. Campbell, Advocate Type, Hospital Clinic B

Ashforth and Kreiner's theory of Dirty Work (1999) proposes that stigmatized workers will engage processes of "social weighting" to manage stigmatization of their work. These processes include condemning the opinions of those who oppose the stigmatized work while revering the opinions of those who support their work.

Study participants denigrated and dismissed the ideas of anti-choice advocates as ignorant, misogynistic, irrational and harmful, and appreciated expressions of gratitude for their work from pro-choice advocates and patients. Ultimately, however, the support or condemnation from people outside the field did not matter greatly to participants. They accepted that opposition to their work would be constant and enthusiastic, but were adamant that it would not deter them from their ideological or practical commitments to abortion. Support for abortion work was "nice", in their view, but they questioned the extent to which the type of "support" they received from pro-choice advocates was actually supportive.

> *"Stigma is very good at shutting people up and once supportive people are shut up effectively, that's how all of [these abortion restrictions] get slammed through. So it does make me mad that pro-choice people have allowed stigma to impact their ability to speak out…I mean we know from all sorts of things that happen in the world that people's rights get taken away, bad things happen when people are silent and don't speak up so that…that makes me really mad. I get really angry… So when people say 'thank you for what you do', I'm like well I don't need a thank you, I need you to have your elevator speech, to, in the day to day conversation, you know, you don't have to get into arguments with people, but I*

> *think it's important for people who do support abortion as a moral good to say 'well, this is my position' and to not hide from it."*
>
> - Ms. Dougherty, Advocate Type, Social Worker, Freestanding Clinic A

I was initially surprised by how little the opinions of pro-choice allies mattered to participants, probably because I like to believe that my support for providers is meaningful to them and shapes outcomes where abortion access and stigmatization is concerned. But I understand why providers may not be particularly invested in approbation for their work. Support for abortion is sometimes scarce and is regularly drowned out by opposition to abortion. If abortion providers were dependent on public gratitude for their work, abortion would have already become obsolete. Also, abortion providers are professionals and understand better than anyone the difference between "being pro-choice" and working every day to make abortion accessible. Often, "support" for abortion really comes down to a "loose political affiliation" that may not be any better informed than views opposing abortion.

> *"I think that people who have thought it out, people who have been challenged, and have asked the right questions about abortion have a much harder time sustaining an anti-choice point of view. If you simply use the words 'pro-choice' and, I hate saying it, but 'pro-life', then you will have people answer questions a certain way that may speak to their affiliations. But if you ask people, 'what would you do in this given clinical situation', then it gets much, much harder to sustain political positions that would eventually lead to women having to make choices that could endanger their health and their lives. So I don't for a minute think that people who are anti-choice and pro-choice are equally informed, but I think that there is a possibility that some people who are pro-choice are not well informed…I'm often interested in why [pro-choice advocates] consider it a positive thing and whether they have any further insights into abortion than people who view it negatively. It's interesting because sometimes neither opinion is particularly deeply held. It's a loose political affiliation that motivates people."*
>
> - Dr. Campbell, Advocate Type, Hospital Clinic B

Being pro-choice is an ideological stance that does not, in and of itself, do anything where abortion and abortion providers are concerned. For example, even as a

"loose political affiliation", being pro-choice does not necessarily mean that a "pro-choice" individual regularly votes to protect abortion access or pays attention to the political landscape of abortion at any given moment, both of which are private activities that can be done without conflict. So while supporting choice is a moral and socially good ideological position to hold, participants were frustrated by their allies' reluctance to act on their beliefs, particularly when difficult conversations about abortion arose.

When pro-choice advocates' support wavered upon confronting difficult truths about abortion, participants felt suddenly abandoned by their allies and alone in advocating for abortion as a social good. As participants described, the average pro-choice individual gets to enjoy their "loose political affiliation" and access to abortion while never fully confronting the details and implications of abortion work.

> "*You know how people in the military say like, 'I feel like people don't understand me, or don't know who I am, or understand what's going on with me because they don't know, they don't do what I do. They're enjoying living in this society where I help protect a small amount of their freedom, but they don't get it.'.... That's sort of how I feel."*
>
> - Dr. Eisler, Advocate Type, Hospital Clinic B

While they acknowledged that it could be isolating, participants described the imbalance in protecting, versus benefiting from, abortion access as "just the way things are" and they were mostly unbothered by it. However, when they felt that they could not share realities of their work without being judged harshly and perhaps abandoned by pro-choice people including their friends and family, participants felt hurt and indignant that acknowledging truths about abortion could so quickly unsettle supposed allies.

Involvement with the fetus was the aspect of abortion work that participants' pro-choice friends and loved ones "couldn't handle". While not dismissing the emotional or moral weight of this most stigmatized aspect of abortion work, participants felt betrayed

by the fact that their supporters had conveniently removed the role of the abortion provider from their support of abortion and choice. For abortion providing physicians, this point was particularly salient.

In the wake of the inflammatory Planned Parenthood videos, many participants were implicitly and explicitly asked by pro-choice friends and loved ones to justify the content and tone of the doctors' discussions of fetal parts. Physician participants did not feel that the doctors in the video had anything to apologize for, and the premise of their friends and loved ones' questions about the videos intimated that the work that they do on a daily basis is amoral, gross and better kept hidden.

> ***"****There are particular things that happen that make me feel very… fringe, you know? Very different from what everyone else is. Just, not the same. The most obvious thing that comes to mind is the Planned Parenthood videos. I watch those videos and I think like, that could very well be me having the exact same conversation and I don't think that the people in the video sound insensitive or callous---they're talking about fetal parts and I spend my entire day with fetal parts, examining them and whatever. So those types of situations make me feel like the vast majority of people have no concept of what I do all day."*
>
> - Dr. Eisler, Advocate Type, Freestanding Clinic B

This disconnect between peoples' ideas about your work and the reality of it would be difficult, particularly when you are very proud of your work. The fact that videos were made by an anti-abortion group added insult to injury in terms of the betrayal that participants felt from their supposed allies.

In addition to these very personal manifestations of the "aloneness" that they experienced, participants were also very moved by public ignorance to the implications of their work beyond the abortion procedure. For example, Planned Parenthood donates fetal tissue for use in stem cell research, which has provided many important medical advances and treatments for common diseases. Knowing this while witnessing public

backlash to doctors in the Planned Parenthood videos discussing donating tissue was infuriating for Dr. Eisler:

> *"You know, you enjoy living in a society where we value women and women's reproductive freedom. And yet you can be swayed by…by this secret video and swayed in such a way that you're suddenly going to say, 'oh Planned Parenthood is terrible.' That's when I want to sort of say, like, you would be the first person to sign up if you have a fetal anomaly or if you were raped, or whatever. And you enjoy that right. But you don't want to deal with the reality of what actually happens, so that pisses me off, like that really enraged me. And the people speaking out against the videos, they'd also be the first to line up for their Alzheimer's treatment, you know…so I guess it's not even just abortion stigma but it's the anti-science of it. Like, this is what you have to do for modern medicine to cure people, like this is what you need. I think that's what makes me the most angry about the stigma piece is that people don't think about the reality of the way things happen. They don't realize that for modern medicine to work and for you to enjoy this right to terminate your pregnancy when it has a medical problem, this is what has to happen. This is what's going on for you to have your Parkinson's treatment. The fetal tissue needs to go to research."*

Dr. Eisler is fully entitled to her outrage at willful ignorance about the "reality of the way things happen". However, many people, including providers, cultivate the collective practice of turning a blind eye to the most challenging realities of abortion, in service of protecting abortion. The highly politicized nature of abortion demands unequivocal, succinct messages that avoid grey area on the issue. In reality, direct, fully honest conversations about abortion can be difficult because there is in fact a lot of grey area in terms of what abortion is and what it means to patients and providers. In fact, one of the only points at which discussing abortion is black and white is whether you agree that women should get to choose whether to terminate or continue a pregnancy, or you do not. Pro-choice advocates sometimes gloss over discussion of the fetus because their priority is the pregnant woman and her choice, but also because the fetus can be conceptually and morally difficult. They worry (rightfully) that acknowledging nuance and complexity to abortion might be misconstrued as anti-choice sentiment instead of

critical thought. For participants, this concern extended to their discussions with abortion providers and non-abortion providers, alike, but they were particularly uncomfortable talking about abortion in mixed company.

> *"I tend to not really talk very graphically or exactly about what I do. When I talk about it, it's usually the patient's story or, you know, the fetal anomaly that we saw or something like that---even with other medical professionals. The only people I would talk about it a little bit more in detail, or I guess, differently, would be the people that are also abortion providers, so people who have done D and E's, seen D and E's, that kind of thing."*
>
> - Dr. Nydegger, Advocate Type, Hospital Clinic A

This sense that "outsiders" cannot really be trusted with detailed information about abortion was common to all participants, but especially to physicians. Their uneasiness with discussing abortion work freely was not rooted in actual mistrust of pro-choice allies, but awareness that being an abortion provider afforded them a particular frame for abortion that was unique. To transport information about the actual abortion procedure outside the context of abortion work would decontextualize it to a degree that could make it seem "creepy", in the words of one physician. Most participants felt more comfortable sharing the less stigmatized aspects of their work, like Dr. Nyedgger's practice of sharing patient's stories, particularly those terminating due to a fetal anomaly since even anti-choice individuals are sometimes sympathetic to those patients' stories.

D. "Constant hiding" and the "visual landscape of abortion": Participant Responses to "who sees what"

> *"I mean, we get down to the nitty gritty. We're in the tissue. That's how deep we're in…And that's the thing that people don't know--- 'Oh my God, you do that?!' And it's like, yeah, I'm looking for decidua and villi and making sure that there's something of a pregnancy there, that it's not somewhere in her body. And people are like, 'What? What? Oh my God.' Yeah, that's what I do."*
>
> - Nurse Kerr, Advocate Type, Hospital Clinic B

Negotiating "who sees what" about details of abortion work was important to participants' management of within-group stigma as well as stigmatization from non-abortion providers. Throughout data collection, I observed that even between abortion researcher and abortion provider in a confidential interview, discussing participants' involvement with fetal tissue was sometimes difficult. This difficulty interested me first as a challenge to collecting important data, since honest, open discussion free from judgment was my aim, especially where complex phenomena were concerned. My uncertainty of how to phrase important questions did not bode well in terms of eliciting good data, even if it reaffirmed my sense that talking about the fetus is hard. For example, what I really wanted to know was: "Why it is so difficult to talk about your role with respect to the fetus? If you could say anything, without worrying that it sounds 'wrong' or 'incomplete', what would you want me to know? To where/what/whom can we trace your discomfort with this discussion? Does being involved with fetal tissue bother you or does the hesitation I'm sensing have more to do with overcoming an established reticence to discussing that aspect of your work? If you *are* uncomfortable with that aspect of your work, is it a moral thing? And if not, what is it---what would you call it, if, for example, you were writing a dissertation about it?" Unfortunately, all of these questions are supremely bad interview questions, as they are accusatory in tone (but not intent) and essentially request that the participant solve a very complex puzzle on my behalf.

Qualitative data collection and analysis inform each other, which, in this case, meant that my difficulty phrasing questions about participant's involvement with fetal tissue was mirrored by an analytic struggle to identify what their reactions to it signified.

Heeding the advice of Kumar (2013) who cautioned that "everything is not abortion stigma", I was reluctant to ascribe participants' discomfort with discussing and actually being involved with fetal tissue to internalized abortion stigma. Participants' feelings about involvement with fetal tissue varied but most were very matter of fact about this aspect of their work, even while expressing discomfort with it:

Dr. Kendrick wanted to cope with her occasional "mixed feelings" about abortion procedures by talking them through, but she sensed vocalizing these concerns was unwelcome among her colleagues. There are many potential explanations for avoiding discussion of the difficult parts of abortion work. First, acknowledging out loud that sometimes it is emotionally difficult to provide abortions can be interpreted as an indictment of abortion or a challenge to its morality. In vocalizing her discomfort to her colleagues, Dr. Kendrick may inadvertently stigmatize those who do not experience the same challenges as her. Alternatively, her concerns may be interpreted as "signs of weakness" or being poorly suited for her chosen profession. While there certainly are moral dimensions to involvement with fetal tissue, often participants' discomfort with it had just as much to do with developing their own conceptual frame for fetal tissue in an abortion, which requires time and support from other providers.

Physicians are certainly the most intimately involved with the abortion procedure, but non-physicians may also see or work with fetal tissue, and these participants had a wide range of responses to this aspect of their work. Early in the data collection process, a nurse at Freestanding Clinic B told me that she does not like when physicians talk about the abortion procedure as they are doing it, and she tells them so. This struck me as stigmatizing of her physician coworkers, so I asked her to explain. Her explanation of

not wanting to hear physicians talk could be interpreted as her not wanting to be distracted and needing to focus on her responsibilities, but all of the examples she gave of what she does not want to hear from physicians had to do with fetal tissue. This, coupled with her repeated emphasis on the separation between work performed at different "ends of the bed", suggested that physicians' discussion of fetal tissue disrupted an important mental distinction she had made between her particular job and abortion. In subsequent interviews with non-physicians, I explored participants' feelings about being involved with fetal tissue. Some were adamant about not even seeing fetal tissue and emotionally "put a wall up" around that aspect of abortion work. Most non-physician participants, however, described gradual processes of becoming adjusted to dealing with fetal tissue. Although they were not as involved with fetal tissue as were their physician counterparts, a unique challenge for non-physicians in this regard was that they did not know what to expect, including whether or not they would be asked to do anything at all with fetal tissue.

> *"You might be very supportive of abortion but things might come up that we see that are hard…you know, the first time I was in the utility room watching the tissue being cleaned after a procedure, it surprised me, some of the things that I could see…I was like, wow, I never knew that I would see those kinds of things, you know? Somebody who doesn't know that they might see those things, regardless of how you feel about abortion, it might be a little hard, you know? So I think just having someone to normalize that and talk about it, that it is a really stigmatized thing and you can have different feelings about it, but your main motivation and your main goal is providing care to these women and being supportive of them. That might help."*
>
> - Ms. Doss, Social Worker, Freestanding Clinic A

Ms. Duvall was in charge of training all medical assistants for Freestanding Clinic A, and her experience in that role was consistent with Ms. Doss' point about non-physicians needing support free from judgment where seeing products of conception is concerned.

> *"One of the girls that I was training the other day, when we were doing the suction part of the procedure, we usually have a drape sheet covering the suction tubes. When the patient is sedated we don't cover it because we need to make sure that everything is making it into the jar and [the trainee medical assistant] kept covering it and I was like, 'we need to see, you don't have to cover it, she's asleep.' And she was like, 'no, it's for me, I don't want to see this.' And I was like, 'oh, ok', but it took a few times for her to finally tell me that that's why she was covering it, almost as if she was embarrassed. So people need to be comfortable telling other people, 'I don't want to see the [products of conception].' It's not something that someone is going to get judged for, it doesn't mean they can't perform their job, but it was sad to see that she was uncomfortable disclosing that information to me."*

Like Ms. Doss and Ms. Duvall, Ms. Murray was an enthusiastic abortion worker, an advocate type to a "t" and her approach to working with fetal tissue may be the best example of these traits. I asked all non-physicians whether observing an abortion procedure was part of their initial training and Ms. Murray explained that, like many participants, it was not a standard component of her medical assistant training. However, she had specifically asked to observe an abortion and felt it was "really important" for her to do in terms of her training and her own developing ideology of abortion.

> *"People have this idea that it's like this really long, drawn out procedure and that it's really dangerous and it's really hard to watch and I think that's especially because a lot of anti-abortion activists have sort of cornered the market on the visual landscape of abortion. So you have this idea that it's this really horrible disgusting thing to watch, and I've, you know, I've studied a lot about abortion and I read a lot about it, but I'd never witnessed it, so I wanted to watch it to sort of remind myself that it's actually like a five-minute procedure that is probably the least gory surgery that I can think, of at least. I wanted to be able to see it and confirm that for myself…. I wish this---I don't know if this is like a good idea or not---but I wish more people could see what an abortion looks like to understand that it's actually a pretty straightforward thing that you don't need to be sedated for, that you can be awake for, that it's pretty quick, it's pretty easy, and it's not this gore fest that people maybe think it is."*

Ms. Murray was correct in her observation that the visual landscape of abortion is dominated by anti-abortion activists, whose interests are best served by making abortion seem as gory and frightening as possible, with no concern for truth about the procedure.

Observing an abortion may not be pleasant, but the experience might prevent people from imagining it as worse than it is. At a minimum, it would offer a directly experienced challenge to the version of abortion put forth by anti-choice groups.

In theory, Ms. Murray's proposal could undermine stigmatization of abortion by sending the message that there is nothing to hide about abortion and there is no shame in providing or obtaining one. In reality, stigma is so entangled with all of our ideas about abortion that providers might always do some amount of hiding aspects of abortion in order to protect access to abortion. For example, consider the complexity of Dr. Kendrick's responses to coworkers who express discomfort with seeing fetal tissue:

> *"There is emotion for me every time someone involved in abortion care has a hard time seeing products of conception. It's like, on one side of it, I'm impressed by them because they're still willing to be there and are still willing to help even though they have something---not against it, but they've got some internal hesitation. So there is a part of me that's like, 'you know what, I appreciate you being here, I am happy to take care of this aspect of the procedure.' There's also another aspect where I'm kind of like, in a really small way, like, 'well then is there something wrong with me, because I'm doing this---like am I the dirtier person? I'm more involved because I'm the one doing it.' And then a really small aspect of like, 'are they safe?' You know if they're not willing to understand that this is what we're all doing, like, this is this world, are they safe to be here or are they on the other side, secretly? And they aren't, but yeah, that always is a kind of weird component of the situation. Or you know, sometimes it's also weird when they're fascinated at the same time. I don't know, it's just a weird situation because some people will want to come over and like, look at every single thing and then I'm almost like, 'oh gosh, I don't want you to see… But yeah, there are a lot of people that refuse to touch the products [of conception]."*

A single prompt (i.e. coworkers being uncomfortable with fetal tissue) elicited these wide-ranging emotional responses from Dr. Kendrick, all of which seemed very understandable and very deeply felt by her. Depending on how she interpreted the meaning of another's discomfort with products of conception, Dr. Kendrick might feel grateful to them, judged by them, suspicious of them or concerned for them. Common to

all of these responses, however, is the fact that they are rooted in Dr. Kendrick's awareness that as a physician, she performs the most stigmatized aspect of abortion.

Physicians had various responses to others' negative reactions to fetal tissue. Dr. Rivers said she did not mind when non-physicians did not want to see or work with fetal tissue and suggested that perhaps some people might just have an "ick factor" when it comes to that aspect of abortion. Dr. Campbell, in contrast, felt any such "ick factor" is unprofessional and out of place in a medical setting. Dr. Simpson provided a third point of view. In response to my question about non-physicians opting out of any aspect of abortion care, he said finds it "very irritating" and noted the negative implications for respectful patient care:

> *"It would be difficult to have that bias and not somehow bring it to the patient in whatever capacity you're interacting with her…we used to, but we really don't have it anymore where people would say, 'well, I'm not going to be in the procedure. I'll educate, I'll do ultrasounds, but I'm not going to be back there where the fetuses are actually getting looked at afterwards.' That was fairly common when we first started at the suburban clinic, we had a lot, quite a few people who were like that. But not anymore. I think it might have a lot do with [the clinic manager] now, she just isn't hiring people who aren't all in.*"

Dr. Kendrick was not neutral like Dr. Rivers, nor did she expect like Drs. Campbell and Simpson that others would be professional and "all in" where abortion is concerned. Dr. Kendrick was worried that others in the O.R. may not have the proper context to understand abortion, so to hedge against that, she described "constant hiding" of the aspects of the procedure that she anticipated would be most difficult for others.

The complexity of reactions within and across participants to talking about, seeing and working with fetal tissue is evidence that the fetus and the abortion procedure are the most stigmatized aspects of abortion. All participants were implicated in abortion

provision to some degree, but physicians' direct and inevitable involvement with the fetus made them uniquely stigmatized, even among their coworkers.

VII. UNIQUE MANIFESTATIONS OF STIGMA BY CLINIC

A. Hospital Clinic A: Medical assistants and within-clinic stigmatization: "We're on our own little island."

At Hospital Clinic A, those who morally objected to being involved in abortion care were not required to do so. All participants from Hospital Clinic A were aware that many medical assistants had opted out of working in the part of the clinic that provides abortions, but participants had very different understandings of how problematic this opting out was, and for whom. Those who had opted out *really* opted out---they would take no part in any aspect of an abortion visit, resulting in an increased workload for the two medical assistants who had not opted out.

> "*The medical assistants who work with us [on abortion care] tell us that there is stigma, that they're stigmatized. When I first got here I was told by our clinic manager that there was nobody---if one of our medical assistants was sick, that there would be nobody else who would even take the vital signs of our patients.*"
>
> - Dr. Nydegger, Advocate Type, Hospital Clinic A

Hospital Clinic A physicians were sympathetic to the increased workload for abortion-providing medical assistants, but tended to compare the stigmatizing implications of the opt out policy to what they felt were more serious forms of stigma. Weighed relative to clinics beset by vocal, persistent protesters, medical assistants exercising their right to opt out of abortion care seemed to be a manageable form of stigmatization.

> *"Are we stigmatized here? No, like, we're fine. The majority of people here are incredibly supportive and get why we do it and want us to keep doing it. There might be a handful of, say, medical assistants who don't want to work in our clinic---that's the level of quote, unquote 'stigma' in this institution, which at the end of the day, if they don't want to participate in abortion care, that's fine, I don't care…However, if I was at a freestanding clinic on a more regular basis, you would feel more of the stigma, say, if you're walking by the protesters. Even*

> *if you're not being targeted, per se, you're still part of what's being protested against, right?"*
>
> - Dr. Rostami, Advocate Type, Hospital Clinic A

Dr. Rostami's supervisory position within the Hospital Clinic A clinic meant that medical assistants might have withheld their negative opinions about abortion from her because she was both their boss and an abortion provider. Nurse Castillo was privy to and critical of medical assistants' judgment of abortion patients and providers. She suspected that medical assistants who had opted out due to religion were taking advantage of religious exception to accommodate their lack of professionalism. As a devout Catholic, abusing faith this way was personally offensive to Nurse Castillo. In a clinical sense, she felt she couldn't trust most medical assistants' abilities to support patients properly and deal with difficult emotional and visceral aspects of abortion care.

> *"The [medical assistants], I wouldn't be able to feel comfortable with all of them…I think they input too much of their personal feelings versus just being a health care advocate…patients' questions like, 'was it a boy or a girl, was it breathing, was it alive', those questions are difficult for the medical assistants….or if [the medical assistants] observed an ultrasound and you know, you had fetal activity or cardiac activity, I think they deal with it a little differently because it's a visual."*
>
> - Nurse Castillo, Utilitarian Type, Hospital Clinic A

Unsurprisingly, the perspectives of the two medical assistants who had *not* opted out of abortion care revealed the most about the implications of others opting out. While the stigmatization and increased workload described by others at Hospital Clinic A was not ideal, it was still a sanitized version of the abortion-providing medical assistants' own experiences with their peers. Abortion-providing medical assistants said that other medical assistants had not just opted out but moved to other clinics altogether because of their opposition to abortions being provided at Hospital Clinic A. While they were not directed at her, personally, Ms. Bryant said, "I mean, I hear it every day" about negative

comments about the abortion-providing staff. I asked about the sort of thing other medical assistants might say, and she offered this example in which Dr. Nydegger, who was pregnant at the time, is referenced:

> "*People make comments about some of the doctors, that they're having babies…I don't join in, but it's like, 'how are you going to go have a baby and you're [doing abortions]*.'"
>
> - Ms. Bryant, Utilitarian Type, Medical Assistant, Hospital Clinic A

I was surprised by the pointed, personal nature of this example. Despite her occasional participation in abortion care, Ms. Bryant had not "run across anybody bad-mouthing or scolding" her in her interactions with the other medical assistants. Ms. De Silva, the other medical assistant who had not opted out of abortion care, was a mainstay of the abortion-providing staff and described "pointless" and frequent clashes with other medical assistants about abortion:

> *"It gets to a point where it's like, you know, we have to agree to disagree, because we aren't getting anywhere. They're on their religious beliefs, me, I'm on my more scientific, medical, you know, my job description beliefs. Like, this is my job."*
>
> - Ms. De Silva, Utilitarian Type, Medical Assistant, Hospital Clinic A

This summative "agreeing to disagree" belied other ways that Ms. De Silva described her perceptions of judgment from her peers. A theme of these descriptions was that everything seemed fine on the surface, but "in the back of their minds, they feel like I'm the devil because I provide abortion care." About bringing an abortion patient into the clinic, Ms. De Silva said:

> *"Sometimes I feel that when they see me get a patient and I'm walking [the patient] back, I feel they look at me like walk of shame type of thing. You know, like, 'oh, there she goes taking another one back there…' But I mean, if they feel like that, I really don't care."*

Ms. De Silva was the ultimate utilitarian type. She had tremendous pride in her work and in her advocacy for patients in whatever health service they required. For her, the moral high ground was defined by a patient's needs, not her beliefs. She earnestly wanted to do right by her job and her patients.

Abortion was not rhetorically or practically political for Ms. Bryant and Ms. De Silva. They used unpolished language that advocate types might balk at. Ironically, the crudest examples typically came from moments in which they are trying to explain myriad negative things they think abortion is not. On other peoples' perceptions of abortion providers, Ms. De Silva said:

> *"Everyone believes we're these bad people, you know, like, going on a murderous rampage in a janitor's closet, you know? But it's not like that."*

Ms. De Silva and Ms. Bryant are medical assistants, and good ones, by all accounts. What they are not is abortion scholars or professional advocates for abortion, and their language reflects that. It should be noted that both of the examples above came near the end of their interviews, when each participant felt really comfortable with me. I do not know, of course, but I doubt that these are their default ways of discussing abortion. That said, anyone involved in abortion care is required to be an advocate for abortion at times, regardless of whether they intend to or not. Ms. De Silva and Ms. Bryant may benefit from some training and discussion about the social history of abortion, which might help them identify ways to talk about abortion in terms that cannot be turned against them or into fodder for anti-choice activists. Whether they choose to adopt more abortion-positive language is their choice, but for it to be a real choice, they may need some support in expressing themselves in their own terms instead of reflecting back the language of their anti-abortion peers.

Another area in which the medical assistants at Hospital Clinic A required support was avoiding burnout. While they were not stigmatized within the abortion providing staff---"we're our own little island, and once you leave the island, you're on your own"---they could not turn to other medical assistants for help with their abortion workload like they could with any other procedure. Meanwhile, patients need abortions:

> *"There is not a lot of people that are willing to help out, it really just lands on one person. And in that case, a lot of the time, it's me. So I do feel burnt out at times…before working here, I didn't know how many abortions were in need. You know, you hear about it, but once I worked here, it's like, wow, it's every single day a multiple, multiple amount of people are calling, whether it's a D and C, a D an E, a miscarriage…you don't really realize the scope of it….If we just had a little bit more people just to try and help, regardless of what they believe in, answer basic questions from patients…if that could get handled three people before it gets to me, that would be great, because even those simple little questions, it adds up when it falls onto one person or just two people. It's kind of like I can't do it anymore."*
>
> - Ms. De Silva, Utilitarian Type, Medical Assistant, Hospital Clinic A

The implications of the opt-out policy at Hospital Clinic A are complex. The very existence of the opt-out policy signals to workers that abortion is morally exceptional among all reproductive health services, which legitimizes stigmatization of abortion work from the outset. Participants in all roles, at all clinics involved in the study, indicated that interactions with abortion patients cemented their belief that abortion care is moral and important. By opting out of abortion care, healthcare professionals deny themselves the opportunity to experience this lesson for themselves. On the other hand, the validity of choosing abortion may still be lost on them when interacting with abortion patients and it is unfair to patients to have anyone who does not respect their decision to be involved in their abortion care.

B. Hospital Clinic B: Becoming an abortion provider: "The human element makes the surgical part more bearable"

Hospital Clinic B has an esteemed reputation as an academic institution and I knew it to be a sought-after placement for family planning fellows. Three of the five participants from Hospital Clinic B were fellows at the time of their interviews, which meant that they were early in their careers as physicians and were still training as abortion providers. Fellowships lasted for two years; the first year focused on clinical training in abortion and in the second year, fellows conducted a research project in family planning. First year fellows performed a high volume of abortions to perfect their skills in the procedure. To get the amount of experience they needed, Hospital Clinic B fellows provided abortions at Hospital Clinic B during the week and took weekend shifts at Freestanding Clinic B, where they could perform several procedures in one day.

At this early stage of their career, Hospital Clinic B family planning fellows were still forming their identities as abortion providers. Like all participants, they experienced stigmatization outside the clinic setting due to their work, but the most difficult aspect of becoming an abortion provider took place within the clinic setting. Confronting the emotional challenges of performing abortions was especially difficult for two Hospital Clinic B fellows among all physicians in the study: Drs. Barnes and Kendrick.

Dr. Barnes was very emotional throughout her interview, and especially so when discussing performing the abortion procedure. Initially, I struggled to reconcile the emotionally fraught way that Dr. Barnes described abortion with her strongly felt commitment to be a physician who provides abortions. These seemed to be paradoxical viewpoints that I initially attributed some kind of cognitive dissonance or internalized

stigmatization on her part, but these attributions felt lazy and incomplete in light of her enthusiasm for her work. She described being an abortion provider as "central to [her] identity" and an important factor in her post-fellowship job search. There are many valid ways to conceptualize abortion, but the politicized nature of abortion in the U.S. means that collective ideas about abortion are mostly represented by pro- and anti-choice messages. It is hard to place Dr. Barnes' views in this dichotomy because concise, consistent messages about abortion do not allow for the nuanced, personal ways that patients and providers like Dr. Barnes experience abortion.

Dr. Barnes was raised Catholic and anti-choice. Both groups are dogmatic about a singular focus on the fetus to the exclusion of all other aspects of abortion, like the health, decisions and rights of the pregnant woman. As Dr. Barnes developed her own views about abortion, she retained the language of "baby" because she retains that idea of the fetus. This in no way makes her anti-choice or self-punishing, despite my initial inability to reconcile her view of the fetus with her commitment to abortion provision. My interview with Dr. Barnes required me to analyze my own frame for abortion, which renewed my personal understanding of what abortion is and why choice is important. For others to benefit from this same exercise, those of us committed to choice should be open and honest about our views so that multiplicities of abortion-supportive views are made visible and a broader group of individuals may recognize that they, too, are in fact pro-choice.

Dr. Kendrick spoke frankly about why providing abortions was sometimes emotionally challenging for her, too. She said her strong emotional responses to doing abortions was something that she "didn't realize was going to play a role" in her career

and that she "really had to explore" them. In previous chapters, Dr. Kendrick has been quoted about how she felt uncomfortable after her first day providing abortions at Freestanding Clinic B and worried about the implications of the fact that she did not feel she could talk with her loved ones about what she had done that day. She has also been quoted about her occasional need to acknowledge that it "sucks to be doing [this abortion procedure] right now" even as being a provider brings her a "sense of calm about a situation that otherwise drives me so nuts." Dr. Kendrick's discomfort was exclusively focused on the surgical aspect of her work, which "can be really terrible sometimes", but that connecting with patients and sharing her discomforts with other providers "helps [her] heart feel better." Unfortunately, she did not feel comfortable talking about emotional challenges of surgeries with her abortion-providing peers at Hospital Clinic B:

> *"It's a weird fear of almost not wanting to admit vulnerability in this group…you know, I talked to [a coworker] about how I was feeling and they were like, 'oh my gosh, I've never felt anything.' And then it's like, maybe I'm being silly. Does this mean I'm less pro-choice? Does this mean that I'm less meant for this field if I'm having these feelings? So as much as I feel like I can depend on my work group, I very quickly established which people are more likely to talk it through with me versus be like, 'oh you'll get over it.'"*

Coupled with the fact that she did not feel comfortable talking about emotional aspects of performing abortions with her loved ones, Dr. Kendrick's apprehension about open, honest communication with her coworkers left her without a good outlet for processing her feelings. She described an occasion on which she had shared her discomfort with a particular procedure with another fellow and felt it planted a seed of doubt about her level of commitment and fit with abortion care:

> "*After I talked with one of my co-fellows, they actually ended up without my knowledge talking to an attending, and then that attending pulled me aside and was like, 'I heard you're having issues' and I was like, 'oh my gosh, no, no, no, no, no, I'm not having issues, I just wanted to process, you know?' So I sort of*

> *felt like the weak person, where every time I go into the O.R. are they going to be like, 'are you comfortable doing this type of thing?'…I'm not concerned about anyone judging my skill but there has been you know, fleeting moments---and again this sounds really weird---but fleeting moments of like, did I choose the right fellowship if I'm having these thoughts? Should I be in this field?"*

What Dr. Kendrick described was a subtle and probably unintentional within-group stigmatization from her peers that, during this formative stage of her career, occasionally shook her confidence that she was right for the job. If she had been able to share her feelings with her peers without judgment or fear of repercussion, Dr. Kendrick would have felt the emotional release of "processing" the uncomfortable feelings she was trying to repress while learning that those feelings were normal and often shared by other abortion doctors, particularly early in their careers.

Dr. Barnes and Dr. Kendrick described specific abortion procedures that were emotionally challenging for them in much greater detail than other physicians in the study. Throughout much of analysis, I did not know what to do with these stories because I do not believe that a physician's emotional response to abortion is necessarily pertinent to abortion provision stigma---there is an emotional weight to abortion and acknowledging it does not mean that a provider has unresolved feelings about the morality of abortion. However, the inclusion of these stories about difficult procedures still felt important and I did not want to dismiss them given how unique the level of detail in them in contrast to other physicians' interviews. The third Hospital Clinic B fellow, Dr. Schaeffer did not describe struggling with emotional dimensions of abortion as her peers did. Juxtaposed with Dr. Schaeffer's interview, I realized that what was significant about Dr. Barnes' and Dr. Kendrick's detailed accounts of difficult procedures was not the content of those accounts so much as their need to divulge them.

In absence of an outlet for their discomfort, Dr. Barnes and Dr. Kendrick essentially used their interviews with me as a way to process, and perhaps purge, some of the emotionally and morally fraught things they were dealing with. As an unwitting proxy for the people they most wanted to share with, I could not provide the support they needed, but I hope they experienced their interviews as a helpful trial run for saying difficult things out loud.

Despite reluctance to admit it, abortion physicians are, in fact, vulnerable and have an important job with complex emotions sometimes associated with it. This is particularly true at the early stages of their career. The fellows at Hospital Clinic B have the opportunity to attend a psychosocial workshop, which is meant to provide support in these areas, but Dr. Kendrick was not yet eligible to attend it at the time of our interview and Dr. Barnes had missed her opportunity to attend because she was having her baby during the workshop that year. Dr. Schaeffer did attend but felt it was not very useful for her, explaining that she does not get emotional about abortion the way some other providers do.

C. Freestanding Clinic A

1. Outside-Clinic Stigmatization: Omnipresent "Anti's"

In public perception, Freestanding Clinic A was synonymous with abortion and outside-clinic stigmatization of Freestanding Clinic A was singularly oppressive among all clinics in the study. The Freestanding Clinic B was regularly protested, as well, but the level of fear and anxiety about "Anti's" at Freestanding Clinic A was unparalleled. The term "Anti's" was used frequently by Freestanding Clinic A staff to refer to anti-abortion activists who organized to harass providers, presented

themselves as patients to trick providers and generally antagonized abortion providers and patients. The impact of "Anti's" on Freestanding Clinic A staff was deep and reached multiple aspects of their lives and work including: having to confront opposition on a daily basis, needing to protect patients from "Anti's" and fearing that they could be trapped or tricked by "Anti's" (Figure 5). The level of "hate-fueled organization" that "Anti's" achieved was what intimidated Freestanding Clinic A participants most. For example, "Anti's" would wear neon vests with "STAFF" printed on the backs to divert patients coming into the clinic and provide them with anti-abortion misinformation. They would call the clinic pretending to be a patient and attempt to bait the Freestanding Clinic A worker on the phone to say something questionable in order to "expose" Freestanding Clinic A. The caution that Freestanding Clinic A participants had to exercise to protect themselves and Freestanding Clinic A from "Anti's" meant that sometimes they were wary of what turned out to be legitimate patients, and this took a tremendous toll on participants.

Freestanding Clinic A participants often expressed befuddlement at the "end game" for "Anti's". They knew, of course, that "Anti's'" ultimate goal was abolition of abortion, but gave considerable thought to understanding them in some small way.

> *"Everyone has their opinion and I respect that, but it doesn't make sense to me for people to stalk our doctors or to yell at our patients. I don't know where they feel like that's going to get them---or trying to do damage to this building, our door glass being broken. We can order new glass like we did, you know? I don't understand where they think they're going to get with what they're doing. But I feel like the best thing for me to do is to focus my energy and my time and my education on being able to properly care for our patients."*
>
> - Ms. Duvall, Advocate Type, Medical Assistant, Freestanding Clinic A

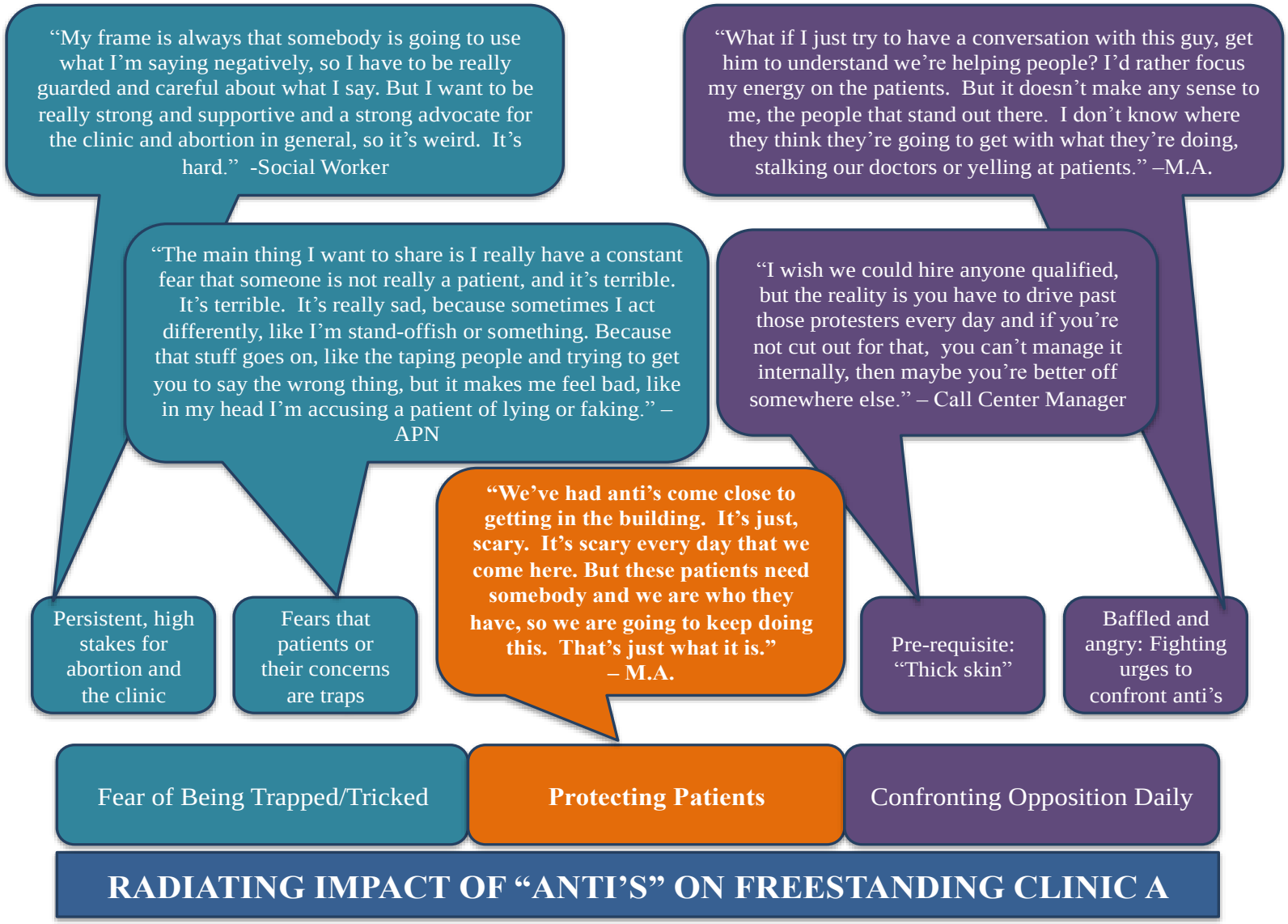

Figure 5: Radiating impact of "Anti's" on Freestanding Clinic A participants and patients

For all the damage they have done, "Anti's" have also provided Freestanding Clinic A workers with a unique shared bond. While "Anti's" intent is to deter and fragment Freestanding Clinic A abortion workers as a group, commiseration over "Anti's" served as one of many ways that Freestanding Clinic A participants identified with and supported one another.

2. <u>Within-clinic cohesion, affinity and support</u>

The fact that the Freestanding Clinic A name is ubiquitous and synonymous with abortion makes it a lightening rod for stigmatization, but also makes a sort of beacon for people who are passionate about reproductive justice and want to work in abortion care. There was a consistency in the sense of mission among Freestanding Clinic A staff that fostered cohesion among them based on a common, unequivocal commitment to abortion rights.

> *"No one is here for the money. No one is here just to get a paycheck…everyone has some degree of buy-in to our mission. At the end of the day, what we're trying to do is provide access to care, and because everyone has that common ground, we've got so much more to work with than you would have [somewhere else]. Everyone typically has a great attitude…we're definitely interconnected and we're all here for the same thing. That makes it really easy."*
>
> - Ms. Lappley, Advocate Type, Call Center Manager, Freestanding Clinic A

More than at any other clinic, Freestanding Clinic A participants described fully trusting their coworkers and enjoying their company in a social sense, not strictly in terms of workplace camaraderie. Freestanding Clinic A participants described themselves as a team and seemed to really feel that they were one. In part, the novelty of being in a completely safe space for pro-choice ideas was exciting to Freestanding Clinic A participants. It felt like they were "part of something important".

> ***"****One thing that's nice that I realized at orientation was like, everybody seems really different but I had to keep reminding myself, like, everybody in this room*

> *supports reproductive justice. And I was like, 'oh, that's crazy!' I feel like I've never been in a room where I could say that about everybody, while [they all] seem so different. So that is still very novel to me and how great that is has not worn off, so I really like the workplace atmosphere, I really like the people I work with."*
>
> - Ms. Murray, Advocate Type, Medical Assistant, Freestanding Clinic A

All Freestanding Clinic A participants but one fell in the advocate type category, which is unsurprising given the onslaught of anti-abortion antagonism they experience. It would be difficult to work at Freestanding Clinic A and not have a sense of mission and opposition regarding abortion, such that even when Freestanding Clinic A participants came to their job with more of a utilitarian viewpoint of abortion work, they became advocate types through their experiences at Freestanding Clinic A.

> *"Before I worked here, I wouldn't have considered myself an advocate. I would have considered myself just another person in the world who like whatever, you know? When I had my phone interview here, they asked me like what are your feelings towards abortion, and I was just like I don't know. I've never had one, I don't know anyone who's had one, I've never had to support someone having one, so it was a thing that existed that I heard about, but I don't know---I knew that some people supported it and some people didn't. So before working here I wouldn't have considered myself an advocate, because I feel like an advocate is someone who knows what they're advocating for. But now absolutely I see myself as an advocate for abortion. And I think that regardless of the situation or what's happening, I think that women have the right to choose what to do with their bodies, just as men have the right to choose what to do with their bodies."*
>
> - Ms. Duvall, Advocate Type, Medical Assistant, Freestanding Clinic A

At other clinics, those would describe themselves as advocates for abortion tended to have medical or women's studies degrees, but being an advocate for abortion was an equal opportunity proposition at Freestanding Clinic A. Perhaps this is because at Freestanding Clinic A, all participants were harassed by "Anti's", were proud of their involvement in abortion care and had a sense of ownership and investment in the clinic. In other settings, Ms. Duvall's sentiment might only be espoused by a medical director or

clinic manager, but at Freestanding Clinic A it was her guiding ethos as a medical assistant:

> *"I see this clinic as my house, my patients are my guests, and the people I work with are my family. And nothing changes my feelings about that."*

D. Freestanding Clinic B

1. Poor within-clinic cohesion and support

Freestanding Clinic B participants were vulnerable to the outside-clinic stigmatizations that shaped Freestanding Clinic A participants' experiences with stigma, but with the slight protection of less name recognition of their clinic, compared to Freestanding Clinic A. The stigmatization that they faced outside the clinic did not have the same bonding effect on Freestanding Clinic B participants as it did for Freestanding Clinic A. In fact, some Freestanding Clinic B participants espoused views that were consistent with anti-abortion advocates. Those same participants would assert their commitment to choice and note that they are aware that their stigmatizing view of patients would be an unpopular opinion within the clinic. Contradictions like these made Freestanding Clinic B singular among clinics in the study in the extent to which you could get very different ideas of what it is like to work there, depending on whom you ask and about what.

Complicating the task of making sense of Freestanding Clinic B providers' divergent experiences and views was the fact that out of 32 employees at Freestanding Clinic B who would have been eligible for participation in the study, only six enrolled. Also, these six were the only ones who contacted me to participate in the study; no one from Freestanding Clinic B was lost to follow up or deemed ineligible in the screening and recruitment process. The small proportion of enrolled versus eligible participants at

Freestanding Clinic B may be due to poor cohesion and mutual judgment among Freestanding Clinic B providers. The prospect of meeting to discuss your experiences with stigma at your place of work may be especially unappealing if you are not especially happy with your work or feel judged in your workplace.

Freestanding Clinic B participants felt that within-clinic stigma at Freestanding Clinic B had to do with the need for a counselor or social worker on staff and staff members' judgment of patients. The high volume of abortion patients at Freestanding Clinic B demanded that everyone on staff performed their prescribed role efficiently. At the time of data collection, no one was tasked with providing counseling services to patients and staff members were discouraged from taking on responsibilities in those areas.

> *"Freestanding Clinic B is really lacking in that whole [counseling] piece, you know it's not 'counseling', it's intake, it's admitting, it's going over paperwork, and there is no formal training for that. There is no training in listening skills, you know like what is the difference between an open-ended question you know a yes/no question or how to reflect feelings---all of that basic listening stuff. And values clarification is part of that, like if you're listening to somebody and they're telling you what they believe, you've got to know what you believe so that you don't confuse those things. And we just never make time for that. It's not part of our culture at Freestanding Clinic B because we take care of so many people, there is just this constant atmosphere of a time/work crush in that clinic. I think*
>
> *it's also just that the managers at the clinic are not social science-y at all, so that's gotten lost and that would be a good thing to add in."*
>
> - Nurse Dahl, Advocate Type, Recovery Room Nurse, Freestanding Clinic B

Nurse Dahl's point that providers have to know what they believe so that they do not confuse it with what patients sometimes believe is particularly important in light of several Freestanding Clinic B participants' concerns that their coworkers openly judge patients. If patients' beliefs can be projected onto and internalized by providers, then providers' judgmental beliefs about patients can certainly be sensed and internalized by

patients. This was a very real possibility at Freestanding Clinic B, where some participants openly shared their harsh judgment of patients with me, and others described being upset by their coworkers denigrating patients.

> *"They'll see how many they've had or even the number of weeks sometimes and it's like, 'well then why did she wait so long?' I mean that's something that they would need to address, but if I see that happening I'll be like, 'oh, I'll talk to her, not you'...I still love [my coworkers] but it's just like, 'whoa, did you really just say that?' That's probably the biggest issue [with coworkers], is them not putting patients first, or saying, "oh, she's been here five times." So what? Stop. Who cares. There's no limit."*
>
> - Ms. Mulroy, Advocate Type, Patient Representative, Freestanding Clinic B

Other Freestanding Clinic B providers reported that their coworkers regularly expressed judgment of how far patients were in their pregnancies when they came for an abortion, the number of abortions they had had, their reasons for terminating and their attitudes in the clinic. Ms. Quinn asserted an even more fundamental stigmatization of Freestanding Clinic B patients by staff members.

> *"Some of my coworkers, I like a lot, some of them I have problems with. Some of them are pretty conservative and especially have a lot of stigma around poor people which is a problem working in abortion care."*

Stigmatization of poor people is a problem in any setting, but as the backdrop for all of participants' other concerns about judgment and stigmatization, it suggests a fundamental tension between staff members and patients at Freestanding Clinic B. Those who were frustrated by others' reluctance to "do better" felt incapable of effecting change in terms of how patients are treated, with the exception of interceding and offering to take patients they think might be treated poorly by other providers.

> *"I mean, this field is not for everyone and you can tell when someone is burnt out and you're just like, 'get a different job, this is not for you.' If someone walks in and you're not there for them, and maybe you're having a bad day, but who cares---they're having a worse day. So you can tell that there are some people that are just not---they don't work as well with patients as others."*

- Ms. Mulroy, Advocate Type, Patient Representative, Freestanding Clinic B

Freestanding Clinic B's high patient volume demands, compartmentalization of work roles and lack of emotional support and counselors could understandably lead to burnout, but most participants were unsympathetic to those who did not rise to the occasion when patients' needs were inconvenient:

> *"There is a need here, figure it out. Do better. Like don't---just because you don't want to deal with it doesn't mean it doesn't exist, you know? And like if somebody is suicidal, we want to know. You should want to know that."*
>
> - Ms. Quinn, Advocate Type, Patient Representative, Freestanding Clinic B

2. <u>The Republican and the Activist: Extremes of abortion views within an abortion clinic</u>

Two of the participants from Freestanding Clinic B had an openly hostile relationship with each other and held directly opposing ideas on issues essential to abortion stigma. Ironically, Ms. Orlowski and Ms. Quinn were actually similar in many ways. Both were patient representatives and expressed dissatisfaction with how limited they were in their role.

> *"If I'm going to stay here, I would want to do something more managerial or take on a different role. I would not be content with doing what I'm doing for a long time and there are some people that work there and have been doing this forever…I know that this can't be my long-term…I think I am one of the only people that feel that way, in terms of knowing I have more skills to offer."*
>
> - Ms. Orlowski, Utilitarian Type, Patient Representative, Freestanding Clinic B

> *"I'm not given the space to invest all that I want to in it…so I don't feel at home at Freestanding Clinic B…I don't feel at home there, but I feel at home in [abortion work]."*
>
> - Ms. Quinn, Advocate Type, Patient Representative, Freestanding Clinic B

Ms. Orlowski had recently obtained a Master's degree in social work and secured a very demanding job unrelated to abortion work. She had worked at Freestanding Clinic B years before, when she was still in high school, and when her current patient

representative position at Freestanding Clinic B became available, she took it "not because [she] wanted to get back into abortion care" but because she so badly needed to leave her other job:

> *"It was kind of just like, there was an opportunity, and I had to take it because what I was doing before, I was probably on the verge of a nervous breakdown."*

She continued to look for other employment and told me she left Freestanding Clinic B off her resume unless she was applying to a "like an inner city school, where a lot of those people will have abortions." She was very concerned she would not find another job due to the stigma of having worked at Freestanding Clinic B.

> *"I feel like people think that this job is like a last resort…and this is horrible but the word that came to my mind is 'bottom feeder'---like it's a bottom feeder job you're working because you can't get anything better, and I feel like I'm judged on that, but it's like, I'm smart, I have an education, you know, I have other opportunities, this is just what I'm doing now."*

Like Ms. Orlowski, Ms. Quinn felt stifled in her patient representative role at Freestanding Clinic B and explained that her abortion activism outside the clinic was much more important to her. She had worked for several years at an abortion clinic in another state and took a part-time job at Freestanding Clinic B to "stay connected" to abortion work while she completed her Master's degree. When Ms. Quinn proposed an emotional triage form to help Freestanding Clinic B staff identify and support patients who are struggling with their feelings, Ms. Orlowski dismissed her attempt on the basis that Freestanding Clinic B staff were not equipped to handle emotional trauma and should not "go messing around with it when you have no idea what you're doing."

> *"People have worked there for like 30 years…so there is this little mafia inside of it, and no one wants to change, because this is their routine…so changing is just extremely hard and somebody like me who comes in who is all about innovation, all about like, 'how do we do this better, I want to make activists out of our patients, let's be the best we can', [that] is really threatening to people there.*

> *And I've felt some strong negativity from a couple of people of how threatened they are by me."*
>
> - Ms. Quinn, Advocate Type, Patient Representative, Freestanding Clinic B

Ms. Quinn believed that strident public endorsement of abortion was key to normalizing it. How she acted on this view could be interpreted as exhibitionism but she believed, "nothing should be taboo in abortion care." While working at a different abortion clinic, Ms. Quinn had had an abortion, filmed her face throughout the procedure and put the video online, hoping to reduce fear and stigma around abortion. She was invited to talk about her video on talk shows, a fact that she was very proud of. Hearing about this, Ms. Orlowski told Ms. Quinn that abortion is "not something you show off". As true to her own convictions as Ms. Quinn was, Ms. Orlowski had never "flat out" told anyone that she worked at Freestanding Clinic B. She feared people would assume she had had an abortion if they knew where she worked. Ms. Quinn was the first person I interviewed from Freestanding Clinic B and Ms. Orlowski was the last, making them bizarre bookends for my conversations with Freestanding Clinic B staff.

In their interviews, neither woman shied away from bold, controversial statements that were not shared by any other participants. Ms. Orlowski was very open with me about her judgment of patients' attitudes, reasons for termination, and number of abortions. In light of these opinions, I wondered why she worked at an abortion clinic, and particularly a freestanding one, where there could have been no confusion about the fact that she would be involved in abortion care. She distinguished between management and her peers in terms of whom at Freestanding Clinic B she felt shared her view, prefacing judgmental statements with, "now, I would never say this to management,

but…" For example, regarding the number of abortions for one woman that is acceptable to her, she said:

> "*I think some of us will just feel like, considering how many [patients] we see, I shouldn't know you by name, you know? I shouldn't recognize you by seeing you. You shouldn't be here three times in a year---you were just here four months ago. We gave you free samples of birth control, all you had to do was take them, but yet you're here again…but I wouldn't let management know that I feel that way, because they are all about 'the cause'. Would I say I'm about the abortion cause? No. Do I think every woman should have a right to choose? Absolutely. Like half of these people, I would never want to walk a mile in their shoes, so I'm not going to deny that to anybody but when it becomes multiple, multiple, multiple abortions, I think it's wrong."*

Ms. Orlowski was concerned that she was "enabling" patients who "should have some type of respect for life" and worried, "am I doing more damage than good?" Other participants in the study expressed concern about patients who had multiple abortions, but explained those concerns in terms of frustration with patients' failure to use contraception when they do not want to be pregnant or, sometimes, worry that a patient's partner is coercing them into sex without contraception. In contrast, Ms. Orlowski felt that having an abortion is a forgivable mistake once, but patients should take every precaution possible to avoid a second abortion, "just like if someone got a DUI, you're not going to drink and drive again." Setting aside the flawed logic of this metaphor, it illustrates that at a basic level, Ms. Orlowski sees abortion as the result of bad choices. The worst of these choices, in Ms. Orlowski's view, was when patients choose to terminate their pregnancy due to the fetus' risk for Down syndrome.

> *"Patients with fetal anomalies will judge [us], which I get. In their mind, this is the worst possible situation that they could be in, and to walk in [the clinic] and see all these women that are terminating pregnancies when you're just trying to have a family…last week, the [male partner of a patient] was very rude and verbally aggressive towards me. Luckily, I didn't find out until after the fact that they were terminating because of Down syndrome… I feel like it's the fetal anomalies and the people who are terminating because of Down syndrome who*

> *are the most judgmental. I remember one time, I said to a woman, 'you have a choice just like everybody else out there, you can carry this pregnancy. You're choosing not to and that is your choice. You don't know what any of them are going through, so don't judge.' And she was like, 'well, I don't have a choice' and I said, 'you absolutely do,' because I do some part-time work with people with Down syndrome…So if I would have known that this rude guy, the way he was talking to me, trying to put a guilt trip on me, if I would have known [that they were terminating for Down's], I would have told him, that, too. Because it's like, don't act like you don't have a choice…those are the ones that really cause my blood to boil by the time I leave…to me, that's playing God. You shouldn't get to pick and choose who you want to keep, you know? But I would never tell my bosses that."*

Judgment of patients who were terminating due to a fetal anomaly was a frequently revisited theme throughout Ms. Orlowski's interview. Although she told the woman terminating for Down syndrome that she could not judge any of the other patients in the clinic, I interpreted this admonition not as defense of other women's rights to choose abortion for whatever reason, but as a way of shaming the woman who was terminating for Down syndrome by letting her know that she was not any different or better than women choosing to end their pregnancies for other reasons.

I wondered how much contact Ms. Orlowski had with patients terminating for fetal anomalies (hoping it was minimal and supervised) and she explained that she had more contact with these patients than she did with other patients because they were often very emotionally distraught and the Freestanding Clinic B management, who were unaware of her feelings about these patients, would ask her to spend extra time with them due to her background in counseling and social work. She did not believe she could be open with her managers about how she felt and not lose her job because "there's no grey area in abortion for them."

> *"I wish I could tell my managers, like, 'hey, don't give me those patients'. I know I have more experience with counseling [than others at Freestanding Clinic B] but I don't want to be associated with these patients because it pisses me off. I*

> *don't have compassion for somebody who is making that decision based on Down syndrome or a disability. To me, that's like playing God. When I have children, I will never get tested for anything, because to me, it's like what I'm given, I will take. You know, I had a sister who died. She was born with congenital heart disease. Nowadays, they could probably spot that [in utero]—and I know because I see patients who will terminate based on heart conditions. She died when she was seven, but they didn't think she'd live to be a year, so it's like, some cases, I just don't want to be a part of it."*

I disagreed with many of Ms. Orlowski's attitudes and practices but liked her, as a person. I was sorry for Ms. Orlowski's family history and could appreciate how hard it was for her to separate that great personal loss from patients' decisions. Ultimately, however, I wished for the sake of Freestanding Clinic B patients that Ms. Orlowski would be honest with her bosses about her views. That seemed unlikely to happen given that she was personally sensitive about the idea that "everyone [at Freestanding Clinic B] would probably end up hating me if they knew how I really felt about things." Curious about what other opinions she had that would be unpopular in an abortion clinic, I asked her to share the thing that she would feel most uncomfortable with her coworkers knowing. I braced myself for something especially shocking and she replied, laughing, "Honestly? That I'm a Republican. They can never know that, that's in the vault."

Ms. Orlowski's opinions are attributable only to herself, but her ability to continue in a position where she overtly judged patients and generally seemed unhappy was made possible by several aspects of work at Freestanding Clinic B. Other participants' accounts suggest that espousing judgmental views of patients was somewhat socially normalized, particularly among the patient representatives. Perhaps these attitudes went unchecked because work roles were so separated from each other and within any particular role, employees might have become complacent in their years on the job. The distinction between "the front", where patient representatives worked and

"the back" where clinical activity took place and management worked, was not just physical, it reflected a difference in permissibility of stigmatizing attitudes within each group (e.g. Ms. Orlowski's insistence that management is "all about the cause" and "don't see grey area"). A counselor or licensed social worker on staff may have been helpful to patients and providers, alike, in identifying and working through value-based conflicts in a safe space. Without someone to fill that role, the person who may have been the least suited to the position was thrust into it. In order to keep her job, Ms. Orlowski hid the opinions that may have disqualified her from a counseling role.

VIII. UNIQUE MANIFESTATIONS OF STIGMA BY CLINIC TYPE

Participants' experiences with stigmatization differed by clinic type in terms of: (1) exposure to overt outside-clinic stigmatization; (2) within-clinic practices of opting out of abortion care; and (3) the challenges of meeting clinic volume demands (Figure 6). Abortion Provider Stigmatization Survey (APSS) scores for Freestanding Clinic A participants were higher than those for participants from both hospital-based clinics and Freestanding Clinic B, indicating greater experience with stigmatization among participants (Table VII). Freestanding Clinic A participants' higher disclosure management subscale scores relative to all other clinics is reflective of the public perception that Freestanding Clinic A is synonymous with abortion; to disclose Freestanding Clinic A as one's employer is to acknowledge association with abortion. This was not the case for participants from the hospital-based clinics or the lesser-known freestanding clinic, Freestanding Clinic B, where APSS scores were even slightly lower than Hospital Clinic B.

A. Differing experiences of outside-clinic stigmatization

Participants who explicitly made comparisons between experiences of outside-clinic stigmatization at freestanding versus hospital-based clinics all worked in hospital-based clinics at least part time; no one who worked exclusively in a freestanding clinic asserted differences between stigmatization experiences at each clinic type. When participants made direct comparisons between clinic types, they tended to focus on outside-clinic stigmatization as opposed to within-group stigmatization among providers. The consensus was that participants in freestanding clinics were much more vulnerable than those in hospital-based clinics.

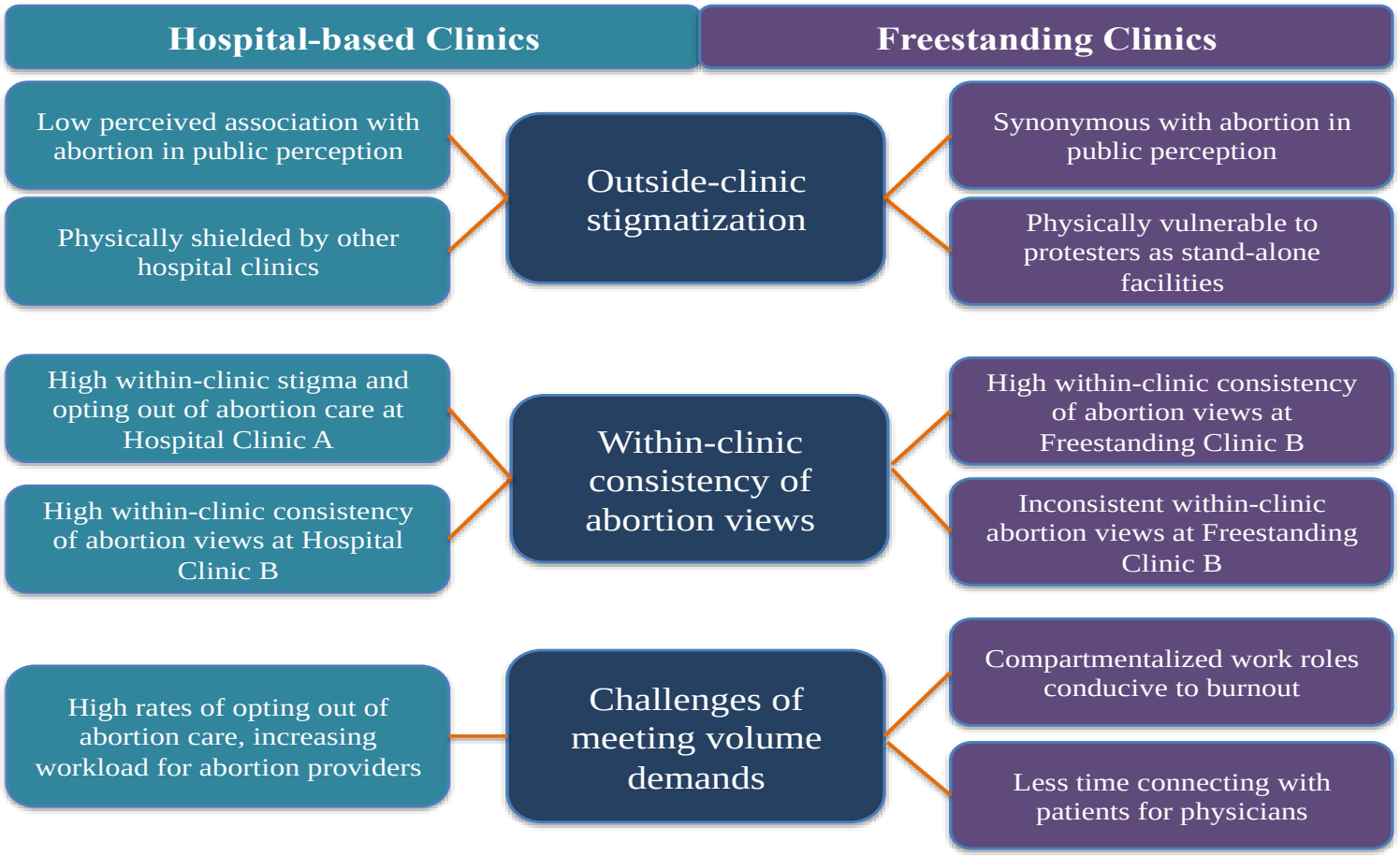

Figure 6: Experiences with stigma by clinic type.

TABLE VII

ABORTION PROVIDER STIGMATIZATION SURVEY SUBSCALE AND COMPOSITE SCALE SCORES BY CLINIC

	Hospital A (n=8)	**Hospital B (n=5)**	**Freestanding A (n=12)**	**Freestanding B (n=6)**
Disclosure Mgmt. Subscale Avg.	22.38	26.6	30.17	23.0
Internal States Subscale Avg.	17.75	17.4	17.0	18.33
Judgment Subscale Avg.	16.13	15.8	18.33	15.67
Social Support Subscale Avg.	9.25	7.2	8.17	9.33
Discrimination Subscale Avg.	4.63	7.4	6.5	5.5
Composite Scale Avg.	70.13	74.4	80.17	71.83
Composite Scale Range	55-85	66-87	61-111	50-97

"I can compartmentalize it now, but I used to be fearful. I feel very protected in a university setting because no protester is going to come into a university setting and protest what we're doing. So here, I feel extremely safe, whereas at Freestanding Clinic A or other places I've worked, they're freestanding. You're threatened."

– Nurse Kerr, Advocate Type, Hospital Clinic B

"I can come to work in scrubs here which is nice, but I think it would be much more difficult if we were in an independent location that provided [abortion] services…I can honestly say I've kind of gotten very lax with the fact that we work at such a large institution. We have security measures, we have our own police on staff here, we have security guards, we don't have protestors outside. Although we have had some scares, you know where they've sent like letters through the mail to our coordinators, but for us, in this clinic, I've never really [been fearful], which is a good thing."

- Nurse Castillo, Utilitarian Type, Hospital Clinic A

In addition to all of the hospital-based supports that Nurse Castillo described, Ms. De Silva noted that the most important protection was the fact that, "the only people that know we provide it here are people that work here and patients that have had it here." This anonymity shielded hospital-based participants from protesters and allowed them greater discretion in terms of what they disclose about their work, and to whom.

B. <u>Consistency of within-clinic views on abortion</u>

Participants in freestanding clinics had the inverse of hospital-based participants' experiences in terms of anonymity and perceived association with abortion. Freestanding clinic providers felt that people did not just associate them and their clinics with abortion, they did so to the exclusion of all other healthcare provided in freestanding clinics. This had important implications for limiting within-clinic stigmatization, since most people would not apply to work at a freestanding clinic if they were not fully committed to choice. Freestanding clinics also had the considerable advantage of being able to screen job applicants for their attitudes about abortion and choice, creating a commonality of mission among workers in freestanding clinics.

> *"In freestanding abortion clinics, I 100% trust the people that I work with. Those are individuals who have chosen to work in an abortion clinic exclusively. Here at Hospital Clinic A, we have our [abortion] clinic in the general gynecology clinic and a lot of the nursing staff and medical assistants, receptionists---they all took a job working in a general gynecology clinic and incidentally, we perform abortion care. So there are people whom I'm sure are not supportive---whom I know are not supportive of our services."*
>
> - Dr. Nydegger, Advocate Type, Hospital Clinic A

There were myriad negative effects of pro- and anti-choice staff members being employed within the same clinic at Hospital Clinic A but the within-clinic stigmatization that was observed among participants at Freestanding Clinic B suggests that a shared

level of comfort with abortion and commitment to choice can be assumed but not guaranteed in freestanding clinics.

C. Challenges to meeting abortion volume demands

The marginalization of abortion care out of mainstream medicine means that the majority of abortions now take place in freestanding clinics (Jones & Kooistra, 2011). Meeting the demand for the high volume of abortions in freestanding clinics has shaped the way abortion care is provided in these settings so that it is very compartmentalized, efficient and different to how care is provided in hospital-based settings. As another function of this high demand for abortions in freestanding clinics, relative to hospital-based clinics, physicians who primarily work in hospital-based clinics often work a few shifts a month at freestanding clinics.

The efficiency of patient care required at freestanding clinics meant that physicians had limited time with patients outside the procedure itself, for which patients were sometimes under anesthesia. This was unfortunate for physicians, who emphasized the satisfaction they got from talking with patients and learning about their lives and the context for their abortion decision. Those conversations had a restorative effect for many participants on the occasions that they felt burnt out or challenged by performing abortion procedures.

> *"The role of taking care of patients at a place like Freestanding Clinic A is very different. So like I was at a hospital for my fellowship and there, when you took care of the patients, you met them, you did their ultrasound, you did their counseling, and then their procedure, so I felt like you really got to like know the full patient and her story. And at Freestanding Clinic A it's a totally different model, because it has to be, because it's a higher clinical volume, so I'm meeting the patient in stirrups, basically, and so I guess I'm not, like, connecting that much with the patient, I kind of just literally take care of them for their procedure…I introduce myself and they get put to sleep. So I guess that would be one thing that I don't enjoy that much about my job is that I feel like I'm not*

> *like I know I'm like taking care of these patients and they all have a story but I'm literally just doing their procedure, for the most part."*
>
> - Dr. Sullivan, Advocate Type, Freestanding Clinic A

Participants in hospital-based settings described more variety and less rigidity in terms of their roles with respect to abortion, making it a less monotonous aspect of their work than it may have been for participants in freestanding clinics. However, when so many other staff members in hospital-based settings opt out of abortion care that it always falls to one or two people, participants in hospital-based settings were confronted with their own set of challenges to meeting the demand for abortion services. This was the case for Ms. De Silva, a medical assistant at Hospital Clinic A as well as for Nurse Merrick, who reflected on her time at Hospital Clinic B prior to working at Freestanding Clinic B:

> *"I've only been at Freestanding Clinic B since February, but I worked at Hospital Clinic B for 10 years and there was one obstetrician who did abortions there, and out of a department of 300 anesthesia providers, you could count on two hands the ones who would actually go down and do the abortion procedures. They'd just say nope, nope, nope, nope, nope, nope, nope. So that was my first really exposure to the different, I'm not going to say biases but different religions and cultures, because when I went to anesthesia school it was like you provide anesthesia. This is your job, no matter what, this is your job. I didn't know you had a right to refuse and I got that a lot at Hospital Clinic B and that was kind of my first experience with you're sitting there waiting for them to find an attending to go down with you because no one does anesthesia for abortions…You know, at first I was first it was okay it was like you know but after a while, after a few years, they're calling the same people all the time and you're like okay, you know really? Is there anybody else in here who is going to help?…You know, you get tired of being the one that they call to go down to do them---and these were all therapeutic abortions, they weren't elective."*
>
> - Nurse Merrick, Nurse Anesthetist, Freestanding Clinic B.

Differentiating between "therapeutic" and "elective" abortions would be unwelcome in freestanding clinics; the assumed shared commitment to choice in freestanding clinics made it taboo to articulate value-laden distinctions between women's

reasons for abortion in these settings. Nurse Merrick's emphasis on the distinction between therapeutic abortions and elective abortions is reflective of a hospital culture that allows stigmatizing logic that indicates some abortions are morally defensible and others are not. That her colleagues doubled down on that assumption and rejected participating in even the "good" kind of abortions is a phenomenon unique to hospital-based settings where abortions are provided.

D. Discordant priorities: Equity, access and quality of care versus academic research

Dr. Rivers of Freestanding Clinic A had some unique perspectives on abortion care in university-based hospital settings like Hospital Clinic A and Hospital Clinic B. She felt that academic abortion providers were hypocritical in claiming commitment to abortion while prioritizing research and academic funding over enhancing the quality of care in non-academic abortion settings and expanding access to abortion. Her criticisms of providers in academic settings can be interpreted as a sort of within-group stigmatization that she herself acknowledged.

> *"Why is it allowable to have one standard of care for Hospital Clinic B and another for poor women who are treated at Freestanding Clinic B and Freestanding Clinic A and wherever else? What happens within the [abortion] community is no one is going to say anything [critical of other providers] because there is so much angst from outside that you don't need the angst from within. You don't need the finger pointing, all of that stuff. But you know, [a doctor from Hospital Clinic B] was a big advocate about anesthesia for women and giving them the options for deep sedation and that every woman has the right for that, but his residents train [outside of Hospital Clinic B] where they don't even give fucking 10 ccs of lidocaine, you know? So I don't need that man saying, like 'you have the resources at an Freestanding Clinic A clinic to do this', it's like yeah, you have the fucking resources at Hospital Clinic B, too! You know, take one of your emeritus chairship positions and that will pay for everyone's care. Or use that grant money that you've got---you know I just lose empathy for the programs when they are hypocritical."*

Dr. Rivers was extremely passionate about abortion and had many great things to say about her colleagues but felt that in a "big picture" sense, they were not doing all that they could to make abortion accessible, which was her focus to the exclusion of other aspects of abortion work, like research. She used the word "hypocritical" a lot regarding her abortion physician peers and the sense that I got from her was that she felt fully committed and had the expectation that, if they really cared about abortion, others would match her level of commitment to making abortion accessible either through funding or their time.

Dr. Rivers dedicated her weekends to driving to areas of neighboring states where women would not have access to abortion if she were not there to take care of them, and she did this as a single mother of two young children. This is important context for Dr. Rivers' indignation that academic abortion providers had funding that they would not (but probably could not) reallocate to expanding abortion access. In her view, she was doing her absolute best to make quality abortion care accessible to all sorts of inconveniently located patients while academic abortion providers prioritized academia over equity in care and were distracted by "proving themselves" to non-abortion providers by establishing themselves as researchers:

> *"I understand they're bound by their academic institutions and what they have to do, but I don't think we need another study showing that, you know, adolescents like the Nuvaring or adolescents like IUDs. Some of it, I think, is people trying to say 'see? Now we're legitimate because now we have research!' The people that you're trying to prove your legitimacy to don't care. They don't care. So I mean it's fine, it's good, but the amount of money that has been spent [on research] probably could have been used to provide abortions for all of the women in the United States who couldn't afford it."*

Stigmatization makes abortion very literally not valued. Abortion research and access to abortion are both important and are actually complementary, but the paucity of

resources for abortion means that decisions between research and access sometimes have to be made. This occasionally presents a conflict of interests among abortion advocates and providers, as it did between Dr. Rivers and providers who work in academia. Unsatisfactory trade-offs occur all the time in abortion care because abortion always starts from a deficit, due to stigma. For example, it is not ideal that physicians do not get to spend as much time as they would like with patients in freestanding clinics, but that is how they are able to provide care to as many women as need it. It is nice that providers in hospital settings can wear scrubs into work without jeopardizing their safety, but it is unfair and frightening that this is a valid concern in the first place.

Dr. Rivers' criticisms of her colleagues in academic hospital settings may seem harsh or misplaced, but her interest in making abortion care as good and as accessible as possible is commendable. Too often, stigma forces people to submit to the standards of those who judge and oppress them. Abortion providers should be the ones who set the standards of care for abortion, even if that entails some within-group dissention with good intentions.

IX. UNIQUE MANIFESTATIONS OF STIGMA BY WORK ROLE: PHYSICIANS AND NON-PHYSICIANS

"I think it's really interesting to be in a field where we have specific lectures on how to avoid having your names on things and the fact that if I get married to my partner, that everything should be in his name, and I try to avoid my name being on anything. It's almost like you disappear a little bit in order to do the work that you want to do and that you think is important."

- Dr. Kendrick, Advocate Type, Hospital Clinic B

"I mean providers get murdered and put on anti-choice websites. Nurses, nurse practitioners, we don't get put on websites. Nobody comes to my house."

- Nurse O'Hara, Advocate Type, Nurse Practitioner, Freestanding Clinic A

A. Blanket Stigmatization of Physicians and Non-physicians

Physicians and non-physicians each had unique sets of challenges and resources available to them in terms of dealing with stigma, but a fundamental level of stigmatization encompassed all participants, irrespective of work role. APSS scores suggested that non-physicians were slightly more stigmatized than their counterparts, but the difference in composite score averages was negligible and can be interpreted as evidence of the blanket stigmatization of all providers (Table VIII).

Qualitative interview data indicated that physicians and non-physicians, alike, experienced stigmatization in similar ways. When asked to describe what abortion stigma means in her own terms, Ms. Duvall, a medical assistant at Freestanding Clinic A, said this:

"*To me, what stigma feels like is the fact that I'm uncomfortable at a table full of strangers after telling them where I work and what I do. Stigma is the fact that some hospitals won't hire me because they're a Catholic hospital and they look at my resume and see Freestanding Clinic A on it. Stigma is you know, just everything---that when my partner's dad first asked me where I worked and I told him, he had nothing to say at all. And it took months and months for him to be comfortable even talking about it because he's a very old fashioned Catholic man. Things like that, that's stigma to me."*

Like Ms. Duvall, other participants asserted the existence of all-inclusive stigmatization by pointing to the use of disclosure management tactics by all provider types as well as anti-abortion advocates' failure to differentiate between work roles in their harassment of providers outside clinics. Ms. Duvall worked at a clinic with a constant, evolving group of protesters, and had given a lot of thought to indiscriminate position of protesters regarding anyone involved with the clinic:

> *"The people standing outside, they don't care if you check people in, they don't care if your job is to come and take the lab stuff away to the lab---you're involved. Our volunteers, who are just standing outside letting people in, they're getting screamed at from the protesters, and I mean, they don't even touch patients. All they do is open a door, and they're getting yelled at and told they're getting told they're going to go to Hell because they're here and they're supporting us. So I would take it as far as to say that people, some people who stigmatize abortion also stigmatize the people who support it."*

Protesters' typical repertoire of threats, shame and fear mongering was sometimes exchanged for a patronizing, falsely protective approach when they believed that the person entering the clinic was a patient. On one occasion, they extended this tact beyond patients to include Ms. Duvall. They attempted to convince her that by working at Freestanding Clinic A, she was betraying her race and being duped by white doctors into participating in black genocide:

> *"Our doctors are definitely more stigmatized [than non-physicians]. People spend time looking these people up online and trying to get their information and screaming their names and making posters with their names. They're not standing outside with any posters that say my name on there, you know what I mean? Because we're just the little people. It's the big fish that they want, which is ridiculous. But I do think that there are different levels of the stigma because when I went outside to do volunteer work one day and escorted people in, the guy outside was telling me that, 'Freestanding Clinic A is racist and you got to get out while you can!' I'm sure that's not how he would talk to a doctor if they were standing out there. I'm sure that he would tell them that they were a baby killer and call them names and things like that. It seemed like they were trying to*

lure me out. So I think that in that sense, their level of stigma for me was, 'oh you know she doesn't know any better, let's help her.'"

- Ms. Duvall, Advocate Type, Medical Assistant, Freestanding Clinic A

In his attempt to "lure her out", this protester demonstrated his racism and disrespect for Ms. Duvall's enthusiastic and informed decision to take part in abortion care. His approach was consistent with the anti-abortion narrative that abortion doctors are predatory and that providing abortions is part of an ulterior motive that harms women.

TABLE VIII

ABORTION PROVIDER STIGMATIZATION SURVEY SUBSCALE AND COMPOSITE SCALE SCORES FOR PHYSICIANS AND NON-PHYSICIANS

	Physicians (n=12)	**Non-physicians (n=19)**
Disclosure Mgmt. Subscale Avg.	25.58	26.58
Internal States Subscale Avg.	16.83	17.95
Judgment Subscale Avg.	16.5	17.05
Social Support Subscale Avg.	7.5	9.16
Discrimination Subscale Avg.	6.42	4.05
Composite Scale Avg.	72.83	76.42
Composite Scale Range	65 - 87	50 - 111

In my many visits to Freestanding Clinic A, I consistently reflected in my field notes that the tone and content of the protesters' messages seemed to suggest that

abortion doctors were somehow complicit in creating the demand for their services, as though abortion was "all their idea" and they were benefiting from it sadistically and monetarily. If this was, in fact, consistent with how they felt, it is no wonder that the focus of protesters and anti-abortion groups' most violent, aggressive and frightening tactics was the "big fish"---the physicians involved in abortion care. Many non-physicians asserted the illogic of the singular focus on physicians, given the division of labor in abortion care.

> *"It's so funny because an anti wouldn't realize this, but the doctor spends the absolute least amount of time with the patient than anybody, you know, patients spend the entire day with the medical assistants and then they spend five minutes with the provider and then they're gone. So it's almost ironic that the person who spends the least amount of time with the patient is you know seemingly given the most stigma from these people."*
>
> - Ms. Duvall, Advocate Type, Medical Assistant, Freestanding Clinic A

Non-physicians' earnest descriptions of how little time physicians spend with patients compared to non-physicians demonstrated the bond participants felt with their colleagues and their desire to protect them. However, it gives "Anti's" credit for thinking about abortion in context and as a process involving a patient and a variety of caregivers, like any other medical procedure. In reality, "Anti's" obsessive, exclusive focus is the fetus, setting abortion physicians clearly apart from non-physicians in terms of vilification and harassment.

B. <u>Unique stigmatizations of physicians</u>

Physicians experienced stigmatizations unique to their role in terms of regulatory legislation, legal liability, stalking and violence, and denigration of their professional capabilities (Figure 7). Regarding the mounting legislative restrictions on them and their work as abortion providers, physicians were indignant about the fact that abortion policy

is largely made by people who are willfully ignorant about abortion. Compared to abortion patients and providers in other parts of the country, physician participants felt that they did not bear the brunt of the legislative restrictions, but were concerned about the implications of these laws nonetheless. All physicians agreed that restrictive abortion policies showed no sign of abating in the near future.

Physicians were also resigned to the idea that, as abortion providers, they would face heightened scrutiny of their work, which may make them more vulnerable to being sued than if they were not involved in abortion care.

> *"In general, when things go wrong in medicine, people look for someone to blame, but I think in abortion care that's perhaps even more pronounced. And I don't know if that's because of the stigma around abortion providers or you know, 'if you had a problem, that doctor must have done something wrong' or whatever, even if it's a known risk…like, 'you came in and signed a bunch of consent forms that said here are the list of possible complications and you agreed to those risks when you wanted to receive the procedure just like you would in any other informed consent.' But in abortion care, people are even more happy to blame you for badness, when it happens."*
>
> - Dr. Eisler, Advocate Type, Freestanding Clinic B

All physician participants described being judged by their peers as being less skilled physicians due to being an abortion provider. In some instances, participants' commitment to abortion was held up as justification for others' low esteem of their skills, as though being an advocate for abortion access was at odds with their ability to reason and learn like other physician. Physician participants described being encouraged by their peers to "branch out" and avoid being "just" an abortion provider.

> *"Our current chairman [at the hospital where I work full-time when I'm not at Freestanding Clinic A] said, 'well Anna, you can't just do abortion.' I was like, 'really? Because you just do cancer', you know? I feel totally fine just doing abortion…in the world of surgery there is a hierarchy of tough procedures, right? If you're like the guy they call for the complicated cancer or a neurosurgeon, you're cooler than someone who does minor procedures like, I don't know, hysteroscopy. And abortion is on the lower end of that [hierarchy of difficulty] so*

> *there is that stigmatization, too. Even in ob/gyn, there is this idea of like, 'oh, you have got to get on labor and delivery so you can meet the residents and they have respect for you because they know that you doing everything.' I'm like, really? Because I think my residents respect me fine for just doing abortions. But even in our world, there is that idea of like, 'do other things, too, so people respect you more.' I'm like no, they just respect me for doing my abortions. But I definitely have that kind of stigma. Like, 'really you just want to do that?' I'm like 'yup!' 'So, won't you get bored?' 'Nope.' So there is that stigma."*
>
> - Dr. Rouse, Advocate Type, Freestanding Clinic A

Dr. Rouse was more strident than other participants in her rejection of supposed concern for her being "just" an abortion provider, but her experiences were consistent with other physicians who described non-abortion providing colleagues' denigration of their skills. Participants attributed these attitudes to anti-choice sentiment among their colleagues and general ignorance about abortion. However, contextualizing others' dismissal of abortion work this way did not allay all harmful effects of this within-group stigmatization from other physicians.

> *"I occasionally feel stigmatized kind of on a profound level, to be honest. And that may just be in my head, but I remember what I thought about this abortion doctor [when I was in residency]. He was an ob/gyn and he would take call a couple of times a month at one of the hospitals where I was a resident. And I remember questioning his skills, like, can he really help me with a C-section or with these forceps or whatever because he's an abortion doctor. So in some ways it's more profound actually, a little bit more meaningful to my psyche than getting screamed at by someone that I consider to be crazy."*
>
> - Dr. Simpson, Advocate Type, Freestanding Clinic A

It is significant that Dr. Simpson, in particular, felt that having his competency doubted was more problematic than "getting screamed at" by protesters. All physicians in the study described being threatened, spit on, stalked or tracked online by anti-abortion groups, but Dr. Simpson had some unique experiences with organized anti-abortion activity. A particularly heinous example of this was when an anti-abortion group learned

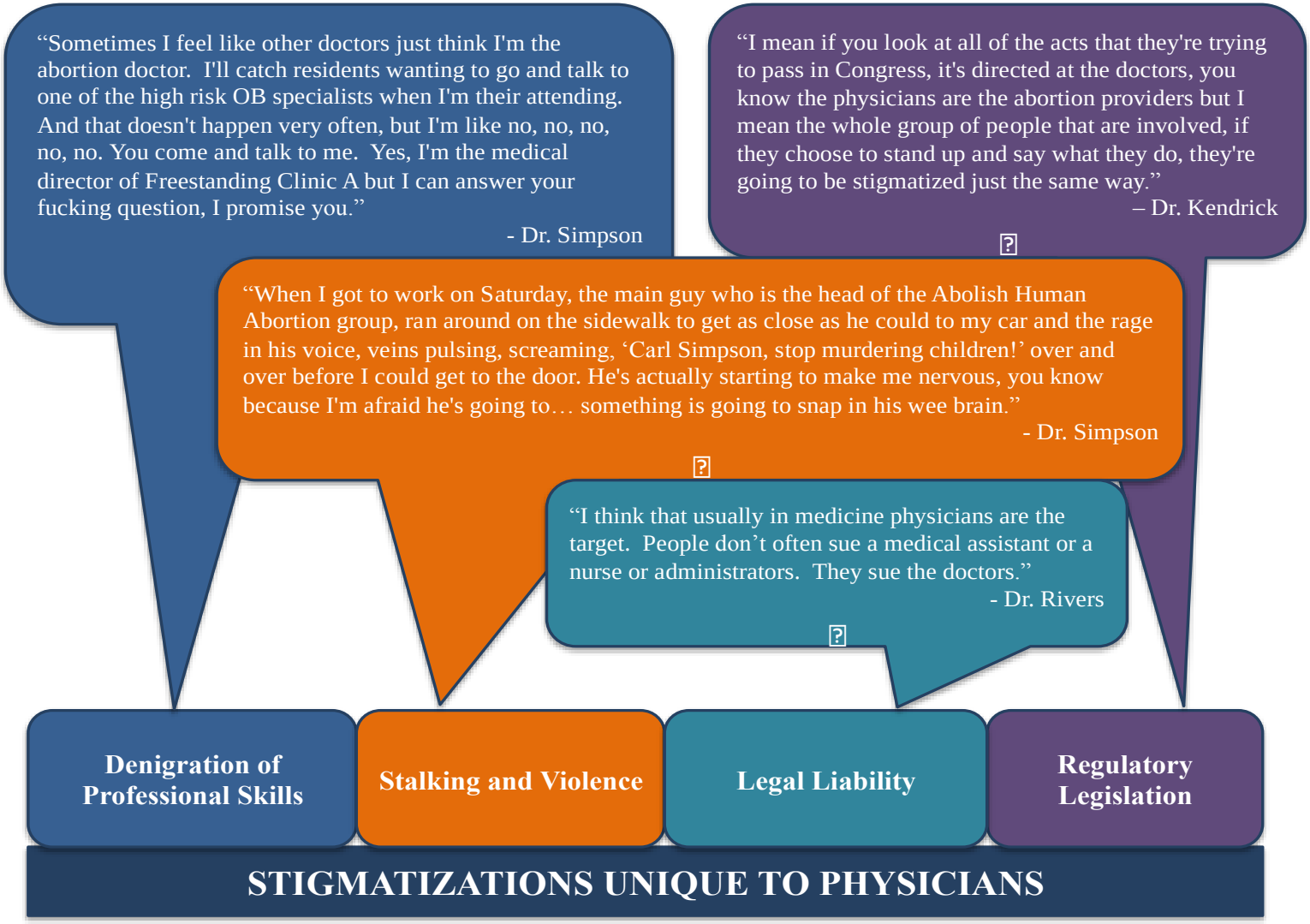

Figure 7: Physician-specific stigmatizations.

that Dr. Simpson would be running in a marathon race and organized to stalk and harass him throughout the race:

> "*The protesters have really been ramping up their activity---they stalked me in the marathon this year. They figured out what my bib number was and my corral time---when I was going to be starting---and they placed themselves around at different mile markers to scream out my name, wave posters, all that."*

The amount of time, planning and organization required to stalk Dr. Simpson this way is chilling. Presumably, the protesters wanted to shame Dr. Simpson and ruin his experience with the marathon, but equally, if not more important, to do so in a way that lets him know that they have access to private information about his life and his whereabouts. This kind of persistent, aggressive and pointedly personal harassment is intended to make providers feel unsafe in all aspects of their lives. While anyone who works in an abortion clinic is complicit in the eyes of anti-abortion groups, they have an especially fervent hatred for physicians who perform the abortion procedure.

C: <u>Non-physicians in freestanding clinics: Limited prestige and low pay</u>

Non-physicians are usually protected from the worst of outside-clinic stigmatization, which is reserved for physicians, but they also experience abortion provision stigma in ways that their physician coworkers do not. Theoretically, prestige counterbalances work stigma to some degree. Physicians have a protective "status shield" (Stenross & Kleinman, 1989) due to their greater incomes, levels of education, and access to professional resources, relative to non-physicians. However, in the case of abortion physicians, it is unclear how much prestige the "physician" aspect of their occupation survives the stigma allotted to the "abortion" aspect of their work. Regardless, non-physicians' work roles and medical assistants, in particular, are not

generally thought to be as prestigious as being a doctor but are still subjected to stigmatization for their association with abortion. This was especially true for non-physicians at freestanding clinics.

> *"[Non-physicians] that are involved get the same stigma, they still can't say 'I work at an abortion clinic', they just say I work at a clinic. So they get the stigma but I don't think that they get the pedestal. I mean when it comes to the pedestal it really is about the physicians…so a lot of those people have the negative aspects but don't get to experience all of the positive aspects to it."*
>
> - Dr. Kendrick, Advocate Type, Hospital Clinic B

Abortion stigma means that abortion work is literally valued less than other aspects of healthcare. There are many ways to earn more money as a physician than one would as an abortion provider. Abortion physicians choose their occupation because making a stigmatized service available to women is important to them. Non-physicians in freestanding clinics also trade higher pay elsewhere for the opportunity to be involved in abortion care, but start from a much smaller potential salary than physicians. This is especially true for medical assistants. Physician participants saw this devaluation of medical assistants' work as a stigma in and of itself.

> *"I mean it's not that I do it for the money but there is a validation in [being paid]…and I mean, those poor medical assistants, their stigma is also that they're totally underpaid and under appreciated so to me that's far worse, you know? And you could only get people to work that hard for that little money if they also have some passion for the issue…they're just not appreciated enough."*
>
> - Dr. Rouse, Advocate Type, Freestanding Clinic A

Low pay for medical assistants and patient representatives in freestanding clinics was sometimes prohibitive to their ability to continue work in abortion care, despite their strong desire to do so.

> *"I don't see myself doing this forever, you know I really don't. I mean I couldn't imagine making the same amount of money, being my age, having two roommates---things like that, that is the downfall of my job, to be honest. If you don't have a degree where you're the nurse anesthetist or you're not the physician*

assistant or you know that makes it hard …I love what I do now, though and that's important, but who knows what I'll do."

- Ms. Mulroy, Advocate Type, Patient Representative, Freestanding Clinic B

D: <u>Unequal access to sustaining influences among physicians and non-physicians</u>

"I don't understand how a provider could fail to be sustained by individual patient experience. There is nothing that can be more sustaining. Certainly, it helps to have support of family and the support of a social structure and I think that groups like the National Abortion Federation and increasingly, Physicians for Reproductive Health can provide that kind of social structure, but knowing on an individual basis how it helps patients is what's so helpful. I frankly think it might be harder for some people who work in more administrative positions to stay connected with the heart of what they do…someone who may not day in, day out see the compelling clinical stories of patients, might fall into the having a job for a job's sake or just failing to remember what it is about this that keeps us all running."

- Dr. Campbell, Advocate Type, Hospital Clinic B

All participants were emphatic about the importance of connecting with patients and with other providers in order to successfully manage stigma and avoid burnout. Due to the high volume of patients in freestanding clinics, physicians sometimes did not get the benefit of patient interaction to the extent that non-physicians did. All physicians who worked at least part time in freestanding clinics indicated that minimal patient interaction could wear on them over time. When they noticed themselves feeling "drained", either recalling specific patient interactions or initiating new ones was helpful.

Sometimes physicians' technical skills meant that for the sake of efficiency, their time could not be spared doing tasks that could be performed by non-physicians. However, their standing as physicians connected them to professional networks of other abortion-providing physicians. These relationships were very important to physicians' sense of support and community in abortion work, which can otherwise be alienating and isolating for physicians. Interacting with smart, compassionate, motivated peers made

physicians that much more enthusiastic about their work and confident in its social importance.

> *"The family planning community is very, very tight knit and very supportive of each other to a point where it truly is like a family. So having that ability to talk to each other about things that happen and how are we going to work on it and how are we going to move forward, I mean, there is nothing like it. There is nothing else like that internal support that we have among our peers and like good friends---you're just really good friends because you care about these things so passionately and have so much in common."*
>
> - Dr. Rostami, Advocate Type, Hospital Clinic B

Connection to other abortion physicians was also important to sharing information that is important for abortion providers but would not be known or discussed by non-abortion providing physicians. Several participants described the security tactics they learned from other abortion physicians who had learned it themselves out of necessity, which reinforced the importance of abortion-providing physicians connecting with each other and sharing information. These connections were usually made during their training, professional associations or at professional meetings like the National Abortion Federation (NAF) conference.

For the most part, non-physicians did not have access to professional conferences or other opportunities to network with other non-physician abortion providers and share information and resources, but they were unanimously, overwhelmingly interested in such opportunities. Some non-physicians had previously been able to attend a NAF conference and described the experience as beneficial, appreciated and important to the work that they, personally, do.

> *"The other thing that's been very useful to me has been going to NAF, especially when it comes to learning about legal issues, which is really important because I have to understand what I'm doing legally, and patients ask me some really prickly legal questions like, you know, 'is the baby in one piece when it comes out?' And I know from NAF about the partial birth abortion law and there is a*

> *really particular way you need to answer that question, to not risk getting the surgeon in trouble. So abortion nurses should be able to go to NAF and if the clinic doesn't want to pay for that it would be great if some outside somebody would….it would make abortion nurses feel like they're part of the larger abortion team."*
>
> - Nurse Dahl, Advocate Type, Recovery Room Nurse, Freestanding Clinic B

Like Nurse Dahl, other non-physicians understood the financial barriers to attending conferences, but felt that not being able to attend signaled that their physician counterparts did not really see non-physicians as "part of the team".

> *"Have a conference that shows that everybody is a part of the team and include different aspects of different roles. I think that helps a lot to let everybody know that their part is important, that it's valued by the other people…you send one physician to NAF and everybody else is just there working, everybody else has emotions and difficult psyche things going on, too…You've got to focus on everyone, and that's one thing that I don't see, you know….that's what I think for the NAF or the other organizations, they need to have sessions and workshops for workers, too because everybody needs education and everybody needs some type of stress relief."*
>
> - Nurse Merrick, Utilitarian Type, Nurse Anesthetist, Freestanding Clinic B

Feeling excluded from the abortion-providing team was especially frustrating for non-physicians because they felt "invisible" or unimportant in their other professional communities, as well.

> *"Abortion is very invisible within nursing and nursing is very invisible within abortion care. Like, if you go to a National Abortion Federation conference, there is no nursing…so I feel invisible in both nursing and abortion care."*
>
> - Nurse Dahl, Advocate Type, Recovery Room Nurse, Freestanding Clinic B

> *"I have done a lot of searching for continuing education [for social work], but I've not encountered one on abortion. One of the things I really want to do, when I have energy, is to do a small, half day continuing education thing for other social workers about certain aspects of [abortion care as a social worker] that I think are critical, so that they can then bring that to their own organizations if they have clients who need an abortion or are dealing with unwanted pregnancies, but there is nothing out there. So long story short, what I want is for other medical professionals and organizations to legitimize abortion at an organizational level so that this can be discussed. And I think that would do a lot to support the rest of us who are involved in abortion care."*
>
> - Ms. Dougherty, Advocate Type, Social Worker, Freestanding Clinic A

> *"I've been a nurse for over 35 years, and I read all my nursing journals and magazines and never is there anything in there about abortion care or miscarriage---there is stuff about pre- and post-op ob/gyn ,but never about a woman going through an abortion or implications of it for her. I mean, there is so much that could be done."*
>
> - Nurse Kerr, Advocate Type, Hospital Clinic B

Increased opportunities for training and conferences would acknowledge non-physicians as members of the team and demonstrate respect for the unique contributions they make to abortion care. Non-physicians were also simply interested in learning from others in their roles at other clinics, in the interest of doing their job as well as possible. They wanted to share information about role-specific specific tasks and learn more about the larger abortion care landscape beyond their clinic.

> *"It would be a great opportunity for me to see what other people's perspective is on what we do, because I know my own thoughts of course, but it would be nice to see things from other people's perspectives who participate in providing abortions. It's something I've always wanted to do. You know I see other medical assistants who get to go to conferences and learn different things about their job or learn different skills and we just don't have that opportunity."*
>
> - Nurse Merrick, Utilitarian Type, Nurse Anesthetist, Freestanding Clinic B

> *"I would like to know more about the different organizations that are involved with abortion, some information on how other clinics operate, or how their staff get through hard situations, and some information on what's going on politically with abortion."*
>
> - Nurse Merrick, Utilitarian Type, Nurse Anesthetist, Freestanding Clinic B

As they enthusiastically described the various trainings or conferences they would like to be a part of, and what they hoped to learn from such experiences, non-physicians would eventually conclude that taking advantage of these opportunities would not be possible, financially. Resources are scarce in abortion care, and participants agreed that the priority in distribution of those resources should be on activities that directly benefit patients. However, making professional conferences, networking and training more accessible to non-physicians would provide returns on that investment in many ways.

Sustaining a robust abortion-providing workforce requires commitment from workers at all levels. Providing professional development opportunities for non-physicians would make them feel "part of the group" and show them that their contributions are appreciated by physicians who otherwise comprise the "abortion provider" group. Creating training and information-sharing opportunities for non-physicians would demonstrate respect the fact that they, like physicians, have important skills and knowledge that require maintenance.

While the community of physicians who provide abortion is small, often invisible and actively marginalized within the medical field, the same is true for non-physicians among their role-specific communities. Failing to nurture non-physicians' desire to be more integrated with the abortion community is an enormous missed opportunity, as it would only lead to greater commitment to the cause and solidarity among all work roles involved in abortion care. If, as non-physicians indicated, simply being included in more professional development activities would make this possible, it seems well worth the financial investment required.

X. DISCUSSION

A. Limited applicability of Dirty Work to stigmatization of abortion providers

The constructs and propositions of Dirty Work make sense when applied to "stigmatized work" in general, and may reflect stigma management processes that are important for workers in occupations other than abortion work. However, results of this study indicated that Dirty Work was of limited applicability in explaining the experiences of abortion providers.

1. Individual versus group-level ideologies of stigmatized work

While Dirty Work assumes an occupational group level of analysis, its outcome is an individual-level construct: work role identification. The meaning of the term is vague in Ashforth and Kreiner's description, but I understand it to mean that stigmatized workers entertain the stigmatized view of their work, engage in various ideological and work group processes and arrive at work role identification, where they conclude they feel good about their work despite its stigmatization.

Dirty Work's focus on group-level ideologies that eventually lead to an individual work role identification did not reflect the experiences of abortion providers because individual abortion providers, not the occupational group as a whole, subjectively determine what their work means to them and how they feel about it. All participants in this study had many responsibilities, of which abortion care was one, and the aspect of their work that they most identified with was sometimes something other than abortion. The variety of work roles included in the sample and participants' individual constructions of their work meant that many "occupational groups" existed within the entire group of abortion providers. Some ideologies of work were common to subgroups

of participants in this study, but those did not necessarily cohere around work roles or work groups. For example, utilitarian and advocate types have different ideologies of the meaning of their work and a mix of work roles and clinic affiliations are represented in each group.

Fundamentally, positive work role identification as a symbol of successful stigma management does not apply to abortion providers. The problem of stigma for abortion providers is not how they feel about themselves or identify with their work role, but that despite how they feel, their work makes them socially, professionally, and personally vulnerable. Most participants in this study felt very proud and fulfilled in their work, but this offered little protection from overt stigmatization and harassment. "Managing" stigmatization does not really reflect abortion providers' experiences, as it implies more control than they actually have. More accurately, providers "tolerate" stigma in the absence of being able to do anything about it other than to remain steadfast in their work, which many participants described as the most important form of advocacy they could do.

2. Assumption that a stigmatized view of abortion predominates workers' identities

Dirty Work suggests that management of stigma is accomplished through stigmatized workers' use of various occupational group ideologies and processes to reject the stigmatized view of their work and replace it with one that makes them feel like a good person doing good work. This is meant to be an ongoing process that takes place while the stigmatized worker occupies the stigmatized role. Study participants' experiences were not consistent with this proposition.

Abortion providers would not be abortion providers if they had not fundamentally rejected the stigmatized version of their work prior to ever becoming involved in abortion care. Providers' conceptualizations of the meaning of their work are rooted in individual morals and beliefs that predate and will be outlived by their involvement in abortion work. In Dirty Work terms, positive work role identification is the endpoint of stigma management processes that occur while workers engage in stigmatized work. Study participants often chose their profession specifically because they rejected the stigmatized view of abortion work and recognized the great need for abortion providers created by that stigma.

B. How providers tolerate abortion stigma: Moral compulsion

The morality of abortion is complex and is not fixed, but how to act on "what is right" comes down to two basic options. Participants in this study did not blind themselves to the uncomfortable truths about abortion or treat them cavalierly in order to feel good about their work. They gave serious consideration to stigmatized views of abortion, holding the uncomfortable realities of abortion among all other aspects of the situation. They reflected on their values, acknowledged that either the pregnant woman or the pregnancy has to be prioritized, and decided how to proceed. Their options were to help the pregnant woman who does not want to be pregnant by terminating the pregnancy or to allow the fetus to continue developing and in so doing fail the pregnant woman. For healthcare providers confronted with this situation, there is no third option; "doing nothing" is effectively choosing to not help the woman, as the pregnancy will continue without interruption.

Through their individual assessments of the morality of abortion, participants arrived at their sense of the meaning of their work. These resulted in groups of advocate and utilitarian types, but the themes that defined these groups are inherently moral. Reconsider the pathways to their sense of pride and fulfillment in abortion care (Figure 8). Through inquiry into their own values and implications of those values for abortion patients, participants arrived at clear moral obligations to provide abortion care, whether those obligations were to patients, to themselves or to abortion as a cause. This is how abortion stigma was "managed" by participants. Given the skills and opportunity to provide abortion care, participants were morally compelled to do so and stigmatization was made tolerable by necessity.

C. Supports and Counterbalances to Stigma for Abortion Providers: Connection and Communication

While providers may not be able to manage stigma in the sense of interacting directly with it, they can counterbalance and sometimes avoid negative effects of stigma through tactics and supports that were helpful to participants. All participants endorsed disclosure management as an effective way to avoid stigmatization. Expanded access to professional development opportunities for non-physicians may impact their pride in their work, commitment to abortion and sense that they are valued team members where abortion is concerned. It would also provide them access to networks of like-minded peers, which physicians indicated was extremely important to counterbalancing stigma.

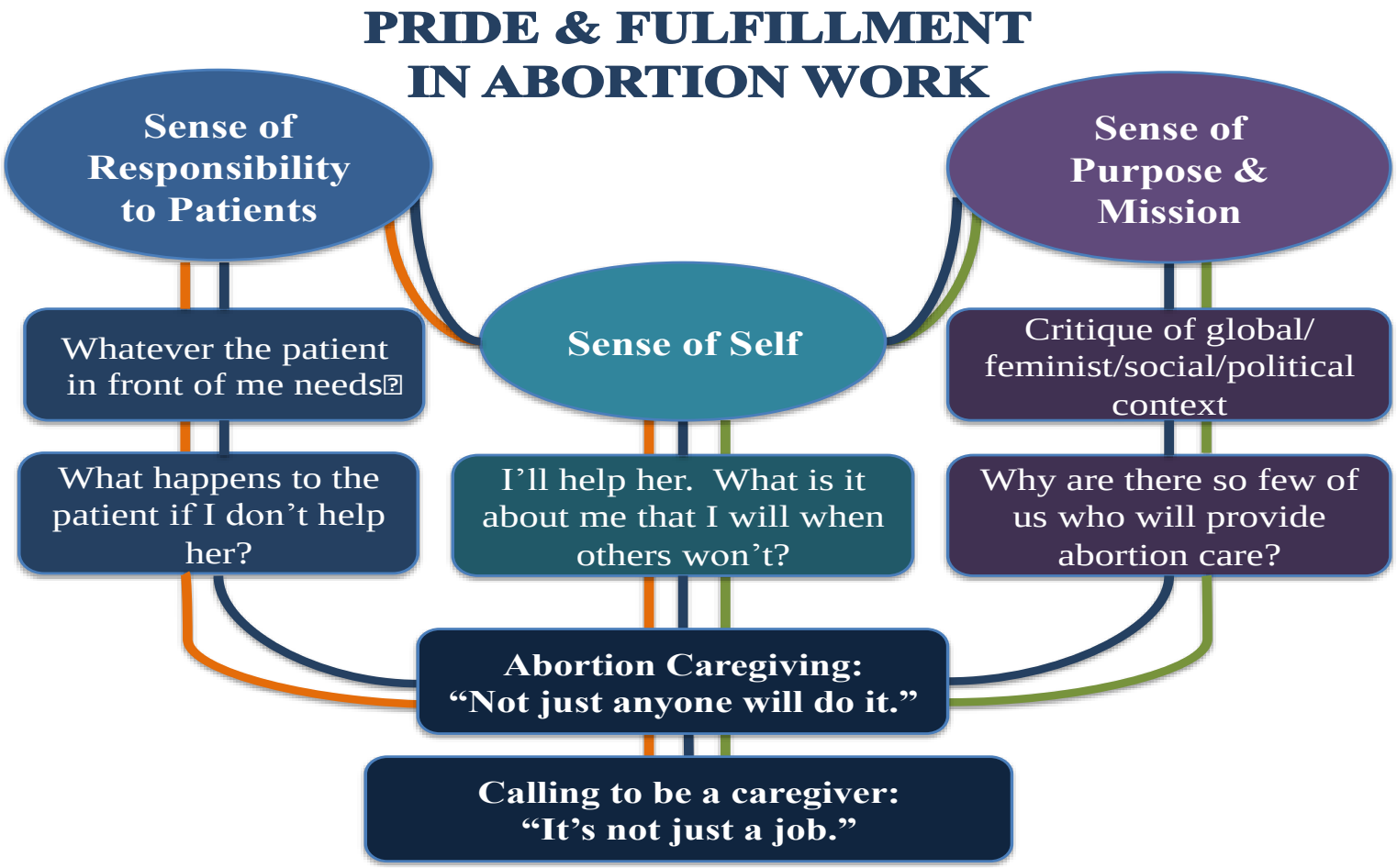

Figure 8: Typical pathways to pride and fulfillment in abortion work.

Communication is key to providers feeling valued, respected and supported in their work. Unfortunately, communicating openly and honestly about abortion can be difficult. The topic is morally, religiously and politically fraught and often avoided altogether when there is perceived potential to offend someone or misrepresent one's own views. The first challenge is figuring out what it is that you want to say, and then you have to figure out how to say it. Simple and intuitive in theory, this is often not the case in practice, particularly for complex ideas that merit discussion specifically because they are hard to talk about.

Even within groups of abortion providers, there were topics that were difficult for participants to know what they wanted to say, and how to say it in a way they were comfortable with. Talking about the fetus, details of the abortion procedure and their feelings about either were particularly challenging. My usually easy, engaged conversations with participants suddenly felt tense when these issues came up, as though we had entered a conversational minefield. Direct communication sometimes became difficult and participants' honest, potentially controversial statements were immediately followed by a series of qualifiers meant to dilute or contextualize the true, if uncomfortable, thing they had just shared. Participants were not alone; I too struggled with this at times in interviews and have certainly struggled with how to phrase things while communicating something important about abortion work while writing this dissertation. However, I had the benefit of knowing more about participants than they knew about me, and while I was confident I would not judge them harshly for anything they shared, they simply had to trust that was the case.

Despite the difficulty in open, honest communication about aspects of their work that were challenging, that was exactly what participants felt would be most helpful to them, individually, and as a group. As Chapter VII illustrated, within each clinic, there were problems in the workgroup that were either born of poor communication or were worsened by poor communication. With the exception of Ms. Orlowski, who felt that being honest with her coworkers would result in the loss of her job, participants all expressed that more open communication with their fellow providers would be beneficial. Key to making this truly helpful and not harmful, however, is that everyone involved would have to commit to a humble approach that allows for saying things imperfectly and acknowledges a diversity of viewpoints. To identify the language that works best to address difficult aspects of abortion work, providers need to be encouraged to broach those topics with whatever language initiates the conversation. There does not need to be consensus on how to talk about abortion, just as there does not need to be a consensus on how to think about abortion. Many participants shared ideas with me that they thought were unique to them and in fact were shared by their peers. Sharing freely with one another will undermine the notion that there is only one acceptable way to think about abortion care and allow providers to see their own views reflected and respected by their peers.

Some participants had done "values clarification" activities about abortion and felt that they were helpful to varying degrees. Dr. Campbell expressed concern that values clarification for abortion care exceptionalizes abortion among all reproductive health services, which may undermine understanding of abortion as a normal aspect of taking care of women. In the Providers' Share Workshop, abortion providers met to

share experiences with abortion work covering topics like memorable stories from abortion work, abortion and identity, abortion politics and strategies for self-care (Harris et al., 2011; Martin et al., 2014). An earlier version of the Abortion Provider Stigma Survey (APSS) demonstrated that providers' stigmatization scores did not change from the baseline assessment to completion of the workshop (Martin et al., 2014), but this may be consistent with my proposition that providers cannot manage stigma so much as tolerate it. The lack of change in Providers Share Workshop participants' stigmatization scores does not mean that the workshop was not beneficial for them in terms of providing them with support that counterbalances stigma. Qualitative inquiry into the effects of the Providers Share Workshop may indicate that it is valuable to providers even if it does not diminish their experience of stigma.

Another route to nurturing communication among providers could involve group discussion about the social history and current state of abortion in the U.S. These discussions may facilitate providers sharing about their own perspectives on abortion. A few participants expressed interest in hearing from people who provided abortions in the 1970's. Understanding their work as part of a movement with historic dimensions may make providers feel renewed in their commitment to providing abortion services.

D. Ethical Dilemmas in Qualitative Research with Abortion Providers

I experienced several ethical dilemmas while conducting this study that may be relevant for other researchers or my own future research. These are particularly important to qualitative research and to protection of confidentiality in research with abortion providers. For example, on one occasion, a participant mentioned to me that she was uncomfortable with situations where a woman terminates a pregnancy due to sex

selection. I worried that she had just indicated that the clinic she works at does something illegal, even though she phrased it as a hypothetical situation. Unsure of the legal implications of her statement and doubtful that my institution's IRB would be helpful, I called a member of my dissertation committee who referred me to a reproductive justice lawyer for the ACLU. The lawyer explained that, due to an injunction filed yearly by the ACLU, it is not illegal to terminate for sex selection in the state where the study took place. I was incredibly relieved and selfishly wondered how I would deal with my research and life being upended by such a situation.

The main ethical challenge I have confronted and still do not know how to respond to, is how to conduct in-depth qualitative interviews with a small (by necessity) sample of providers and not expose anyone's identity, thereby making them vulnerable to judgment, embarrassment, harassment or professional repercussions. All participants understood that their interviews were confidential, and I made a point to note in the consenting process that the abortion-providing community is small and it is possible that other providers might be able to identify them if they read results of the study when they are published. I am also concerned that anti-choice groups could identify clinics or providers. Despite their informed consent, I still struggle with how to protect participants' anonymity sufficiently, and expect to continue struggling with that as long as I study anything related to abortion or stigma. Rigorous member checking is one way to ensure that participants are involved in deciding what information is shared about them, and will make their informed consent for participation more meaningful by allowing them to responding to results.

E. Limitations and Directions for Future Research

The findings of this study should be interpreted in light of its limitations. Given the socio-political context of abortion in the U.S. as I was recruiting participants and collecting data, it is possible that the sample over-represents people who considered themselves advocates for abortion and underrepresents those who felt unconnected to abortion as a political cause or who were intimidated by the idea of being recorded as they discussed abortion. Also participants' experiences with stigmatization may be very different than other providers, particularly those who work in rural, suburban or politically conservative areas.

Relying primarily on qualitative interview data allowed me access to rich personal stories and viewpoints that may not have been shared in a group setting, but I was not able to triangulate that data with direct observation of group dynamics on which participants reported. Participants may have provided me with socially desirable responses on topics that would hurt my perception of them, their reputation, that of their clinic and workgroup, or of abortion as a whole.

This study was my dissertation project for completion of my PhD in Public Health. As an academic project, I had limited funds available to conduct the study and the scope of it had to be manageable by just me. This meant that with the exception of my second coder's assistance with coding, I was unable to approach study design and analysis in a collaborative manner. This is a significant limitation because an important reflexive tool is peer consultation (Berger, 2015). In addition to enhancing the trustworthiness of the findings, it would have been ideal for analysis of qualitative data to share that task with at least one other qualitative researcher who was familiar with the

data as I was. As the culminating project demonstrating my abilities in research, it was frustrating to have to compromise on methodological decisions in service of the study as a dissertation. To facilitate the highest quality of qualitative research among PhD students' dissertation work, academic institutions and advisors should consider team dissertation projects where individual student inquiries are represented but facilitated by group analysis.

Future analyses of the data from this study will triangulate individual items of the APSS with the qualitative interview data to identify aspects of stigma that were captured uniquely by either method. Future studies of abortion provision stigma should include larger, more geographically inclusive samples of providers. This would facilitate comparisons that highlight the effects of state-level policies on providers' experiences of stigma and represent a greater diversity of provider experiences.

XI. CONCLUSION

"Stigma just needs to go away. And it shows no signs of going away."
- Dr. Simpson, Advocate Type, Freestanding Clinic A

There is no way, and should not be a way, to impose on everyone a uniform conceptualization of the morality of abortion. To advocate that we can or should impose a particular construction of abortion on everyone is an inherently anti-choice logic. Thus, stigmatization of abortion is inevitable, and even good insofar as it reflects individuals' freedom to conceptualize a pregnancy in whatever way suits them best. This is why we advocate choice.

In absence of a way to impose their own conceptualization of abortion on everyone, those who think of abortion as amoral use informal (e.g. shaming, harassment, silencing) and formal (e.g. legislation) techniques of social control to restrict individuals' freedom to act on their own understanding of pregnancy, abortion and what is right for them. Politicization of abortion and the fact that the group that advocates continued access to abortion is referred to as "pro-choice" has made it so that "choice" is now sort of synonymous with advocating for abortion. This is unfortunate, as the close association of "abortion" and "choice" probably precludes thoughtful consideration of what choice really means, and who is actually pro-choice. Essentially, choice is the antithesis to control. If you want to control other peoples' ability to have an abortion, then you are not pro-choice. Everyone else is pro-choice by default, regardless of how they conceptualize abortion or whether they would ever have an abortion. Identifying one's own pro-choice beliefs is a first step towards acting on those beliefs, which is crucial to protecting women's right to choose.

Anti-choice sentiment and legislation currently has a terrifying momentum and will effectively eliminate access to abortion if not met with tenacious resistance from pro-choice people. To be passive about access to abortion now is to concede to anti-choice aims. The fact that providers in this study felt alone and misunderstood is not attributable to anti-choice activists, it is the failing of pro-choice people to visibly, proudly support abortion and abortion providers, specifically. Support can come in many forms, and should. Small things, when adopted by large groups of people, can create new social norms and political will. People who support choice need to speak proudly about it when it comes up in casual conversation, share their personal experiences with abortion if they are comfortable doing so, encourage their friends and loved ones to distinguish "pro-life" from "anti-choice" in their ideas and language, stay informed about the ever-changing political landscape of abortion, vote, discuss abortion in their faith communities, volunteer for a clinic, donate to an abortion fund, challenge anti-choice legislators and legislation, run for political office, include abortion-positive storylines in the media, become an abortion provider…in short, pro-choice individuals must act on their ideological commitments and "loose political affiliations" where choice is concerned.

Providers will continue providing compassionate abortion care, but they require support to counterbalance their stigmatization and to keep abortion accessible. Ideally, abortion would be in public perception what providers know it to be in their private interactions with patients: a safe, normal medical procedure that is important to women's health and wellbeing.

APPENDICES

Appendix A: Research Methods Crosswalks

Research Questions – Constructs Crosswalk

Main Research Question	Sub-Research Question	Constructs
1. How is the experience and management of abortion provision stigma similar or different for providers working in freestanding versus hospital-based clinics?		• Work role identity • Salience of social perceptions of dirtiness • Strength of occupational/workgroup culture • Occupational/workgroup ideologies • Social weighting • Morality in abortion provision • Pride in abortion provision • Satisfaction in abortion provision • Selective disclosure of abortion provision • Abortion advocacy • Professionalization of abortion provision
2. What does abortion provision work mean to abortion providers?	**2a. What do abortion providers feel are the defining features of their work?**	• Work role identity • Occupational/workgroup ideologies
	2b. How do abortion providers feel about the defining features of their work?	• Work role identity • Occupational/workgroup ideologies • Selective social comparisons • Morality in abortion provision • Pride/satisfaction in abortion work

Appendix A: Research Methods Crosswalks (continued)

Research Questions – Constructs Crosswalk

Main Research Question	Sub-Research Question	Constructs
3. How do abortion providers experience stigmatization of their work?	**3a. Where and when is stigma salient for abortion providers? How does it manifest?**	• Work role identity • Salience of social perceptions of dirtiness
	3b. When abortion providers experience stigmatization of their work, how do they feel it impacts them?	• Work role identity • Salience of social perceptions of dirtiness • Strength of occupational/workgroup culture • Occupational/workgroup ideologies • Social weighting • Pride in abortion provision • Satisfaction in abortion provision • Selective disclosure of abortion provision • Professionalization of abortion provision

Appendix A: Research Methods Crosswalks (continued)

Research Questions – Constructs Crosswalk

Main Research Question	Sub-Research Question	Constructs
		•
4. How do providers respond to stigmatization of their work?	**4a. What ideologies are important to abortion providers' management of stigma?**	• Work role identity • Salience of social perceptions of dirtiness • Occupational/workgroup ideologies • Social weighting • Pride/satisfaction in abortion provision
	4b. What actions are important to abortion providers' experiences and management of stigma?	• Work role identity • Salience of social perceptions of dirtiness • Strength of occupational/workgroup culture • Selective disclosure of abortion provision • Abortion advocacy • Professionalization of abortion provision

Appendix A: Research Methods Crosswalks (continued)

Construct – Definition – Measurement Crosswalk

Construct	Definition	Observation	Interview	APSS
"Dirty Work" Constructs				
Work role identity	The set of central, distinctive, and enduring characteristics that typify a line of work		X	
Salience of social perceptions of dirtiness	Extent to which stigma can be observed, felt and experienced by dirty workers.	X	X	X
Strength of occupational/workgroup culture	Cohesion of values/beliefs/norms and engagement of "us" versus "them" logic among workers in a given occupation.	X	X	X
Occupational/workgroup ideologies: Reframing	Process of transforming the meaning of a stigmatized occupation.		X	X
Occupational/workgroup ideologies: Refocusing	Process of shifting attention from the "dirty" aspects of the work to less stigmatized features of the occupation.		X	

Appendix A: Research Methods Crosswalks (continued)

Construct – Definition – Measurement Crosswalk

Construct	Definition	Observation	Interview	APSS
Occupational/workgroup ideologies: Recalibrating	Process of modifying the perceived magnitude and/or valence of a given aspect of dirty work.		X	
Social weighting: Condemning condemners	Impugning the motives, character, knowledge or authority of critical outsiders as moral arbiters of dirty work.		X	X
Social weighting: Supporting supporters	Placing credence in outsiders who have a positive view of dirty work.		X	X
Social weighting: Selective social comparisons	Making downward social comparisons that provide the dirty worker with self-esteem in their work.		X	
Additional Constructs				
Pride in abortion provision work	A high opinion of one's importance or merit courtesy of involvement in abortion care.		X	X
Morality in abortion provision	System of values or principles of conduct that dictate that abortion is right in a given instance, and that by extension, abortion care is right.		X	X

Appendix A: Research Methods Crosswalks (continued)

Construct – Definition – Measurement Crosswalk

Construct	Definition	Observation	Interview	APSS
Satisfaction in abortion provision	Gratification and enjoyment of abortion care responsibilities and activities		X	
Selective disclosure of abortion provision	Act of judiciously, not indiscriminately, sharing information about one's role in abortion work, including job titles, names of workplace and specific work roles and responsibilities.		X	X
Abortion advocacy	Active support of abortion outside the activities and responsibilities of one's abortion provision work role.		X	
Professionalization of abortion provision	Activities that seek to enhance the esteem of the occupation through attainment of special knowledge, skills, training or collegiality among those within the profession.		X	

Appendix A: Research Methods Crosswalks (continued)

Construct – Instrumentation Crosswalk

Construct	Question (abbreviated)	Instrument
"Dirty Work" Constructs		
Work role identity	1. Can you give me a quick overview of your roles and responsibilities here in in the clinic? 2. How does the term "abortion provider" work for you, personally? Other terms that you like better or more accurately describe your work? 3. How does abortion fit into your sense of your job? 6. From "just a job" to a "calling", where does abortion work fall for you? 7. How do you think you might feel if you stopped being involved in abortion care? 11. How does stigma impact you and others in abortion work? 14. Do you identify as an abortion advocate? 17. Anything else people should know about abortion provision work or stigma associated with it?	Interview

Appendix A: Research Methods Crosswalks (continued)

Construct – Instrumentation Crosswalk

Construct	Question (abbreviated)	Instrument
Salience of social perceptions of dirtiness	A3. Safety infrastructure (e.g., fence, metal detectors, protective glass)? A4. Anti-abortion activities/messages?	Observation
	9. Is abortion stigmatized? Are abortion providers stigmatized? Why do you say so? 10. Instances, interactions that have made you feel that abortion work is stigmatized? Reaction to it? 11. How does stigma matter? What is its impact? 17. Anything else people should know about abortion provision work or stigma?	Interview
	2. Newspapers/television take a balanced view about abortion care. 4. I feel that patients use me as an emotional punching bag.	APSS
Strength of occupational/workgroup culture	B2. Connected to other health services/clinics? B3. Spaces used by workers outside the exam rooms---description?	Observation
	1a. With whom do you work? What is the group dynamic like? 12. Faced with stigma, what ideas or patterns of thought help deal with stigma? What ideas or patterns of thought make stigma worse? Reinforced by others? If so, by whom?	Interview
	6. I feel connected to others who do this work.	APSS

Appendix A: Research Methods Crosswalks (continued)

Construct – Instrumentation Crosswalk

Construct	Question (abbreviated)	Instrument
Occupational/workgroup ideologies: Reframing Refocusing Recalibrating	5. How would you describe the importance of your work to patients, coworkers, yourself? 6. From "just a job" to a "calling", where does abortion work fall for you? 7. How do you think you might feel if you stopped being involved in abortion care? 10. Instances, interactions that have made you feel that abortion work is stigmatized? Reaction to it? 12. Faced with stigma, what ideas or patterns of thought help deal with stigma? What ideas or patterns of thought make stigma worse?	Interview
	5. I am proud that I work in abortion care. 6. I feel connected to others who do this work. 7. By providing abortions I am making a positive contribution to society.	APSS
Social weighting: Condemning condemners Supporting supporters Selective social comparisons	10. Instances, interactions that have made you feel that abortion work is stigmatized? Reaction to it? 12. Faced with stigma, what ideas or patterns of thought help deal with stigma? What ideas or patterns of thought make stigma worse? 13. How, if at all, do the opinions of others about your work matter to you?	Interview
	2. Newspapers/television take a balanced view about abortion care.	APSS

Appendix A: Research Methods Crosswalks (continued)

Construct – Instrumentation Crosswalk

Construct	Question (abbreviated)	Instrument
Additional Constructs		
Morality in abortion provision	5. How would you describe the importance of your work to patients, coworkers, yourself? 6. From "just a job" to a "calling", where does abortion work fall for you? 12. Faced with stigma, what ideas or patterns of thought help deal with stigma? What ideas or patterns of thought make stigma worse?	Interview
	7. By providing abortions I am making a positive contribution to society.	APSS
Pride in abortion provision	5. How would you describe the importance of your work to patients, coworkers, yourself? 6. From "just a job" to a "calling", where does abortion work fall for you? 12. Faced with stigma, what ideas or patterns of thought help deal with stigma? What ideas or patterns of thought make stigma worse?	Interview
	5. I am proud that I work in abortion care. 7. By providing abortions I am making a positive contribution to society.	APSS

Appendix A: Research Methods Crosswalks (continued)

Construct – Instrumentation Crosswalk

Construct	Question (abbreviated)	Instrument
Satisfaction in abortion provision	5. How would you describe the importance of your work to patients, coworkers, yourself? 6. From "just a job" to a "calling where does abortion work fall for you? 12. Faced with stigma, what ideas or patterns of thought help deal with stigma? What ideas or patterns of thought make stigma worse?	Interview
Selective disclosure of abortion provision	3. How do you describe your job to different people? How do you determine how it will be described?	Interview
	1. People's reactions to my being an abortion worker make me keep to myself. 3. I feel marginalized by other health workers because of my decision to work in abortion care. 8. I feel like if I tell people about my work they will *only* see me as an abortion worker. 9. I worry about telling people I work in abortion care. 10. It bothers me if people in my neighborhood know that I work in abortion care. 11. I avoid telling people what I do for a living. 12. I am afraid that if I tell people I work in abortion care I could put myself or my loved ones at risk for violence. 13. I find it important to share with people that I work in abortion care.	APSS

Appendix A: Research Methods Crosswalks (continued)

Construct – Instrumentation Crosswalk

Construct	Question (abbreviated)	Instrument
Abortion advocacy	14. Do you identify as an abortion advocate?	Interview
Professionalization of abortion provision	16. Professional supports that would be helpful to you or others in dealing with stigmatization of your work?	Interview

Appendix B: Data Collection Instruments

Structured Interview Guide for Clinic Administrators

"*These are questions I am asking clinic administrators or other staff members about the clinic itself in order to develop a sampling strategy and finalize the study design for my dissertation research project on stigmatization of abortion providers. At this stage, I want to know things that will help me describe each clinic setting and help me match clinic settings to facilitate comparison of these settings. To that end, I'm collecting information about the clinic size, volume, staff size, institutional resources for dealing with stigma and most basically, would your clinic ever consider participating in research. Thank you for your time and help*!"

1. Can you please verify that your clinic offers abortion services and tell me what types of abortions are performed at your clinic (e.g., surgical, medical)?

2. Approximately how many patients of any type are seen per day or week at your clinic? Approximately how many are patients seeking abortion services?

3. What are the four types of staff roles most involved in providing abortion care (e.g., physicians, NP's, medical assistants, social workers, counselors, etc.)?

4. Approximately how many staff are employed at your clinic?
    a. Full-time?
    b. Part-time?

5. Is there any formalized support for dealing with work-related stress and stigma in the clinic?
    a. If such support exists, who can access it?

6. Is there any abortion advocacy arm to the clinic or component of clinic activities? For example, I'm aware that some larger clinics are parts of larger organizations that have abortion advocacy and public affairs activities, like a Planned Parenthood might. Whether on a large scale or small, does your clinic have organized abortion advocacy activities such as public demonstrations, lobbying, abortion rights social marketing campaigns or anything along those lines?

7. Is there a possibility that your clinic could serve as a recruitment and data collection site for my dissertation research? If so, with whom should I talk to formalize research plans at your site?

8. To complete the study design, I want to make sure my list of abortion clinics in the city is complete. Would you please listen to/review this list of abortion clinics and let me know if you know of any clinics that provide abortion care but are not on this list? *Provide clinic administrator with current list of abortion clinics in the city.*

Appendix B: Data Collection Instruments (continued)

Physical Setting of Clinic Observation Guide

Date:
Begin time:
End time:
Observer:
Clinic:

Section A: Outside the clinic:

1. Grand tour
2. Obvious that it is a reproductive health clinic?
3. Safety infrastructure (e.g., fence, metal detectors, protective glass)?
4. Anti-abortion activities/messages?
5. Supportive messages/activities?

Section B: Inside the clinic:

1. Grand tour
2. Connected to other health services/clinics?
3. Exam rooms?
4. Spaces used by workers outside the exam rooms?
5. Reproductive health messages (more general than abortion)?
6. Abortion messages?

Questions?

Appendix B: Data Collection Instruments (continued)

In-depth Interview Guide

Introduction:
Thank you for your willingness to participate in this interview. Your perceptions and experiences will be really valuable to understanding how abortion providers experience stigmatization of their work, how stigma is dealt with, and what we can do better to support abortion providers in dealing with work-related stigma.

Is it alright with you if I record our conversation? The recording will not be attached to your name, in order to protect your privacy. I am also going to take notes as we talk, to make sure I get everything and follow-up on any important questions or ideas that come up.

Do you have any questions or comments before we begin?

1. First of all, thanks for agreeing to talk with me today---I really appreciate it. So, based on the information we've previously discussed, I have some idea about your work here, but can you give me a quick overview of your roles and responsibilities here in the clinic?
    a. With whom do you accomplish these responsibilities? Whom would you say is included in your "workgroup"? (No need to name names, job titles/work roles suffice.)
        i. What is the group dynamic like?
            1. Is it a static or rotating group?
            2. Do you feel you can depend on each other at work?
            3. Do you socialize, joke or share friendly conversations with one another?

2. For the purposes of this study, I've included all sorts of work roles involved in abortion under the umbrella label of "abortion provider", but I understand that not everyone who is involved in abortion services would call himself or herself an "abortion provider". How does that term work for you?
    a. Are there other terms that you like better or feel more accurately describe work? If so, what are they?

3. When you describe your job to people outside the clinic, what do you say you do?
    a. Is this different than how you would describe it to people within the clinic?
    b. What about other colleagues in the health/medical field?
    c. How do you determine the way you're going to describe your job to a given person?

4. Great, thank you for that. As you know, I'm trying to learn more about what being involved in abortion care means to a variety of workers involved in abortion

Appendix B: Data Collection Instruments (continued)

In-depth Interview Guide

care. I don't assume that it means the same thing for everyone, by any means, so can you please tell me about how abortion figures into your sense of what your job is?

5. Assume I know nothing about abortion. How would you describe how the work that you, personally, do here is important to abortion patients?
    a. How is your work important to your coworkers?
    b. How is your work important to you?
    c. What about in a more global sense?

6. For some people a job is just a job, while others feel that their job is their passion or their calling. Probably, most people are somewhere in between. Where would you say your involvement in abortion care falls on that spectrum?

7. How do you feel about the tasks and activities associated with your job? Do you enjoy them? Why or why not?
    a. What parts, specifically, are satisfying or unsatisfying? What about them is satisfying or unsatisfying?

8. How do you think you might feel if someday you stopped being involved abortion care?
    a. Can you please tell me why you think you'd feel that way?
    b. Can you imagine this happening in the future? If so, what do you imagine would prompt that change?

9. Thank you for all of that---we're going to switch gears a bit now to talk about stigmatization of abortion, and stigmatization of people who work in abortion care. So we're both on the same page, if something is stigmatized, that means that it's disgraced or disapproved of by at least part of society.
    a. If I say, "abortion is stigmatized", what reaction do you have to that statement?
        i. Can you please elaborate on that? Why do you say that?
    b. What about if I say, "abortion *providers* and *people who work* in abortion care are stigmatized"---what is your reaction to that?
        i. Does this statement ring true for you, personally? If so, can you please describe how you've felt stigmatized?
        ii. What about for you as a group, here at the clinic---is it your sense that you're all subject to stigma?
            1. If so, do you think that stigma is relatively less or greater for some than others? Can you tell me about that please?
    c. What about if I say, "abortion providers and people who work in abortion care are *not* stigmatized", what would be your reaction to that?

Appendix B: Data Collection Instruments (continued)

In-depth Interview Guide

[If participant has any indication of agreement with that statement]

i. What about that statement rings true to you? Are there any exceptions where you think abortion providers might be stigmatized?

ii. *[If participant has any indication of disagreement with that statement]* How would you explain that that statement is wrong?

10. Stigma is tricky in that it isn't tangible---we can't easily point to a specific thing and say "that is stigma". That said, we can sense the presence of stigma through interactions, ideas, attitudes, actions, rules---all sorts of things. Thinking broadly about your own experience as an abortion provider, what are some instances, things, or interactions that have made you feel that abortion or abortion work is stigmatized?
    a. What reaction did you have to it?
        i. What, if anything, did you think in response to it?
        ii. What, if anything, did you do in response to it?
    b. Even if not in your own personal experience, how do you think stigmatization of abortion provision might come up for others in this line of work?

11. Let's once again assume I know nothing about abortion. How would you explain to me why stigmatization of abortion work matters? What is the impact of stigma?
    a. How would/has it impacted you, personally, to experience stigmatization of your work?
    b. How would/has it impacted people you work with to experience stigmatization of abortion work?
    c. Are there other possible ways that you think stigmatization of abortion work matters, even if they're not relevant for you or someone you know? If so, please tell me about them.

12. In the face of stigma, there are certain ideas or patterns of thought that help sustain people.
    a. What are some ideas or ways of thinking that help you deal with stigmatization of your work, or avoid it altogether?
        i. Where do you think these ideas come from?
            1. Are they innate to you?
            2. Reinforced by others? If so, by whom?
    b. What about thoughts that you have that make the feeling of being stigmatized worse?
        i. Where do you think these ideas come from?
            1. Are they innate to you? Reinforced by others?

Appendix B: Data Collection Instruments (continued)

In-depth Interview Guide

13. Abortion work is different than a lot of jobs, in that people outside the occupation have strong opinions about it---some of these are very supportive, others are very unsupportive. How, if at all, do the opinions of others about your work matter to you?
    - *a.* Do they matter sometimes more than others? If so, when?
    - *b.* *If participant has only discussed negative opinions of others:* What about people who express support for abortion or abortion work---is that important to you? If so, how?
    - *c.* *If participant has only discussed positive opinions of others:* What about people who are unsupportive of abortion or abortion work---is that important to you? If so, how?

14. Some people involved in abortion care describe themselves as abortion advocates while others do not. Is this a label you would use for yourself? Why or why not?
    - *a.* Are you involved in abortion advocacy activities outside of work? If so, can you please tell me about them?
        - *i.* Why do you take the time and effort to do this?
        - *ii.* How do you feel it affects you to be involved in abortion advocacy outside of work?
            1. How, if at all, does it benefit you?
            2. How, if at all, does it take a toll on you?

15. Apart from personal processes or ways of thinking, are there any activities or actions that are helpful to you or others in dealing with stigmatization of abortion work?
    - *a.* In your personal life?
    - *b.* In your work?

16. Even if they are not currently accessible to you in your clinic or organization, are there any professional supports, activities or opportunities that you think would be helpful to you or others in dealing with stigmatization of your work?
    - *a.* What about values clarification activities?
    - *b.* What about networking with abortion providing colleagues?
    - c. What about other additional training?

17. When jobs or behaviors are stigmatized, the people who do them are not always able to talk freely about them. Before we wrap up, I want to give you the opportunity to say anything else that has occurred to you throughout our conversation regarding your work, stigmatization of your work, or what it all means to you. Is there anything else that people should know? Feel free to take a minute to think about this.

Appendix B: Data Collection Instruments (continued)

In-depth Interview Guide

18. Thank you so much for your thoughts, your openness and your time. Those are all the questions I have---do you have any questions for me?

End of Interview

****Ask participant if they would like to be sent a copy of their interview transcript to review, highlight anything that they are not comfortable with having reported and add anything they feel is important but neglected to say during the interview.*

Appendix B: Data Collection Instruments (continued)

Abortion Provision Stigma and Professional Quality of Life Survey

Section A: Demographics

1. What is your age? _____
2. What is your gender? _____
3. What educational degrees do you hold? _____
4. What is your job title or role within this clinic? _____
5. How many hours per week do you work at this clinic? _____
6. How long have you been employed at this clinic? _____
7. How long have you been involved in abortion care (including your time at any other clinics you may have worked at in the past)? _____

Section B: Abortion Provision Stigma Scale

Please consider your experiences as someone who works in abortion services. Indicate how often you have felt or experienced the following by circling: : All of the time [1], Often [2], Sometimes [3], Rarely [4], Never [5].

	All of the time	**Often**	**Sometimes**	**Rarely**	**Never**
People's reactions to my being an abortion worker make me keep to myself.*	1	2	3	4	5
Newspapers/television take a balanced view about abortion are.	1	2	3	4	5
I feel marginalized by other health workers because of my decision to work in abortion care.*	1	2	3	4	5

Appendix B: Data Collection Instruments (continued)

Abortion Provision Stigma and Professional Quality of Life Survey

	All of the time	**Often**	**Sometimes**	**Rarely**	**Never**
I feel that patients use me as an emotional punching bag.*	1	2	3	4	5
I am proud that I work in abortion care.	1	2	3	4	5
I feel connected to others who do this work.	1	2	3	4	5
By providing abortions I am making a positive contribution to society.	1	2	3	4	5
I feel like if I tell people about my work they will only see me as an abortion worker.*	1	2	3	4	5
I worry about telling people I work in abortion care.*	1	2	3	4	5
It bothers me if people in my neighborhood know that I work in abortion care.*	1	2	3	4	5
I avoid telling people what I do for a living.	1	2	3	4	5
I am afraid that if I tell people I work in abortion I could put myself or loved ones at risk for violence.*	1	2	3	4	5
I find it important to share with people that I work in abortion care.	1	2	3	4	5

Appendix C: Sampling and Recruitment Grid

Clinic	Total staff	Work roles "Most involved in abortion care"
Freestanding Clinics		
Freestanding Clinic A	• Approximately 12 full-time	• Physician • Medical Assistant • Sedation provider • Recovery room staff
Freestanding Clinic B	• 32 full-time • 16 part-time • Approximately 48 total	• Physician Assistants/Nurse Practitioners • Physicians • Medical Assistants • Admitters
Hospital-based Clinics		
Hospital Clinic A	• 1 full-time • 6 – 7 part-time • Approximately 7 - 8 total	• Medical assistants • Clinic administrator • Physicians and fellows • Nurse
Hospital Clinic B	• 3 full-time • 6 part-time • Approximately 9 total	• Physicians and fellows • Nurse Practitioner • Nurses

Appendix D: In-depth Interview Codebook

Stigmatization of Abortion Providers Codebook

Parent codes: 10
Total codes (excluding parent codes): 46

Code	Description
Job Description	Initial discussion and description of participant's job or role within the clinic setting
• Work group descript	Description of who participant considers to be included in their "workgroup", whether that is a static or rotating group.
• Work group like	Discussion of whether participant likes their coworkers or "workgroup", how they get along.
• Work group depend	Discussion of extent to which participant feels he/she can depend on the people they work with, and what makes them feel that way.
"Abortion Provider"	How participant feels about the term "abortion provider" as applied to them, personally.
Disclosure of Abortion Provision	
• Disclose to Med	How participant describes/discloses their job to others in the medical field.
• Disclose to Others	How participant describes/discloses their job to people other than colleagues in the medical field, such as people they meet socially.
• Disclose Criteria	Criteria that participants use to determine how they will describe their work and what they will disclose to medical colleagues and others, including the setting, personal characteristics, etc. Should be used in conjunction with another disclosure code.
Abortion to Job Relationship	Participant's response to the question of how abortion "figures into your sense of what your job is".
• Role Import Global	How participant perceives that the role they personally play in the provision of abortion care is important in a global or general sense.

Appendix D: In-depth Interview Codebook (continued)

Stigmatization of Abortion Providers Codebook

Code	Description
• Role Import Coworkers	How participant perceives that the role they personally play in the provision of abortion care is important to their coworkers.
• Role Import Patients	How participant perceives that the role they personally play in the provision of abortion care is important to their patients.
• Role Import Self	How participant perceives that the role they personally play in the provision of abortion care is important to his/herself. Don't use when in reference to passion scale question.
Job Passion Scale	How participant describes his/her relationship to their work in terms of the prompted work passion scale.
• Tasks Enjoy	Description of the specific tasks or activities associated with their work that the participant enjoys or looks forward to.
• Tasks Dislike	Description of the specific tasks or activities associated with their work that the participant dislikes or does not look forward to.
Stop Ab Care	How participant would feel if he/she stopped being involved in the provision of abortion care someday.
• Stig Ab	Participant's agreement or lack thereof with the, "abortion is stigmatized" prompt.
• Stig Ab Providers	Participant's agreement or lack thereof with the, "abortion providers are stigmatized" prompt.
• No Stig Ab Providers	Participant's agreement or lack thereof with the, "abortion providers are not stigmatized" prompt.
• Stig Ab Providers Caveats	Following or contained within the stigma prompts discussion, any qualifiers, nuance, caveats or other description of how stigmatization may differ across providers.
• Stig Evid Global/Ideologic	How stigma is evident in global, general, ideological terms. This includes the participant's perception, something they have directly observed, something they count as the impact of stigma (i.e. why it matters) or something they'd count as "evidence" of stigma in a global or general sense.

Appendix D: In-depth Interview Codebook (continued)

Stigmatization of Abortion Providers Codebook

Code	Description
• Stig Evid Policy/Politics	How stigma is evident in policy or political discussion/debate. This includes the participant's perception, something they have directly observed, something they count as the impact of stigma (i.e. why it matters) or something they'd count as "evidence" of stigma in terms of policy or politics. Should not be used when participant is describing disclosure management, their role importance or responding to the stigma prompt questions. Use the associated codes for those discussions in those cases.
• Stig Evid Other Providers	How stigma is evident in the ways that it impacts other abortion providers. This can includes the participant's perception, something they have directly observed, something they count as the impact of stigma (i.e. why it matters) or something they'd count as "evidence" of stigma in terms of how they perceive stigma affecting other providers. Should not be used when participant is describing disclosure management, their role importance or responding to the stigma prompt questions. Use the associated codes for those discussions in those cases.
• Stig Evid Patients	How stigma is evident in the ways that it impacts past, current or future patients. This includes the participant's perception, something they have directly observed, something they count as the impact of stigma (i.e. why it matters) or something they'd count as "evidence" of stigma in terms of how they perceive stigma affecting abortion patients. Should not be used when participant is describing disclosure management, their role importance or responding to the stigma prompt questions. Use the associated codes for those discussions in those cases.
• Stig Evid Self	How stigma is evident in the ways that it impacts the participant. This includes the participant's perception, something they have directly observed, something they count as the impact of stigma (i.e. why it matters) or something they'd count as "evidence" of stigma in terms of him/herself. responding to the stigma prompt questions.

Appendix D: In-depth Interview Codebook (continued)

Stigmatization of Abortion Providers Codebook

Code	Description
• Stig Evid Null	How stigma is not evident, either for participant or anyone else. This includes the participant's perception, something they have directly observed, something they count as the impact of stigma (i.e. why it matters) or something they'd count as "evidence" of how stigma does not really matter or exist.
• Stigma Evid React	Participant's response to being confronted with evidence of stigma. Should not be used for disclosure management, role importance or responding to the stigma prompts.
• Op Condemners	How and whether the negative opinions and condemnations of people outside the abortion workforce matter to or impact the participant.
• Op Supporters	How and whether the positive opinions and support of people outside the abortion workforce matter to or impact the participant.
• Op Null	Indication from participants that the opinions of people outside the abortion workforce either do not matter, positive and negative, alike.
• Advoc Label	How participant feels about the label or term "advocate" as applied to him/herself.
• Advoc Meaning	What being an advocate means to participant, in terms of roles and activities or purpose of those activities.
• Advoc Aspirations	Advocacy roles/activities that the participant wants to do, or thinks he/she "should" do.
• Support Values	Extent to which values clarification activities appeal to participant, personally, or would be helpful to coworkers and abortion providers as a whole.
• Support Networks	Networking or connecting with other abortion providers as a means of feeling good about abortion work.
• Support Train/Conf	Training and conferences as opportunities to feel good about abortion work.
• Support Other	Ideas of how stigma could be combated, abortion providers could feel supported, or abortion providers could have greater satisfaction in their work. Exclude v.c., networks, conferences or training.

Appendix D: In-depth Interview Codebook (continued)

Stigmatization of Abortion Providers Codebook

Emergent Codes
n=14

Code	Description
Pride in abortion work	Participant implicitly or explicitly indicates pride in his/her involvement in abortion care.
Patients stories as meaningful/helpful	Participant describes how patients' stories make abortion care meaningful or more satisfying.
Debriefing as helpful	Participants indicate that "debriefing" or talking with others in the clinic is helpful for dealing with difficult cases, difficult patients, harassment, stigma, or other negative things associated with abortion work.
Contrasting clinic types	Participant explicitly references differences between freestanding clinics versus hospital-based or academic institution-based clinics.
Contrasting work roles	Participant explicitly references and describes differences between work roles involved in abortion care such as physicians, social workers, medical assistants, etc.
Opting out of abortion involvement	Participant discusses coworkers opting out of being involved in some aspect of abortion care, or opting out of abortion care completely.
Judging patients – coworkers	Participant describes situations in which they have felt or might feel judgmental of an abortion patient.
Judging patients – self	Participant describes instances where they feel a coworker was being judgmental of an abortion patient.
Meeting volume demands	Participant describes how the volume of patients or the rush to get work done affects them, their work, or patients' experiences at the clinic.
Clashing with coworkers	Participant describes how they have personally been involved in or are aware of clashes, disagreement or "bad blood" between coworkers within their clinic.

Appendix D: In-depth Interview Codebook (continued)

Stigmatization of Abortion Providers Codebook

Code	Description
Protestor harassment	Participant discusses the activities or effects of activities engaged in by anti-abortion protestors. "Protestors" refers to people actively fighting against choice and abortion, not just people who are ideologically opposed to abortion or indicate they are opposed to abortion in conversation.
Being trapped/tricked by "Anti's"	Participant's indication that they or others in abortion care are concerned about being trapped or tricked by anti-choice protestors and activists for the purpose of "exposing" them or their clinic and undermining abortion care.
Planned Parenthood videos	Any discussion of the Planned Parenthood videos or their impact.
Educating others about abortion	Participant discusses how he/she tries to explain abortion, why it is important, or other abortion-related issues to others in an unofficial capacity (i.e. not as in a lecture or testimony). Do not use when describing their attempts to educate others as a way that they feel they are an advocate (in response to "advocacy" questions).

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VITA

MOLLY K. MURPHY

EDUCATION

PhD, Community Health Sciences 2011 - 2017
Graduate Concentration in Gender and Women's Studies
University of Illinois-Chicago, School of Public Health
Dissertation Title: Abortion providers' experiences with stigmatization in different work roles, clinics and clinic types.

Master of Public Health, Behavioral Sciences
Emory University, Rollins School of Public Health 2006 - 2008
Thesis Title: Homeless youth shelter workers' perspectives and practices regarding commercial sexual exploitation of homeless youth

Bachelor of Arts
University of Wisconsin-Madison 2000 - 2004
Major: Spanish Literature; Graduation with Honors

FELLOWSHIPS & AWARDS

Alice J. Dan Dissertation Award, University of Illinois-Chicago 2015 - 2016
Awarded for mixed methods dissertation research on stigmatization of abortion providers in freestanding and hospital-based settings

Associate Service Fellow, Division of Violence Prevention, CDC 2010 - 2011
Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Jane Fonda Adolescent Reproductive Health Fellow, Emory University 2008 - 2010
Jane Fonda Center for Adolescent Reproductive Health, Emory University School of Medicine

PUBLICATIONS

WORKS PUBLISHED

Murphy, M.K., Bennet, N., & Kottke, M. (2016) Development and Pilot Test of a Commercial Sexual Exploitation Prevention Tool: A Brief Report, Violence and Victims, 31(1), 103-110. DOI: 10.1891/0886-6708.

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Murphy, M.K., Stoffel, C., Nolan, M. & Haider, S. (2016) Interdependent barriers to providing adolescents with long-acting reversible contraception (LARC): Qualitative insights from providers. Journal of Pediatric and Adolescent Gynecology, 25(9), 436-42. DOI: 10.1016/j.jpag.2016.01.125.

WORKS ACCEPTED FOR PUBLICATION

Murphy, M.K., Burke, P. & Haider, S. A Qualitative Application of Diffusion of Innovations to Adolescents' Perceptions of Long-acting Reversible Contraception's Attributes, (accepted for publication in the Journal of Pediatric and Adolescent Gynecology on November 15, 2016).

PRESENTATIONS

Murphy, M.K., Stoffel, C., Nolan, M. & Haider,S. ""It's just a bigger deal": Providers' perceptions and experiences with providing LARC to adolescents." North American Society of Pediatric and Adolescent Gynecology, Orlando, Florida, April 2015.

Murphy, M.K., Buffington, A., McRae, K., Harwood, B., Schwartz, A. & Peacock, N. "Women's Perceptions of Reproductive Control: Personal Agency and Its Limits." International Congress on Qualitative Inquiry, Champagne-Urbana, IL, May 2012.

Murphy, M.K., "Commercial Sexual Exploitation of Children: Individual Risk and Community Intervention." Healthy Teen Network Conference, Austin, Texas, October 2010.
Melissa Kottke, Marion Howard**, Molly Murphy** & Marie Mitchell, "Making Sex Education Relevant in a Rapidly Changing World", Society for Research on Adolescence Conference, Philadelphia, Pennsylvania, March 14, 2010.

Murphy, M.K., "Commercial Sexual Exploitation of Children: Clinicians' Opportunities for Intervention." Association of Reproductive Health Professionals Conference, Atlanta, Georgia, September, 2009.

GRANTS

George H. Miller Health Science Student Research (HSSR) Award 2015 - 2016
Co-Principal Investigator $10,000

- Awarded to develop and evaluate a long-acting reversible contraceptive intervention in Chicago school-based health centers.

Society of Family Planning Trainee Award 2015 - 2016
Principal Investigator $7,500

- Awarded to fund mixed methods dissertation research on stigmatization of abortion providers in freestanding and hospital-based settings.

Harold and Kayrita Anderson Family Foundation 2009 - 2010
Principal Investigator $25,000

- Developed, created and pilot tested an interactive web-based primary prevention tool for use among adolescent females at risk for commercial sexual exploitation.

PROFESSIONAL SERVICE & AFFILITIONS

MEMBERSHIP

- Sex Worker Outreach Project (SWOP) – Chicago 2013 - present
- American Public Health Association 2011 - present
- Georgia Task force on Commercial Sexual Exploitation 2009 - 2011

MANUSCRIPT REVIEWER

- Journal of Healthcare for the Poor and Underserved
- Health Promotion Practice
- Journal of Adolescent and Pediatric Gynecology