

“I do something different and extraordinary”: U.S. Abortion Providers and Positive Identity
Work

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Abstract

This study aims to answer two questions: how does the codification of restrictive state legislation affect the work that U.S abortion workers do; and what are the mechanisms of positive identity work used by abortion workers. Occupational identity is a major component of self-identity, and this is especially true of individuals who do ‘dirty’ or stigmatized work. The experience of stigma as a result of being an abortion worker, and the transformation of stigma into positive self-identity, has been documented in several qualitative studies. But what mechanisms of identity work facilitate this positive transformation of stigma? I find that abortion workers valorize their work and construct it as a necessary and normal part of health care. I interpret these mechanisms of identity work as restorative, and situate my findings in states with restrictive abortion laws.

Abortion is a highly stigmatized medical procedure in the United States and individuals involved with abortion as providers, employees of abortion clinics, or women who have had abortions, are highly stigmatized as well (Norris et al., 2011). Much research on abortion in the U.S. has focused on the political, religious and social discourses surrounding abortion, violence by anti-abortion activists, and the effects of stigma on women seeking abortions. Relatively little study has focused on abortion workers. While demand for abortions is unlikely to wane, the identity of abortion workers is subject to variation based on factors such as political and social context, ease of abortion provision, and esteem in the medical community. Through researching abortion workers' experiences of abortion-related stigma and identity work, much can be learned about the current state and future of abortion provision. Research on abortion workers will provide insight into how this population adapts to both diffuse stigma and codified abortion regulations. This study focuses on how restrictive state abortion legislation impacts abortion workers' occupation, and the positive identity work abortion workers demonstrate.

Before exploring restrictive state abortion laws and abortion worker identity, it is important to discuss how state governments are able to legally regulate abortion access. The momentous Supreme Court decision in *Roe v. Wade* (1973) legalized abortion in the U.S. Under this decision, state governments could not regulate a physician's ability to provide abortions the first trimester of pregnancy, could regulate but not prohibit abortions in the second trimester, and could enact restrictive or prohibitive laws on abortion in the third trimester provided there were exceptions to ensure the life or health of the woman (*Roe v. Wade*, 1973). However, subsequent Supreme Court cases, including *Webster v. Reproductive Health Services* (1980), *Hodgson v. Minnesota* (1990), *Rust v. Sullivan* (1991), and *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992), undermined the initial strength of *Roe v. Wade*. These decisions

gave state legislatures the ability to impose regulations on abortion access and provision, as long as the regulations did not “‘unduly burden’ the fundamental right” of abortion and had “legitimate, rational justification” (City of Akron v. Akron Center for Reproductive Health, 1983; Justice Stevens, 1992).

Medoff (2009) identifies the six major types of state abortion laws that the Supreme Court ruled constitutionally permissible. These include: prohibiting the use of public funds to pay the cost of an abortion; requiring parental consent for unmarried teen minors seeking abortions; mandatory delay laws, usually enforcing a 24 hour waiting period; mandatory counseling regarding medical or non-medical risks of abortion; prohibiting the dilation and extraction abortion technique¹; and enacting targeted regulation of abortion provider laws, commonly known as TRAP laws. TRAP laws impose requirements on abortion providers not normally imposed on facilities that perform comparable medical services, including health facility licensing and physical plant and administrative requirements (Medoff, 2009).

In 2013 alone, 70 restrictions on abortion were adopted by 22 different states, with legislation ranging from limits on medication abortions to restrictions on insurance coverage for abortion care (Guttmacher Institute, 2014). The past three years mark a period of unprecedented volume of state legislation regulating abortion. Over 200 abortion restrictions were enacted during 2011-2013, while just 189 were enacted during the entire previous decade, 2001-2010 (Guttmacher Institute, 2014). Currently, 32 states ban the use of state funds for abortion except when federal funds are available, 26 states require a waiting period between counseling and the abortion procedure, and 17 states that require women receive non-medical counseling prior to their abortion. Under the new healthcare law, popularly known as ‘Obamacare,’ 23 states have

¹ See Partial-Birth Abortion Ban Act of 2003

passed laws banning private insurance coverage of abortion in any exchanges in their state (National Women's Law Center [NWLC], 2014).

There are numerous individual examples of the recent surge in restrictive state abortion legislation. In 2012, the Michigan state legislature passed HB5711, which requires facilities advertising abortion services to be licensed as free-standing surgical centers, and that physicians who have been subject to prior disciplinary actions and provide more than six abortions per month carry \$1,000,000 in malpractice insurance coverage (Harris, Debbink, & Hassinger, 2012). Ohio state law requires abortion clinicians to offer patients the option of viewing an ultrasound of the fetus, watching the fetus's heartbeat, and to tell patients the odds that their pregnancy would be carried to term if they changed their minds (Eckholm, 2013). In 2013, the North Carolina legislature passed S.B. 353, which requires abortion clinics to meet yet-to-be released requirements that will resemble ambulatory surgical care center standards; renovations necessary to meet these standards are estimated to cost upwards of \$1,000,000 for each clinic (Ridenour, 2013). In November of 2013, a U.S. Court of Appeals allowed Texas officials to enforce a provision requiring abortion providers to have admitting privileges at a nearby hospital. As a result of this law, a third of the state's abortion clinics have stopped providing abortions (NWLC, 2014).

State-level legislation regulating abortion is widespread in the U.S. and directly affects the way in which abortion workers provide abortion care. However, we know little about the impact of this legislation on how abortion workers see themselves and their day-to-day work. In this study, I explore the experiences of stigma and the positive identity work of abortion workers in states that have passed restrictive abortion legislation.

Literature Review

I first review the existing literature on abortion attitudes, stigma, and positive identity work. I begin by discussing attitudes towards abortion in the U.S. and how they apply to abortion workers. I then trace abortion workers' experience of stigma in several social and cultural contexts. I finish with a discussion of how occupation-related stigma is transformed by abortion workers into positive identities. My study builds on this research by exploring how abortion workers see themselves and engage in positive identity work.

Abortion Attitudes in the United States

Researchers have posited that abortion is a highly contentious issue in the U.S. because contrasting beliefs about abortion represent different worldviews or value systems (Luker 1984). Abortion attitudes can be viewed as an example of symbolic politics, where predispositions or responses to particular symbols that occur in early socialization are activated by political symbols later in life. Political symbols concern issues such as political ideology, morality, and religiosity (Sahar & Karasawa, 2005). Abortion approval in the U.S. is negatively related to religiosity, as well as moral traditionalism and political conservatism (Cook, Jelen, & Wilcox, 1992; Harris & Mills, 1985; Zucker, 1999). Sahar and Karasawa (2005) find that abortion in the U.S., as opposed to other countries, is strongly tied to the political ideology of respondents.

However, a majority of Americans do not endorse an absolute stance on abortion but vary their position according to the circumstances (Cook et al., 1992; Jelen, 1988; Granberg & Granberg, 1980). For example, respondents who do not approve of abortion in the case of a married woman who doesn't want more children often do approve of abortion when a pregnant woman's health is in danger (Harris & Mills, 1985). Sahar and Karasawa (2005) cite attribution

theory to explain this phenomenon. When the causes of a negative event are perceived to be out of the control of the individual experiencing the event, bystanders are more likely to feel pity and empathy. Therefore, a woman choosing to end an unwanted pregnancy that occurred as a result of rape would garner more approval from Americans than a woman choosing to end a pregnancy that occurred as a result of sex within a committed relationship. So while abortion attitudes are tied to Americans' political ideologies and factors such as religiosity and conservatism, most Americans adjust their views on abortion to particular situations.

In accordance with attribution theory, national surveys show that the majority of Americans think abortion should neither be strictly legal or illegal in all circumstances (Blake & Del Penal, 1981). Polling data show consistency in U.S. public opinion; from 1976 to 2008, between 80 and 85% of Americans have supported keeping abortion legal. However, the vast majority of these abortion supporters believe that abortion should be legal only in certain circumstances, including fetal impairment, threat to the health of the pregnant woman, or in cases of pregnancy resulting from rape or incest. Abortions that occur due to these circumstances constitute a very small number of total abortions in the U.S.; therefore, the majority of U.S. citizens who believe that abortion should be legal do not approve of the reasons why most abortions in the U.S. are performed (Joffe & Weitz, 2010). Additionally, many Americans at the end of the 20th century reported that they consider abortion to be morally wrong. A 1998 CBS News Poll reported that 50% of Americans viewed abortion as equivalent to the murder of a child (Goldberg & Elder, 1998).

Employees of abortion clinics and abortion providers in the U.S. work under contradictory circumstances. The majority of Americans believe abortion should be legal, but only approve of abortions in relatively rare situations. Respondents to nationwide surveys who

claim that abortion is morally wrong and akin to murder still maintain that abortion should be legally available. The contradicting and often negative views on abortion in the U.S. contribute to the stigmatization of individuals associated with abortion, including abortion workers.

Stigma

Despite the fact that elective abortions are among the most commonly performed surgical procedures in the U.S., stigma regarding abortion is present on a broad array of cultural, social and political contexts. Goffman (1963, p.3) describes stigma as “an attribute that is deeply discrediting” which leads to a reduction of the possessor from a whole, ‘normal’ person to a tainted one in the eyes of non-stigmatized individuals. People who are stigmatized possess an attribute or aspect of self that is devalued by others, leading to social devaluing, ostracizing, and denigration (Crocker, Major, & Steele, 1998). Link and Phelan (2001) conceptualize stigma as existing when “elements of labeling, stereotyping, separation, status loss, and discrimination occur” (Link & Phelan 2001, p. 377).

Kumar et al. outline the production of stigma against people associated with abortion, facilitated by the under-reporting of abortion procedures by women and providers, resulting in the misconception that abortion procedures are rare (Kumar et al., 2009). Abortion stigma is then created when this ‘exceptional’ category of people (women who have abortions, abortion workers or providers) are considered deviant in comparison to a normative category (mothers, doctors in other practices). Labels and generalizations are then applied to the deviant category: in the case of abortion workers, labels like murderer, baby-killer, dirty, selfish, and morally corrupt abound (Kumar et al., 2009). Once an exceptional, deviant category is defined, discrimination against individuals within that category is enacted on societal, community, and individual levels.

Stigmatized occupations, or ‘dirty work,’ as defined by Hughes (1951) and expanded upon by Ashforth and Kreiner (1999), are associated with work that is physically dirty, involves contact with stigmatized people, and is morally offensive. Abortion work meets these criteria by being associated with all three taints: physical (blood, fetal matter); social (contact with stigmatized clients who are seeking abortions); and moral (ambiguous definition of the beginning of ‘life,’ conflicting ideologies about the morality of pregnancy termination) (Harris et al., 2011; O’Donnell et al. 2011). Occupation inhabits a central role in personal identity in the U.S., so occupational stigma carries particularly high costs for both the work and self-identities of individuals (Hughes, 1958; Kreiner, Ashforth, & Sluss, 2006; Harris et al., 2011).

Kumar et al. (2009) posit that abortion stigma is constructed and carried out through the following cultural and social contexts: framing discourse/mass culture; governmental/structural; organizational/institutional; community/interpersonal; and individual. While Kumar et al.’s focus is stigma as it effects women who have had abortion procedures, I extend their categories to include Ashforth and Kreiner’s (1999) concept of stigmatized professions to show how stigma is experienced by abortion workers.

Framing discourse/mass culture. Abortion is so stigmatized that American women recently interviewed by Hayden (2011) confessed that they would rather self-induce abortions, without aid or medical experience, than go to an abortion clinic. In the last ten years, women in South Carolina, Pennsylvania, New York, Texas, and Massachusetts have been criminally charged with soliciting illegal abortions, or performing abortions on themselves (Hayden, 2011). Since the 1980s, abortion clinics have been targeted both physically and rhetorically by anti-abortion activists as epicenters of evil, and abortion providers as corrupt, manipulating women into getting abortions against their nature and personal desires (Hayden, 2011). The anti-abortion

movement, rooted in conservative Christianity and the political right-wing, seeks to negatively sway cultural values and beliefs about abortion. Anti-abortion activists employ tactics such as picketing, holding vigils outside clinics, and distributing flyers to the neighbors of abortion providers about the providers' occupation (Norris et al., 2011; Hayden, 2011). The erosion of public support for abortion is a tactic to aid the imposition of institutional and legal limits on abortion (Joffe, 2009).

Technological advances in the past several decades (fetal photography, ultrasound, fetal surgery) have facilitated the personification of the fetus and the conflation of fetus and infant, adding to debates regarding fetal personhood and gestational age limits (Norris et al., 2011). Anti-abortion activists have joined this debate by using fetal images in protests which emphasize the independence of fetuses from the women who carry them (Taylor, 2008). This construction of the fetus as an independent person frames abortion workers as committing cruel and unjustified murders of children (Norris et al., 2011). Abortion activists also contribute to abortion stigma by highlighting 'good' and 'bad' reasons for seeking abortion services. Invoking the mantra "safe, legal, and rare" perpetuates stigma, framing abortion procedures as exceptional and only valid in certain circumstances (Weitz, 2010).

The framing of abortion as murderous and immoral by political and religious anti-abortion activists has grave consequences. Extreme anti-abortion groups have inflicted harassment, vandalism, and violent attacks on abortion clinics and employees, resulting in post-traumatic stress disorder in individuals and a climate of fear among abortion workers in general (Fitzpatrick & Wilson, 1999). The fear of violence, especially in hostile political environments, leads to fewer doctors choosing to provide abortions, and fewer abortion providers leads to restricted abortion access (Maxwell, 2002). While violence against abortion workers is

considered extreme by most anti-abortion organizations, the link between popular cultural and media discourse about abortion and violence is inescapable. The murder of Dr. George Tiller, one of the few U.S. doctors to perform late-term abortions, was condemned by most anti-abortion groups, but Tiller was routinely targeted by mainstream media venues, even nicknamed “Tiller the Baby Killer” on one national television program (Siegel & Sara, 2006).

Governmental/structural. Political and legalized stigma against abortion work is evident in the U.S. The ability of state governments to enact restrictions on abortion such as mandatory consent laws reflect an ideology where abortion is considered, if not illegal, close to criminal activity (Kumar et al., 2009). Research shows that state abortion laws significantly deter “physicians/organizations from becoming or remaining abortion providers resulting in less access for women to abortion services” (Medoff, 2009 p. 235). Abortion is a politically polarized issue, in which the ideological positions of the Republican and Democratic parties have become increasingly distant. Over the last four decades, the Republican Party has become increasingly anti-abortion and while the Democratic Party has remained protective of abortion services, regardless of constituent attitudes. Medoff, analyzing the determinants of enacting state TRAP laws from 1974 to 2008, finds that these polarized ideologies “in conjunction with institutional control of the legislative/executive branches of state government” are statistically significant when predicting the enactment of a TRAP law in the hypothesized direction (Medoff, 2012 p. 257).

Kahane (1994) finds that the ideology of individual state governors, as well as their affiliations with either the Republican or Democratic Party, has a statistically significant effect on the political position the governor takes on abortion, while constituent ideology has no effect. The Supreme Court decisions discussed above, enabling state governments to restrict abortion

access, show bias against abortion at both national and state levels of government. During a 2007 workshop in which 17 U.S. abortion workers met to discuss their experiences, several participants reported awareness of being targeted and stigmatized by restrictive legislation, some disclosing fears that abortion procedures will be entirely recriminalized in the near future (Harris et al., 2011).

Organizational/institutional. Stigma towards abortion workers is present even in the institutions that provide abortion training. Abortion is marginalized within medical settings, with limited training available for willing clinicians and institutional policies restricting abortion provision. Indeed, about half of trained providers do not ultimately provide abortions (Steinauer et al., 2009; Freedman et al., 2010). Most abortions in the United States are provided in free-standing clinics, isolating the procedure from mainstream healthcare and marginalizing providers (Joffe, 1995; Norris et al., 2011). About 87% of U.S. counties and 31% of U.S. metropolitan areas do not have an abortion provider (Finer & Henshaw, 2003; Jones & Kooistra, 2011). In a 2007 workshop, abortion providers discussed the stereotype that they are unable to practice other forms of medicine, and accompanying feelings of shame and inadequacy (Harris et al., 2011, 2012). In a qualitative study of 14 abortion workers in a Western state, abortion providers reported their medical peers avoided discussing abortion work, implying the procedure is ‘dirty’ (O’Donnell et al., 2011). On average, abortion work is less profitable than similar out-patient procedures, leading to economic disparities between abortion providers and other physicians (Grimes, 1992; Wear, 2002).

There is little literature regarding if and how the current system of free-standing abortion clinics and marginalized medical training negatively affects non-physician abortion workers. In Harris et al.’s 2007 workshop, stigma as marginalization within the medical community was

found to impact only physician participants (Harris et al., 2011). However, a similar study found that abortion workers who do not perform abortions (such as clinic managers or office managers) are more vulnerable to stigma and resulting loss of self-esteem than abortion providers because they do not have the high status of being a physician (O'Donnell, Weiz, & Freedman, 2011).

Community/interpersonal. Stigma towards abortion workers is apparent in community and individual relationships. There is little space for abortion workers to discuss their work in the public sphere without risk of being ostracized, denigrated, or subjected to violence. This leads abortion workers to avoid discussing their employment or to intentionally conceal their involvement in abortion provision (O'Donnell et al., 2011; Harris et al., 2011). In O'Donnell et al.'s (2011) in-depth interviews with abortion workers in a Western state, most participants described a screening process they employed with acquaintances and strangers before choosing whether or not to disclose their employment.

Virtually all abortion workers report experiencing interpersonal stigma or taking steps to avoid it. In Harris et al.'s (2011) workshop, one individual wondered if her employment was disclosed to her church community, she would be able to attend church services. Other abortion workers cited friendships that ended once their occupation was disclosed, extended family members who considered them murderers, and close friends and family who were supportive of abortion rights but reluctant to discuss the abortion worker's occupation (Harris et al., 2011; O'Donnell et al., 2011). Silence and disclosing abortion work selectively protects abortion workers from harassment and preserves relationships; however, this silence reinforces the distorted image of abortion providers as illegitimate and deviant, and abortion procedures as rare (Harris et al., 2012). Workers are subject to interpersonal stigma even within their place of employment. Abortion workers report patients who denigrate abortion clinics and providers as

immoral and dirty while they seek abortion procedures, leaving the workers feeling attacked, anxious and devalued (Harris et al., 2011; O'Donnell et al., 2011).

Individual. The stigma of abortion is deeply felt by individual abortion workers, and is reflected in their actions and perceptions of themselves and their work. In both O'Donnell et al. and Harris et al.'s studies, most participants refrained from discussing their occupation as a way to ensure their own and their families' safety and avoid confrontation. However, the same respondents expressed a sense of isolation and disconnection from being unable to share their occupation in most public spaces and relationships (O'Donnell et al., 2011; Harris et al., 2012). Secrecy, self-censorship, and silence are tactics often used by abortion workers to avoid both awkwardness in social situations and outright harassment and violence (Harris et al., 2011, 2011). Most abortion workers expressed frustration with having to be careful about accidentally disclosing their occupation or being 'outed' as an abortion worker. Concealment of a stigmatized aspect of one's identity has been found to lead to stress, anxiety, health consequences and psychological disorders, including internalization of stigma (Major & Gramzow, 1999; Quinn & Chaudior, 2009; Norris et al., 2011).

In Wear's (2002) qualitative study of seven abortion providers in Ohio, one participant referred to their work as a "necessary evil," and another pointed out that if complications arise while performing a different type of standard medical procedure, such as a hysterectomy, that doctor doing the procedure is not then called upon to defend the existence of hysterectomy procedures (Wear, 2002). The same Ohioan providers reported living in fear, experiencing vandalism, high speed chases, stalking, and death threats; one participant admitted to wearing a bulletproof vest to and from work (Wear, 2002). Abortion providers also expressed a sense of punishment, and being watched by opponents of abortion looking for mistakes (Harris et al.,

2012). Participants reported that state-level abortion legislation left them wary of unknowingly breaking the law, and felt that mandatory consent laws imply that abortion workers would otherwise lie or coerce patients (Harris et al., 2011). Interpersonal stigmatization, combined with cultural and legal restrictions that reinforce the notion that abortion is morally wrong, create a disincentive for health professionals and staff to become involved in abortion care and a sense of shame, isolation, and fear for abortion workers (O'Donnell et al., 2011; Norris et al., 2011).

It is important to note that findings show not all abortion workers view their work as inherently stigmatized or tainted (O'Donnell et al., 2011). At least one participant in each of the above studies reported speaking openly about their work to avoid secrecy and resist the implicit judgment of others. Others framed purposeful disclosure to friends and acquaintances as an obligation to patients and the public, using their public identity as an abortion worker to connect with others who support abortion rights and engage people with different views in discussion. Purposeful disclosure was also cited as a manifestation of personal pride and resistance to the framing of abortion work as 'dirty' (Harris et al., 2011; O'Donnell et al., 2011).

These qualitative studies of abortion workers are each limited to a relatively small number of participants and one location in the U.S. However, the combination of stigma, risks accompanying disclosure, and the small number of abortion workers nationwide make relatively small, geographically-concentrated studies the only conceivable way to gather data on this population. Because participation in interview-based research is voluntary, abortion workers in these studies may be a select group based on the degree of experienced stigma and willingness to discuss it publicly. It is possible that abortion workers who do not participate in studies do not experience stigma to the degree that their interviewed colleagues do, or that stigma is not a

significant part of their identities or lives. Additionally, there simply are not very many in-depth qualitative studies of abortion workers discussing their experiences with their work.

Positive Identity Work

Stigmatization is a process that can be actively resisted and transformed by the stigmatized population. Ashforth and Kreiner (1999) posit that work-based stigma fosters a strong occupational culture and identity among people who do ‘dirty’ work. People generally seek positive self-definitions and identities, including occupational identity (Ashforth & Kreiner, 1999). To create and maintain positive identities, members of stigmatized professions often engage in the following identity work: reframing the meaning attached to the stigmatized profession into a positive value; recalibrating the standards that assess the value of their profession; and refocusing on non-stigmatized aspects of their occupation (Hughes, 1958; Ashforth & Kreiner, 1999). Examples of positive identity work utilized by other stigmatized groups is found in the work of Snow and Anderson (1987), Brown and Toyoki (2013), and Tracy and Scott (2006), among others.

The findings from several studies of abortion workers are consistent with Ashforth and Kreiner’s (1999) theory. Despite social and political stigma surrounding abortion, abortion workers engage in identity work to resist stigma and transform negative narratives into positive occupational identities. Abortion work, framed by others as tainted, was positively reframed by abortion workers as a privilege. Participants discussed the value of enabling women to choose if and when they become parents and the gratifying aspects of this power (O’Donnell et al., 2011). Respondents recalibrated their work by emphasizing positive aspects, such as providing access to healthcare for vulnerable populations (O’Donnell et al., 2011; Wear, 2002). Abortion workers

refocused on helpful aspects of their work, including the satisfaction of being able to change patients' lives in a short outpatient procedure (O'Donnell et al., 2011). Participants cited belief in the goodness of abortion work, and the pleasure of working with like-minded colleagues, as enabling them to ignore and deflect interpersonal stigma by patients and acquaintances (O'Donnell et al., 2011; Wear, 2002). Abortion workers reported their place of work relatively protected from stigmatization due to supportive colleagues who share similar goals and struggles; the experience of a supportive work culture is cited by individuals involved in other stigmatized professions (Ashforth & Kreiner, 1999; Norris et al., 2011; O'Donnell et al., 2011).

Studies of abortion workers show that positive identity work is successful: participants have positive self-image, belief in the importance of their work, and feelings of occupational satisfaction (Joffe, 1995; Wear, 2002; Harris et al., 2011; O'Donnell et al., 2011). Even abortion workers who described the physical and social violence inflicted upon themselves and their families report their work as rewarding and express conviction that they are doing important work (Wear, 2002; Harris et al., 2011). In fact, the stigma surrounding abortion practice in the U.S. served as motivation for some workers to become involved in abortion in the first place. Joffe's (1995) extensive study of abortion providers before and after *Roe v. Wade* shows many physicians chose to do so after witnessing the physical and mental pain of women who visited illegal abortion providers or attempted abortions themselves. Abortion providers interviewed by Wear (2002) reported choosing their careers as a way to prevent the pain caused by unsafe abortions, and because of the limited number of abortions providers in the U.S.

It is possible that there are abortion workers that do not regard their occupation as central to their identity, whether because of lack of experienced stigma or because their employment has nothing to do with their personal or political beliefs. The majority of the above studies focus

prominently on the experience of doctors who perform abortions, rather than abortion workers working in administrative or secretarial positions in abortion clinics, though Harris et al. (2011) found that stigma was present across all types of abortion work. However, the experience of stigma and strategies of positive reframing work may vary for physicians versus non-medical employees.

In sum, abortion work is a complicated and multifaceted issue in the U.S. The majority of U.S. citizens believe abortion should be legal. However, this same population approves of abortion only in limited circumstances that make up a minority of actual abortion procedures. Access to abortion is a nationwide legal right, but regulations on its access and provision have been passed in a majority of states, creating a kind of legalized stigma (Guttmacher Institute, 2014; Kumar et al., 2009). About one third of all U.S. women will undergo an elective abortion, but abortion workers experience stigma on cultural, social and individual levels because of their involvement with a tainted activity (Norris et al., 2011; Guttmacher Institute, 2014). Despite the negative associations with abortion, abortion workers utilize identity work to retain positive occupational and personal identities.

While the studies above explore the stigmatization of abortion workers, none focus specifically on the experiences and positive identity work of abortion workers operating under restrictive abortion state legislation. Do abortion workers experience the same types and degrees of stigma in these legal contexts? How does abortion provision and identity work manifest after such legislation is implemented? This study focuses specifically on abortion workers in states that have passed abortion legislation fundamentally changing how abortion workers provide abortion care.

Methods

I utilized qualitative methods, specifically a semi-structured interview guide, to allow participants to express themselves freely rather than responding to prescribed options. This method allowed me to analyze the verbal processes of identity work engaged in by participants. Each interview was audio-recorded and transcribed, then coded and analyzed.

Interviews began with questions designed to measure participant knowledge and impact of state abortion legislation, experienced stigma, and identity as an abortion worker. Sample questions include:

- How did you first begin this work? What has changed since you first started?
- How did you first find out about the legislation in your state regarding abortion?

Unplanned questions based on participant answers to initial questions were asked, and redundant questions were eliminated. The participants guided the direction of the conversation. Each interview lasted between a half-hour and an hour. In-person interviews took place in locations chosen by the participant, including a public park and the abortion clinic where the participant worked. I conducted phone interviews with participants who live in different states.

Participants

The study population in this research consists of 11 abortion workers and one former abortion worker who live and work in states that have passed restrictive abortion legislation. I included the former clinic employee in this study because this individual is still highly involved in abortion work, continues to volunteer in the clinic in which she worked, and expressed interest in being interviewed. As seen in Table 1, the study population was not limited to employees of

one line of abortion work, allowing a larger sample population. However, this provides an overly simplistic view of ‘abortion workers’ as a homogenous group, when the varied roles, required education, and pay scale of jobs within abortion work lead to differences between them. I initially limited my study to participants within North Carolina but had difficulty identifying willing participants. This may have been caused by the absence of an ‘in’ to vouch for my study, and the fact that two similar qualitative studies of abortion workers have recently been conducted in North Carolina. Utilizing snowball sampling methods, I was able to interview several abortion workers in other states. The small number of respondents, similar to the studies cited above, reflects reluctance of abortion workers to participate in this study, whether because of fear of repercussions from anti-abortion activists, unfamiliarity with the researcher, or lack of interest in discussing their occupation.

Table 1.

Participant Occupation

Number of Respondents	Occupation
8	Physician
2	Certified Nursing Assistant
1	Clinic Manager
1	Office Manager (Former)

All of the 12 abortion workers interviewed in this study are U.S. citizens and between the ages of 25 and 70. Only one respondent, a physician, is male. While the number of interviewees was limited, the inclusion of individuals doing abortion work in different capacities and in several states allows for a broader discussion of the similar concerns and identity work mechanisms. Due to risk of identity exposure, respondents’ exact age, the name of their place of

work, and their race was not recorded. The majority of respondents are white and between the ages of 30 and 50.

Recruitment

Because of the stigmatized nature of their work and history of harassment and violence by anti-abortion activists, abortion workers are often wary of participating in research studies (Wear 2002). Acknowledging this obstacle, I used a variety of methods to contact potential interview subjects, including snowball sampling techniques. I obtained the email addresses of individuals involved in pro-abortion activism, asking them to forward my information to abortion workers. I also obtained a list of active abortion clinics in North Carolina through the website of abortion advocacy organization NARAL Pro-Choice America and contacted abortion clinics via their websites and over the phone. I personally went to abortion clinics near my university and dropped off flyers describing my research, and volunteered as an escort to form relationships with clinic workers. Initial participants then referred me to their colleagues.

I provided each participant interviewed in person with a consent form detailing the project and their rights as a participant, which was signed and dated before the recorded interview began. When conducting phone interviews, I read the form aloud and participants verbally consented. To ensure anonymity, participant names, places of work, and identifying information were not used in interviews. In subsequent transcriptions and analysis, participants are referred to by their occupation and a number ordering their interview. For example, the first interview was with “Clinic Manager 1,” the second was with “Physician 2,” and so on. Table 2 identifies the states where individual participants reside and practice abortion work.

Table 2

Participant State of Residence

Participant	State
Clinic Manager 1	North Carolina
Physician 2	North Carolina
Office Manager 3	North Carolina
Physician 4	Pennsylvania
Certified Nursing Assistant 5	North Carolina
Physician 6	Virginia
Physician 7	Pennsylvania
Physician 8	Virginia
Physician 9	Georgia
Physician 10	Texas
Physician 11	Texas
Certified Nursing Assistant 12	North Carolina

Key Concepts

The concepts of identity and identity work are ambiguous and can be interpreted a number of different ways. I draw on Snow and Anderson's (1987) ethnographic study of the homeless to inform my definition of identity and identity work. By identity work, I mean mechanisms "individuals engage in to create, present and sustain personal identities" and that provide them with a "measure of self-worth and dignity" (Snow & Anderson, 1987 p. 1348). The definition of identity in this study closely follows Snow and Anderson's definition of self-concept, "one's overarching view or image of her- or himself" (Snow & Anderson, 1987 p. 1348). However, I analyze participant identity in terms of their decision to join a stigmatized occupation rather than a social group. The physician participants in this study are located in an otherwise highly respected profession but choose to do specific work that is stigmatized. In accordance with the methodology of Tracy and Scott's (2006) study of "taint management" among correctional officers, I focus on the discursive processes and verbal construction of identities of abortion workers. I also draw on Brown and Toyoki's study of identity work among prisoners as "activities [that] involve people manoeuvring in relation to available discourses in order to formulate, maintain, evaluate and revise self-narratives which promote liveability" (Brown & Toyoki, 2013 p. 875).

Limitations

Generalizations to the entire population of U.S. abortion workers in states with restrictive abortion legislation should be made cautiously. Participants were individuals who volunteered to take part in the research study. This sets the study sample apart from the population of abortion workers, the vast majority of whom were not contacted for this study, and those who were aware

of this study but did not agree to be interviewed. I conducted four interviews in person and the remainder over the phone. The two distinct methods of interviewing I utilized may have resulted in different responses from participants who were interviewed via one method versus the other.

Results

This study aims to answer two questions: how does the codification of restrictive legislation affect the work that abortion workers do; and what are the mechanisms used by abortion workers to create and maintain positive identities? First, I discuss participant awareness of restrictive state abortion laws and the impact of such laws on abortion workers. This section draws on interviews with both physician and non-physician participants, and explores the legal context within which participants engage in identity work. Second, I explore the identity work employed by participants as stigmatized abortion workers in politically hostile environments. Finding significant differences between the identity work employed by physicians and non-physicians, I address these groups separately. I find that physician participants utilize three mechanisms of identity work-normalizing, valorizing, and framing abortion as necessary-to maintain positive work and self-identities. I argue that these mechanisms are specifically suited to individuals who are members of an otherwise high status occupation but choose to join a stigmatized group.

Awareness of Restrictive Abortion Laws

All participants, physician and non-physician, were able to explain the content of restrictive abortion laws in their respective states. However, Texas and North Carolina passed restrictive state abortion laws in the past year. Therefore, the seven participants working in these states had more to say about the new laws and their implementation than participants in states where laws

have already been integrated into abortion work, such as Pennsylvania and Georgia. Physicians 10 and 11 reported that before abortion legislation was passed via special session of the Texas legislature in 2013, they were aware of several proposed abortion bills that had not made it out of committee. Several participants directly named the Republican party and specific political figures as being the force behind anti-abortion laws: “This is what Rick Perry wants, this is what the Republicans want” (Physician 10), and, “Both chambers of the legislature had a power play going on, they each had their own bill, and the governor got caught in that” (Physician 2). Physician 2 noted that the laws passed in North Carolina were modeled after those in Virginia and South Carolina, reflecting that legislators “see what’s being passed in other states. Nothing’s original.”

In several cases, participants cited state abortion laws as being confusing or ambiguous, especially in North Carolina and Texas where recently passed legislation has not yet been fully incorporated into clinic policies. Physician 10, discussing a recent incident where a lawyer representing her hospital was mistaken about a law regulating the gestational age limits, stated, “The authors of the bill do this on purpose because it confuses people.” In North Carolina, a TRAP law was passed in July 2013 but has not gone into effect. Both physicians and non-physicians in North Carolina framed a recently passed TRAP law’s implementation as a “waiting game”; they do not know if the eventual restrictions will be easily met or will require clinics to be shut down and rebuilt.

Several participants cited feeling wary of unknowingly violating abortion laws. Office Manager 3 recalled about implementing a mandatory consent law, “We were very unclear as to what need[ed] to be included in the counseling, who need[ed] to do the counseling... There was a lot of nervousness.” Clinic Manager 1 described being “in the dark” because she does not have

direct contact with the state department responsible for writing the abortion regulations. The four non-physician participants all reported feeling stress about possibly being out of work if their clinic closed down, either temporarily or permanently, in response to state laws: “I remember lots of handwringing and late nights where we weren’t sure what was going to happen” (Office Manager 3). In states where current abortion legislation has been enacted for more than a year, participants recalled the confusion that followed laws being passed, clinic closures, and the expenses associated with complying with laws.

Participants also reported being aware of the passage of restrictive abortion legislation in states other than their own. In several cases, participants were aware of the abortion laws in neighboring states because they often serve out-of-state patients who have travelled to get abortions legally barred their own states. Physician 10 in Texas reported seeing many patients from Oklahoma because the gestational age limit in that state is lower than in Texas, while Clinic Manager 1 often sees women travelling from South Carolina and Virginia for similar reasons.

Every participant framed restrictive abortion legislation passed at the state level as the primary source of future abortion restrictions in the U.S. Clinic Manager 1 stated, “It’s not a matter of [Roe v. Wade] being overturned through the Supreme Court, but it’s a matter of state laws being passed that makes abortion inaccessible for women, not necessarily illegal but inaccessible.” The overall volume of restrictive abortion laws in the past several years was noted by nearly all participants. Physician 4 discussed the “huge amount of hostility towards abortion...and political momentum” to restrict abortion access and provision nation-wide. Several participants framed the passage of restrictive abortion legislation across the country as having no end in sight, with Physician 6 remarking “I think we have a big battle ahead,” and Physician 4 saying, “People have to face the reality of what happens when abortion is illegal or

difficult to access in their personal lives... And that's a frightening prospect and that's where I think we might be headed."

Impact of Restrictive Abortion Laws

Overwhelmingly, participants reported that the abortion laws in their states are ineffective in reaching their ostensible goal, which is to make abortion safer. CNA 5 remarked about following a newly implemented law, "There was no clear like, oh, this makes it better, this makes it safer, this makes it more transparent. It didn't do anything. There was no evaluation of the process." Instead, these laws are seen as making abortion provision and access more difficult without any tangible benefits. Physician 11 called the laws "a waste of time" and Physician 4 said they were "incredibly unimportant, incredibly expensive while being incredibly unimportant." Physician 2 used the analogy of a baseball pitcher to illustrate the state legislatures' actions, saying, "Sometimes the pitcher just throws a pitch in the dirt to see if the batter will swing at it. It's a wasted pitch, and a lot of this stuff is pitches in the dirt. They throw this stuff out there, make you jump through the hoops, it takes time, it takes energy, it takes money and it burns the hell out of you."

The implementation period following the passage of restrictive state abortion laws was stressed as a particularly difficult time for abortion workers. Regarding the TRAP law in North Carolina, Physician 4 remarked, "It will certainly be a financial hardship for many places to accommodate it and I would not be surprised if several places have to shut down or work in reduced hours." Physician 10 referenced a clinic in Fort Worth, Texas that has been rendered unusable by a recent law: "They don't have any providers that can get admitting privileges within 30 miles of their brand new, fancy surgery center. So they're prepared with the physical

structure but because of the other law, they don't have a doctor that can work there. It's going unused." Physician 2 personally opened a clinic in North Carolina that was shut down following the passage of abortion laws in July 2013. He reported his clinic was shut down over a technicality regarding lab data, calling his clinic closure "a show of force."

Participants reported restrictive state abortion laws as negatively impacting women's access to timely and quality medical care. When a law requiring a 24 hour waiting period was passed in North Carolina, CNAs 5 and 12 recalled turning away patients who were unaware of the law and could not return the next day for their procedure due to financial or childcare constraints. Office Manager 3 discussed the difficulties of satisfying mandatory 24 hour consent laws with women who needed to keep their abortions a secret from controlling or abusive partners. Clinic workers would use code words to protect their patients but this often proved ineffective, causing patients to miss their over-the-phone counselling and delay their procedure: "We would miss a lot of phone calls because we would call and then we wouldn't get the patient on the phone and we would say, 'Oh this is Betty calling her. Just tell her to call Betty back,' and they would never know who Betty was."

Several participants, discussing the lack of Medicaid coverage for abortions, reported a disproportionate negative effect on impoverished women. Many physicians recalled women in special circumstances, including pregnancy as a result of sexual assault or carrying medically futile pregnancies, who could not afford abortions without Medicaid coverage. Office Manager 3 stated, "It's discriminatory...Poor women deserve the same health care as rich women." Physician 9 told the story of a woman pregnant with a fetus diagnosed with a fetal anomaly, ensuring it will die within hours of birth. However, because exceptions to the gestational age limit must go through several medical and legal committees, and because abortions not including

rape and incest are not covered by Medicaid in Georgia, “it’s going to lead to her not getting the procedure...she can’t afford it, she can’t afford to go to places that will do it for less price.” The same physician reflected, “Just changing Medicaid to cover lethal anomalies would change women’s lives in a really significant way. It’s hard to tell someone, your baby has no head but you have to carry it and deliver it.”

Restrictive abortion laws force participants to give abortion care in a way that goes against their wishes. CNA 5 described enforcing the 24-consent law that requires women to go through mandatory counseling 24 hours before their abortion as “very degrading” and said “because of the political tension and the intimidation that I feel the law provides for abortion services, I have felt like we have not been able to provide what I would like to provide as far as quality of care.” Physician 11 reflected on mandatory ultrasound viewing laws:

In any other aspect of my career, if a patient asks me not to do something, I respect that. But with this, if [patients] say I don’t want to hear the description of the fetus or I don’t want to hear the heartbeat, I just have to say, I’m sorry I have to do it anyway. You can cover your ears or avert your eyes, but I must turn the screen towards you and play this heartbeat and that’s ridiculous.

Participants cited similar outrage regarding consent procedures, including text outlining links between adverse psychological and health effects of abortion. Several physicians reported that they read government-mandated statements regarding links between breast cancer and infertility and abortion to patients, “then immediately contradict them” (Physician 10). Clinic Manger 1 noted that adverse psychological effects resulting from abortion are controversial, highly subjective, and that a woman impregnated by rape or incest is unlikely to view her

pregnancy as a “baby” or her pregnancy as having a “father,” terms used in mandatory counselling procedures. Physician 2 made his feelings about state-written medical materials clear:

I resent the fact that legislatures and legislators are practicing medicine without a license. They have no knowledge, no training, no licensure, and they are dictating consent issues, they’re dictating practice issues, they’re dictating testing issues that only are in the purview of physicians.

Many participants described doing their best to take on the effects of the laws themselves in order to defray patient monetary and time costs: “Providers have been bending over backwards to try to find ways to make it work that can work with their practices and their staffing and can also best accommodate patient needs” (Physician 4). Laws that require physicians (rather than other qualified healthcare workers) to complete consent procedures, ultrasounds, and administration of medication restrict the number of patients that can be seen. Physician 11 reflected that obeying the laws gives her less “clinic time to see patients, it’s less time for me to operate, it’s less time for me to do administrative stuff like...changing aspects of the clinic that make the flow better or reviewing records or doing any of the other things most normal physicians do.” Physicians reported both less time to see patients and being overwhelmed by the number of patients at their clinics. Physician 10 reported doing 60 abortion procedures in one day, saying “it’s overwhelming and exhausting for the physicians and it’s exhausting for the staff and it’s not sustainable in any way.”

Overall, participants report restrictive state abortion laws create obstacles to their ability to effectively do their jobs, provide quality and timely patient care, and, perhaps most

importantly, do not have positive effects on patient health or safety. This examination of participant awareness of restrictive state abortion laws, and the difficulties following such laws, gives perspective on the legal environment in which participants work. I now turn to an exploration of participant identity work in this context.

Effect of restrictive state abortion laws on identity work. One unique aspect of this study is its exclusive focus on participants working under restrictive state abortion laws. This distinction from other studies of abortion workers yields a necessary question: how are the mechanisms of identity work outlined above effected by restrictive state abortion laws? It is possible that the identity work processes discussed below are unique to abortion workers operating in hostile legal environments rather than states which have neutral or permissive policies towards abortion. Suggesting this possibility are reports from physician participants who previously worked in states with very liberal abortion laws including Oregon, California, New York, and Washington, D.C. These participants repeatedly mentioned the stark differences between their ability to provide care, their comfort disclosing their occupation, and the views of other health workers regarding abortion. For example, Physician 9 reflected, “it was huge and crazy, the difference... what kind of care and what level of care that I could provide for my patients in Portland, Oregon and then coming [to Georgia], taking a five hour flight here and the vast difference of what I can provide my patients here, is really sad.”

However, without a comparison study among abortion workers in states without restrictive state legislation, no conclusions can be made regarding the effect of restrictive legislation on the distinct types of identity work performed by abortion workers. The previous sections regarding participant knowledge and experience of restrictive abortion laws

contextualize the identity work mechanisms described below, but further research is needed to claim that a constricting legal context leads to a certain type of positive identity work.

Stigma

Participants discussed experiencing stigma on multiple social and institutional levels. Several participants reported stigma from within the medical community. When asked about his relationships with other doctors who do not provide abortions, Physician 2 stated, “I’m isolated. I don’t have a support group among physicians.” Physician 11 reported getting fed up with “people thinking [I’m] a lesser physician” because she is an abortion provider. Physician 8 discussed experiencing pushback from nurses at the hospital where she works because previously, “there was a culture where you don’t talk about [abortion].” Physician 2 and Physician 10 compared websites run by anti-abortion activists with their names or the names of their colleagues alongside threatening messages to “domestic terrorism.” Physician 6 was personally targeted by anti-abortion activists: her neighborhood was papered with flyers comparing her to a traitor in a WWII concentration camp.

Several participants cited interactions with protestors outside clinics as being frustrating and potentially dangerous, with CNA 12 saying, “I can’t stand them, they’re terrible.” Physician 11, revealing that if there is a fire in her clinic, she is not supposed to exit the building but has been told to remain in a fire-rated stairwell for her own safety, said, “It’s like having to cross a picket line every day to go to work. And even though it’s not in the forefront of your mind, there are times that you do wonder about your safety.” While Physician 10 has not experienced any direct hostility due to abortion provision, she has taken several security precautions, including

having all mail sent to a UPS mailbox, living in a house with a security gate, and practicing under her maiden name.

Participants cited experiencing stigma in their interpersonal relationships. Physician 7 commented, “It’s certainly uncomfortable, right, to be an abortion provider, and...there are certain jobs that don’t want to have me, there are certain people that don’t want to date me, things like that, that are really frustrating.” Physician 7 recalled a long-time friend who refused to disclose the fact that the participant was an abortion provider to friends and colleagues, leading Physician 7 to wonder, “I still make her nervous? What must other people think?” Most participants said that their close relatives, including parents, siblings, and spouses, were supportive of their abortion work. One exception was CNA 12, who has only told her mother about her work at an abortion clinic as her father and siblings are all very anti-abortion.

All participants cited utilizing non-disclosure and silence about their occupation in order to mitigate stigma. While Physician 4 reported not having many negative experiences because of her association with abortion, she is “not particularly verbose about it.” Physician 7 also showed discretion disclosing her occupation, saying, “I certainly won’t ever hide what I do but I do not introduce myself as, ‘Oh hey. I’m ---- and I do abortions.’ I just tell people I’m a gynecologist.” Clinic Manager 1 reiterated the tactic of non-disclosure, saying, “I’m always careful about what I say. I never tell people what I do because...I don’t really want to hear someone’s negative opinion.”

It is clear that participants in this study experience frustration due to their stigmatization on multiple cultural and social levels. This stigma goes beyond the social devaluing, stereotyping, and separation outlined by Link and Phelan (2001); stigma related to abortion work

carries the threat of violence both inside and outside the workplace. Participants make choices about where to live, when to go outside, and who to befriend based on keeping themselves and their families comfortable and safe. This is the far-reaching and unavoidable stigma under which the participants in this study engage in identity work.

Identity Work

I define identity as participants' over-arching view of themselves as abortion workers. I define identity work as the verbal processes and mechanisms participants use to positively frame themselves and their identities as abortion workers. Though both physician and non-physician abortion workers are members of a stigmatized occupation, I found the identification with abortion work and the identity work engaged in by each group varied; therefore, my findings are divided between non-physician and physician participants.

Non-Physicians. Among non-physician participants, three out of the four non-physician participants did not make a pre-meditated decision to pursue an occupation involved with abortion. This route to abortion work is distinctly different from physician participants who were enrolled in medical school and had to make specific choices to pursue abortion-related electives and training. Furthermore, when asked whether they would find another job working at an abortion clinic if their current clinic shut down, CNAs 5 and 12 said that they would not necessarily do so and Office Manager 3 no longer does abortion work. Because they do not conduct the actual procedure, abortion does not inherently define non-physician occupations as it does for the physician participants. I found abortion to be less integral to non-physician participant identity and resulting identity work than that of physician participants. Therefore, I have limited my findings to the identity work mechanisms employed by physician participants.

Physicians. Among the eight participants who are physicians practicing abortion under restrictive state abortion laws, all reported having a positive occupational and self-identity. This positivity can be seen in statements such as, “Out of all the things I do, I consider providing abortions to be probably the most important, if not the most rewarding” (Physician 11), “I love my work and...the passion that I have for it” (Physician 10), and “It’s some of the most satisfying work that I do” (Physician 6). Despite facing pervasive stigma, no physicians reported past or future plans to stop abortion provision: “[Not providing abortions] is nothing I’ve seriously considered” (Physician 11). What identity work do physicians who provide abortions employ to maintain such positivity even as members of a stigmatized occupation in politically hostile environments? The physician participants in this study utilized three general mechanisms when discussing their work as abortion providers and the subject of abortion itself: normalizing, framing abortion as necessary, and valorizing.

Normalizing

***“It’s just another surgery”:* Abortion as a common procedure.** Physician participants framed themselves and other abortion providers as normal physicians who perform an everyday procedure by emphasizing the number of women who have received abortions. The majority of participants cited abortion as “common” at some point in their interviews, and nearly all referenced the statistic that one third of American women will undergo abortion at some point in their lives. Physician 7 stated, “It’s a part of people’s lives as much as childbirth.” Physician 8 specifically mentioned normalizing providers as well as clients, remarking, “We have to not only normalize the circumstance to say that a number of women go through this, and you probably know some of them, but also...the provider is a thirty-something-year-old female with kids.” Physician participants emphasized the ease of the surgical procedure itself with statements such

as, “It’s just another surgery...it’s orders of magnitude safer than getting your gall bladder out” (Physician 7) and “[it’s a] three minute procedure” (Physician 11). Physician 6 went further, saying abortion is “much easier and much better than getting a tooth pulled. Ask anyone who’s had a tooth pulled and anyone who’s had an abortion how they feel the next day.”

“That’s part of healthcare”: Abortion as Healthcare. Physician participants normalized themselves by discussing abortion as integral to healthcare in general. Physician 10 stated, “[Abortion is] part of healthcare and that’s part of women’s health.” Every physician participant is an OB/GYN and the majority expressed strong opinions that abortion care should be a normal part of OB/GBYN training and duties even though “OB/GYN programs don’t offer [abortion training] generally” (Physician 4). Physician 2 remarked, “The American College and the American Board of OB/GYN say [OB/GYNs] should at least know how to take care of complications. Well, how do you know how to take care of complications if you don’t know how to do the procedure?”

Other participants disapproved of OB/GYNs who do not provide abortion care: “[If you’re an OB/GYN, there’s no reason this shouldn’t be a part of what you’re doing, and the reason it’s not part of what you’re doing is because people aren’t willing to work through the political boundaries that exist to make it happen for people” (Physician 8). Several physician participants remarked that providing abortions is, for them, a realization of what it means to provide comprehensive healthcare. Physician 7 expressed surprise that her willingness to provide abortions was notable, saying, “I certainly don’t mean to minimize the importance of abortion to a woman’s life but I didn’t realize it was going to sort of define me.”

Another manifestation of normalization utilized by certain physician participants was to emphasize the aspects of their work that do not involve abortion, in an effort to show themselves

as more than ‘the abortion doctor.’ The majority of physician participants provide abortions in clinics while also teaching residents, operating private practices, or working in hospitals.

Physician 9 remarked:

I’m not just an abortion provider. I’m an ob-gyn who provides abortions-just like a cardiologist is not a person who does CATS. He’s a cardiologist who also does heart CATS. The abortions are just some of the procedures I do as an ob-gyn. But unfortunately in the world, it’s one of the only procedures where if you do that, you become the abortion provider.

Two participants, however, started out as general OB/GYNS and now dedicate most of their careers to abortion provision and advocacy and did not attempt to normalize themselves by discussing occupational duties beyond abortion. These physicians (2 and 6) are older than the rest of the participants and their careers gradually became more centered on abortion provision.

Physician participants normalized their occupation as abortion workers by discussing abortion as an everyday medical procedure and themselves as typical doctors doing their best to provide healthcare to patients. The mechanism of normalization corresponds with Kumar et al.’s (2009) discussion of abortion workers and women who have had abortions as an ‘exceptional’ category that is considered deviant in comparison to a normative category. Physician participants’ normalization of themselves as abortion providers is a way to combat the idea that abortion is an exceptional procedure, and thus combat stigma against themselves and abortion in general. Through normalization, physician participants effectively communicate a positive image of themselves as normal and their work as acceptable, even conventional, despite lawmakers, other doctors, and U.S. citizens who (according to the physician participants) mistakenly think

otherwise. The image of ‘normality’ allows physician participants to maintain positive identities, even while experiencing stigma and working under restrictive state laws.

Framing Abortion as Necessary

“What she needs”: *Necessity.* Another identity work mechanism used by physician participants was the framing of abortion as a necessary healthcare procedure. This can be seen as a subset of normalizing: participants frame abortion as medically and socially necessary to combat the stigma of abortion as something outside the purview of ‘normal’ physicians. Physician participants repeatedly discussed abortion provision as necessary, emphasizing its importance as an accessible medical procedure and as a service uniquely needed by women. As Physician 2 stated, “[abortion]’s an exceedingly vital service. It’s probably the best healthcare that you can provide to women.” Other physicians stressed that truly caring for patients necessitated providing patients with abortions with statements such as, “The actual surgery isn’t what it’s about. It’s about patient care” (Physician 7). Physician 8, reflecting on working in a hospital as a resident that did not provide elective abortions, said “we couldn’t provide women with the services they needed.” The experience of not being able to adequately serve patients led Physician 8 to seek out abortion training. Physician participants also reported that restrictive state laws magnify the need for accessible abortion: “I knew that I wouldn’t be able to come to a place like Texas that is so in need of abortion providers and not be providing” (Physician 10).

Physicians framed their provision of abortions, not as a decision, but as a requirement of their field: “[Abortion is] something that people need, that I [am] willing to do, and that’s what I should be doing” (Physician 4). Physicians 10 and 11, working in Texas under newly implemented and very restrictive laws, framed their provision as abortion as doubly necessary because abortion access in their state has been severely limited. Physician 10 emphasized patient

needs above physician desires: “The physicians should see themselves first and foremost as their patient’s advocate in their own health and also in the public health sphere” (Physician 9). This understanding of abortion as a necessary medical procedure frames physician participants as providing abortions not due to a personal preference or gain but because abortions are an essential part of healthcare and what it means to be an OB/GYN. Physicians also emphasized that abortion is often the last resort for women who have no other option: “If you don’t provide for this patient then that patient’s not ever going to get what she needs” (Physician 8).

By stressing the necessity of providing abortion care to patients, physician participants framed abortion as something they have to provide in order to be good, moral doctors and effectively serve their patients. Stressing the necessity of abortion provision is a tactic utilized in response to the elements of labeling, stereotyping, separation, status loss, and discrimination that are leveled against stigmatized groups (Crocker, Major, & Steele, 1998). By illustrating how essential abortion provision is, physician participants strive to combat stigma that relegates abortion providers to a category separate from normal physicians providing necessary medical care. This tactic of identity work, as a subset of normalizing, shows physician participants framing themselves as normal doctors providing a vital healthcare procedure.

Valorizing

***“It’s a calling and a cause”:* Abortion provision.** Physician participants valorized abortion provision by emphasizing the unique nature and heroism of being an abortion provider in a country with limited physicians willing to provide abortions, and in states with restrictive abortion laws. Physician 9 remarked, “[I] do something that’s different and extraordinary,” while Physician 11 stated, “There’s something to be said about providing a service that’s going to

change someone's life and you being one of few people who can actually do it." Other physicians remarked that restrictions on abortion lead to a scarcity of abortion providers in their state, leaving them as part of a special and irreplaceable few: "If I'm not providing, there's no one to do it in my place" (Physician 11). Physician 10, who is taking time off for family reasons, stated, "Taking leave right now is totally the worst time in so many ways because I'm needed more now than I have been before." Several physicians discussed how their fellow abortion workers were inspired, impassioned, and doing abortion care for the right reasons: "And we're not a bunch of bottom feeders. Once again, most of the people who work in these places, for the most part, it is not a career, it's a calling and a cause" (Physician 2).

Many physician participants discussed abortion through a human rights or ethical perspective. Physician 10 reflected, "Providing abortions is one of the most humanitarian aspects of medicine that I have participated in." Physician 8, reflecting on her residency, remembered having to transfer women seeking abortions to hospital in a nearby city: "I really felt like that was grossly inadequate, and quite frankly I felt like it was unethical." Physician 9 reported she was originally unhappy with the elitism she saw among her peers in medical school, but providing abortions allowed her to impact women's lives directly and focus on community and patient health. Three physicians mentioned their conviction that providing abortion is not just a part of women's health, but directly impacts the health of entire communities. Still others valorized abortion simply: "Out of all the things I do, I consider providing abortions to be probably the most important" (Physician 11).

"It's about the patients": Patient care. Physician participants further valorized themselves and their work by discussing how their abortion provision positively impacted patients. All physician participants framed their dedication to continue to provide abortions as a

decision made for their patients: “It’s about the patients, and it’s hard to constantly try to protect your patients. We protect them medically, clinically, to keep it safe” (Physician 4). Physician 2 stated, “I help more people in a tangible way in one week here than I would help in three months in my general OB/GYN practice.”

Physicians also valorized the effort and sacrifice necessary to provide quality care to patients under restrictive state abortion laws: “You have such insurmountable barriers just to get one patient, it doesn’t matter even how far she is, just to give that one patient what she needs and to work out her finances and everything else that goes along with getting her what she needs” (Physician 8). “Providers have been bending over backwards to try to make [regulations] work” (Physician 4). Physician 8 emphasized the singularity of her ability to provide abortions to women who most likely have no other option: “In this area you have to be so much more of an advocate for your patients because if you don’t provide [an abortion] for this patient then that patient is not ever going to get what she needs.” Physicians emphasized their power to affect change in women’s lives: “It’s huge, and the impact it has on these people’s lives, I mean the relief rather than the regret, is unbelievable” (Physician 7).

Physician participants frame themselves as valiant and heroic doctors in the face of intense stigma and restrictive state laws. By framing abortion work in moral and ethical terms and themselves as unique among medical professionals, physician participants combat stigma that devalues their work and their identities. The mechanism of valorizing shows participants working to combat the devaluing and deviant labels that are associated with stigmatized groups (Crocker, Major, & Steele, 1998; Kumar et al., 2009). Valorization is particularly interesting when juxtaposed with normalization, as the two tactics are seemingly at odds. However, the examples above show participants framing abortion provision and themselves as normal and that

they should be considered as such, ostensibly in the future. Physician participants' valorization of themselves and their work regards the present state of abortion, which is stigmatized and highly regulated in the states in which they practice. The marked difference between seeking the eventual normalization of abortion providers, while valorizing their present abortion provision, was visible in each physician participant interview.

In sum, physician participants exhibited three distinct tactics of identity work: normalizing abortion provision, framing their work as necessary, and valorizing themselves and other providers. While participants varied in the degree they referenced these types of identity work, all three were visible in each interview. Through employing a combination of normalizing the procedure of abortion and its place in healthcare, valorizing their own work as abortion providers and as patient advocates, and stressing the necessity of abortion services, physician participants create and maintain positive occupational and personal identities.

Discussion

Physician participants working in states with restrictive state legislation exhibited the identity work mechanisms of normalizing themselves and other abortion providers, framing abortion provision as necessary, and valorizing abortion providers. These tactics are examples of what I call 'restorative' identity work, resulting from physician participants' membership in an otherwise respected occupation. The results of this study have implications both for abortion workers specifically and for the study of identity work in general.

Impact of Restrictive State Abortion Laws on Participants

In the eyes of abortion worker participants, restrictive state abortion laws negatively impact their ability to perform their jobs. Participants view restrictive state legislation as

pointless, condescending to women seeking abortions, medically unsound, and not reaching its ostensible goal of making abortion safer. These laws force abortion workers to perform their jobs and care for patients in a way that is inconsistent with their own views and preferences for abortion work, patient care, and healthcare. Participants view state legislation as the primary way abortion access is being restricted and the site of contemporary cultural and legal ‘battles’ over abortion. Indeed, from the point of view of participants, the primary purpose of state abortion laws is to stigmatize the procedure of abortion and all people associated with its provision.

Restorative Identity Work

The participants in this study are part of a ‘dirty’ or stigmatized occupation, and physician participants participate in discursive processes of identity work, positively reframing themselves and abortion. Uniquely, abortion providers are part of an occupation that is otherwise highly regarded. Physicians, including OB/GYNs, are part of a highly-respected professional class that is associated with high status and prestige in the U.S. (Treiman, 1976; Nakao & Treas, 1994; Fujishiro, Xu & Gong, 2010). It is only their provision of abortion and association with its physical, moral, and social taints that relegates physician participants to a stigmatized occupation. This distinguishes the identity work in this study from that undertaken by the homeless and prison populations explored by Snow and Anderson (1987) and Brown and Toyoki (2013), respectively. OB/GYNs are not “at the margin or bottom of status orders,” nor have they “fallen through the cracks of society and linger at the very bottom of the status system” (Brown & Toyoki, 2013 p. 877; Snow & Anderson, 1987 p. 1338). The identity work performed by homeless or imprisoned individuals attempts to promote liveability in a context in which their entire identity is devalued and they are discriminated against. Unlike the correctional officers in Tracy and Scott’s (2006) study of taint management, abortion providers are members of an

occupation viewed by U.S. society as worthy of esteem and respect, allowing abortion providers to have something to ‘restore.’

I refer to the mechanisms of identity work undertaken by physician participants in this study as restorative. The tactics of framing themselves and other abortion providers as heroic, normal physicians providing a necessary medical service are ways in which physician participants attempt to restore the status and respect accorded to medical professionals performing vital medical procedures, such as OB/GYNs who do not provide abortions. The physician participants in this study willingly made a choice to become abortion providers and accept the stigma associated with abortion because they believe the work is essential and valuable. Through normalizing abortion care as a standard medical procedure, valorizing themselves and their colleagues as unique among physicians, and emphasizing the necessity of abortion to healthcare, these participants do not disassociate from their stigmatized occupation. Instead, they seek to restore the respect accorded to other medical professionals by U.S. society to themselves and their work.

Implications for Identity Work and Future Research

The analysis of abortion workers’ engagement in restorative identity work under restrictive state abortion laws has broad implications. First, identity work varies even among people in similarly stigmatized occupations. There are factors that affect the degree to which individuals have to engage in identity work to maintain positive identities. In this case, my findings suggest the possibility that restrictive state abortion laws affect the intensity of stigma experienced by participants and the resulting identity work. The importance of the occupation to the individual also played an important role in identity work. While non-physician participants

are abortion workers, they do not perform the procedure, are not labeled as ‘abortion doctors,’ and can find jobs that have nothing to do with abortion. Abortion is less integral to non-physician participant identity and identity work than for physician participants.

Second, choice of membership in a stigmatized group shapes identity work. Unlike homeless or imprisoned populations, or occupations that are not widely respected, abortion providers are part of a respected and high-status occupation, but choose to become abortion providers. The physician participants of this study also chose to continue providing abortions in politically hostile states. Therefore, while the stigma faced by abortion providers is very real, the physician participants accept being ‘tainted’ because of their belief in abortion work and try through tactics of identity work to restore the respect and esteem accorded to physicians who do not provide abortions.

Further research on the identity work among abortion workers in states with politically liberal or neutral attitudes towards abortion will likely reveal distinctions between identity work performed under restrictive state laws and identity work performed by abortion workers generally. Studies with larger sample sizes and distinguished by type of abortion law in effect may yield more specificity about the types and mechanisms of identity work undertaken by abortion workers. Finally, further research is needed to explore how choice to assume membership in a stigmatized group affects individuals and resulting positive identity work. The decision to take on a role that is stigmatized within an otherwise highly respected professional class deserves continued attention.

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