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Category Evolution Under Conditions of Stigma: The Segregation of Abortion Provision into Specialist Clinics in the United States

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Abstract. Organizational involvement in stigmatized practices, that is, practices that attract substantial societal condemnation, is often challenging, inasmuch as it requires the successful management of stakeholder disapproval. In this regard, existing work on organizational stigma has highlighted the advantages of situating stigmatized practices within large, generalist organizations, because doing so allows for stigma dilution—that is, organizations can reduce stakeholder disapproval by increasing their relative engagement in uncontested practices, thereby straddling multiple categories in the eyes of audiences. This line of argument, however, runs counter to the empirical observation that stigmatized practices often remain overwhelmingly concentrated within smaller, specialist organizations, even though these are often not optimally positioned to cope with stigma. In this paper, therefore, we undertake an in-depth historical analysis of a revelatory case—abortion provision in the United States following the landmark *Roe v. Wade* U.S. Supreme Court decision—to build theory of how stigmatized categories can come to be populated predominantly by specialists. Building on primary and secondary archival materials, we identify three mechanisms that shaped category evolution and resulted in the de facto segregation of abortion into specialist organizations: the founding of freestanding facilities by values-driven providers, the exit of generalist organizations from the category, and the involuntary specialization of remaining providers, as customers no longer frequented them for other services and they soon became labeled simply as "abortion clinics." We conclude by discussing the implications of our findings for the stigma literature and the generalizability of our theorizing to other settings.

Supplemental Material: The online appendix is available at https://doi.org/10.1287/orsc.2021.1450.

Keywords: stigma • categories • abortion • clinics • Roe v. Wade • generalists • specialists

To survive and grow, organizations must not only cater to their customers; they must also conform to the expectations of their institutional environment, since success and survival depend to a substantial degree on adherence to institutional norms (DiMaggio and Powell 1983), the achievement of legitimacy (Suchman 1995, Hampel and Tracey 2018), and the maintenance of harmonious stakeholder relationships (Hiatt et al. 2018). For organizations that are involved in the provision of contentious goods and services, however, managing stakeholder expectations tends to be a challenge, since such activities are generally subject to widespread societal condemnation. And, indeed, entire sectors of the economy—ranging from the production and sale of tobacco (Hsu and Grodal 2020) and cannabis (Lashley and Pollock 2020) to pornography (Voss 2015) and arms production (Vergne 2012, Durand and Vergne 2015)—are characterized by a substantial degree of stigma (Devers et al. 2009), which results in ostracism from business partners (Jensen 2006), regulatory roadblocks (Lashley and Pollock 2020), and greater difficulty accessing resources (Pfeffer and Salancik 1978). Recently, organizational scholars have built on categorization theory (Negro et al. 2010) to define *stigmatized categories* as groups of organizations that jointly face stakeholder disapproval as a result of their common engagement in a stigmatized practice (Vergne, 2012, Piazza and Perretti 2015).

For organizations that belong to stigmatized categories, coping with the consequences of stigma is typically challenging (Tracey and Phillips 2016); small, specialist organizations, in particular, often lack good options for the management of stigma. For example, attempts to decouple the organization from controversial activities (Elsbach and Sutton 1992) might be unsuccessful if such activities are core to the organization's mission (Hudson 2008), and attempts to leverage stigma to gain broad acceptance for a stigmatized practice (Helms and Patterson 2014) might backfire and draw unwanted attention to the organization if the stigmatized practice is highly contentious. Similarly, boundary management and concealment

processes (Hudson and Okhuysen 2009, Wolfe and Blithe 2015)—whereby organizations attempt to disguise their involvement in controversial practices—might prove challenging when the stigma surrounding core practices is in the spotlight of public debate (Hilgartner and Bosk 1988). In addition, fighting the consequences of stigma can be costly in the day-to-day, with firms facing substantial investments in security, higher insurance costs, difficulties finding contractors or suppliers, and ongoing legal fees. As a result, small specialist organizations that engage in stigmatized practices often find themselves "between a rock and a hard place," struggling to contain the fallout of stakeholder disapproval or struggling to afford to fight it.

Large generalist organizations, on the other hand, are typically better equipped to cope with the consequences of stigma. In addition to having greater resources available to them due to their size—which expands the range of stigma management options available to them—diversified firms can engage in *stigma dilution* (Vergne 2012) to cope with stigmatization. By pursuing a variety of other, uncontested practices, organizations work to "dilute" their involvement in stigmatized practices and, by extension, reduce disapproval from audiences, which then perceive them as straddling multiple categories. Boeing, for example, "manages to keep disapproval at a low level" despite being one of the world's largest arms producers, due to the company being better known for manufacturing commercial aircraft (Vergne 2012, p. 1028). As a result, advocates of stigmatized goods and services often encourage the involvement of generalists in their provision, partly on the grounds that these organizations are better able to withstand stakeholder pressure, which makes the continued availability of such goods and services more likely. For example, contraception advocates have, at different points in time, fought for the availability of condoms in generalist stores such as supermarkets (Enright and Cloatre 2018) and for emergency contraception—the so-called "morning-after pill"—to be available over-the-counter on drugstore shelves (MacMillan 2017).

Yet, empirical observation of stigmatized practices being carried out "in the wild" reveals a strikingly different pattern: from sex shops (Tyler 2011) to marijuana dispensaries (Dioun 2017, 2018; Hsu et al. 2018) and gun stores, specialist organizations not only persist, but often handle the lion's share of the provision of stigmatized goods and services. Additionally, it is these organizations that often bear the brunt of stigma to its extreme and most disruptive consequences, facing discrimination from resource providers such as landlords and financial institutions, as well as protests and, on occasion, violence (Press 2006, Freedman et al. 2010). This raises the question of what might explain the empirical observation that many stigmatized categories remain largely populated by specialist organizations—a trend which is especially surprising considering the inherent difficulties such organizations face. Additionally, given the manifest advantages of stigma dilution for containing stakeholder disapproval, it is also unclear why we do not regularly see specialist organizations within stigmatized categories diversifying into less stigmatized goods or services.

To shed light on these issues, we carry out a historical case analysis (Kieser 1994, Ingram et al. 2012, Leblebici 2014) of the category of abortion provision in the United States. By leveraging primary archival data from abortion advocates and opponents, as well as records from abortion clinics and accounts from clinic founders, in addition to secondary data from historians, sociologists, and journalists, we find that the abortion provision category changed considerably in terms of both membership and the degree of specialization of its members over our period of study. We identify three processes that shifted the balance of the category toward specialist organizations: the entry of values-driven providers; the exit of generalist hospitals based on stakeholder pressure; and, finally, the involuntary specialization of remaining providers, as stand-alone facilities became—both materially and cognitively—simply "abortion clinics." As a direct result of these processes, not only did abortions come to be primarily offered by specialist organizations, but the practice became de facto *segregated* into such organizations, as over time stigma caused generalists to exit and created a barrier to the diversification of the remaining providers into other, nonstigmatized services. Our work thus contributes to the literatures on stigma and categories by fostering a better understanding of the category-level organization of stigmatized practices.

Theoretical Background

Organizational Approaches to Stigmatization

In the social sciences, the study of stigma—a "mark" (attribute) that links a person to undesirable characteristics—dates back to sociologist Erving Goffman (1963); however, the study of stigmatization at the organizational and interorganizational level is a much more recent phenomenon (Devers et al. 2009). Whereas Goffman (1963) examined the vilification of individuals based on their ascribed characteristics such as race, sexual orientation, and disability status, organizational stigma scholars have typically drawn a distinction between *event* and *core* stigma (Hudson 2008). Event stigma is thought to arise as a result of discrete, episodic, and anomalous events such as bankruptcy (Sutton and Callahan 1987), fraud (Jonsson et al. 2009), and product recalls (Rhee and Haunschild 2006), and, as such, it tends to be temporally bounded. By contrast, core stigma tends to be enduring, having

to do with activities that an organization engages in routinely and which are, as the label suggests, core to its continued existence, as in the case of the men's bathhouses in Hudson and Okhuysen (2009). As Hudson (2008, p. 253) wrote, core stigma in organizations is due to the nature of "who it is, what it does, and whom it serves." At the same time, as noted by Lashley and Pollock (2020, p. 4), "core stigma is a categorical phenomenon," inasmuch as audiences categorize firms that engage in the same vilified practice as a collectively deviant group. Recently, organizational scholars have thus drawn on categorization theory (Negro et al. 2010) to introduce the notion of *stigmatized category*, defined as any group of organizations "whose liability prompts out-group members to keep their distance to avoid a potentially harmful association" (Vergne 2012, p. 1030). Stigmatized categories comprise organizations that audiences recognize as part of a set as a result of their common engagement in a stigmatized practice.[1]

The Importance of Stigma Management Strategies

For organizations in stigmatized categories, surviving and thriving requires effective management of audience disapproval, so as to mitigate the negative externalities of stigma. In this regard, the categorization literature (e.g., Negro et al. 2010) has underscored how organizations can claim membership in multiple categories at the same time—a process known as "category straddling" (Zuckerman 2000). For stigmatized organizations, category straddling creates an opportunity for *stigma dilution* (Vergne 2012, Piazza and Perretti 2015): by engaging in stigmatized and nonstigmatized practices simultaneously, organizations are able to dilute their involvement in controversial activities that are likely to draw scrutiny. In so doing, the rationale is that "additional membership in non-stigmatized categories can deflect attention from the stigma and dilute the vilifying association" (Vergne 2012, p. 1032).

Perhaps the best testament to the effectiveness of stigma dilution in reducing stakeholder disapproval is that, in many sectors of the economy, stigmatized practices are frequently organized within diversified, generalist firms. Tobacco companies such as Philip Morris, for example, continued to engage in diversification long after this strategy came to be seen as detrimental for shareholder wealth, because investing in noncontroversial areas of business allowed it to "drown out" attacks from litigants and the media while building social and political capital (Beneish et al. 2008). In a similar fashion, nuclear power generation has historically taken place within diversified electric utility companies that engage in multiple forms of power generation, both in the United States (Piazza and Perretti 2015) and elsewhere (Davis 2012). And in the arms industry, as noted by Vergne (2012, p. 1038), "most arms producers are not pure players and realize a significant share of their business through civilian activities (e.g., Boeing)." The advantages of situating stigmatized practices within generalist organizations are manifest: because generalists' involvement in a stigmatized practice is, by definition, partial, they are unlikely to elicit the same level of contention that a specialist organization would.

By contrast, smaller specialist organizations are typically unable to execute this strategy (Hudson 2008). The existing literature, however, has examined a number of organization-level responses to stigma available to specialist organizations, including, for example, a careful management of the boundary between the stigmatized organization and its partners (e.g., Hudson and Okhuysen 2009), concealment (Wolfe and Blithe 2015), as well as negotiations with stigmatizing audiences so as to establish acceptance for contested activities (Helms and Patterson 2014, Hampel and Tracey 2017). These kinds of responses are not without risk, however. Concealment and boundary management processes, in particular, might only succeed if the stigmatized practice is not perceived as salient or widely regarded as a social problem (Hilgartner and Bosk 1988). When substantial opposition to a practice exists, specialist organizations might have a difficult time dissembling, dissimulating, or attempting to establish practice legitimacy. For example, men's bathhouses of the kind described in Hudson and Okhuysen (2009) have existed in major U.S. cities for well over a century, successfully deploying concealment strategies to avoid public scrutiny. Such strategies, however, were only effective insofar as the practices that bathhouses engaged in were not widely perceived as a social problem. When the AIDS epidemic became widespread in the 1980s and same-sex relations came under greater scrutiny, New York and San Francisco ordered all bathhouses closed (Carroll 1985b). This example highlights how, under such circumstances, the very survival of stigmatized organizations is likely to be in jeopardy. In particular, the fact that specialist organizations are heavily invested in the stigmatized practice makes them obvious and visible targets, and additionally their small size often makes them unable to mount an effective response.

The Puzzle of Specialists' Prevalence and Endurance Within Stigmatized Categories

The aforementioned arguments point to the fact that organizational stigma scholarship has had relatively little to say about the category-level organization of stigmatized practices—that is, how the engagement in a given practice is distributed *across* types of organizations within a stigmatized category. Undergirding this lack of research is, perhaps, the assumption

that novel stigmatized practices are inextricably linked to the founding of new organizations (Aldrich and Fiol 1994), and that the trajectories of such practices are, in turn, tied to the efforts of the organizations that engage in them. This is, for example, the case for Hampel and Tracey's (2017) study of the Thomas Cook travel agency and Helms and Patterson's (2014) work on mixed martial arts fighting. In both cases, a new stigmatized practice was introduced and championed by small specialist organizations, and the same specialists persisted in the category as they ultimately gained societal acceptance. However, empirical evidence also indicates that the distribution of organizational types within stigmatized categories can shift over time. For example, stigmatized practices can move beyond small, newly founded organizations to be taken up by larger, relatively well-established generalists over time. The sale of liquor in the United States, for example, initially took place in specialized liquor stores—some of which were state-run—and only later was it taken up by generalist retailers such as grocery stores. In other cases, former specialists can become generalists through diversification, as seen in the case of the tobacco companies (Pyatt and Horwitz 1985).

As discussed in the previous section, such category membership shifts from specialist to generalist organizations can be explained by the fact that the latter often have superior resources and are better able to contain stakeholder disapproval through stigma dilution. To the degree that the distribution of different types of organizations changes within stigmatized categories over time, therefore, a reasonable baseline expectation would be for them to move toward greater generalism—through the diversification of specialists, for example, as well as through the entry and persistence of generalists. Empirical observation, however, reveals numerous instances of the opposite trend—that is, stigmatized practices that had been taken up by generalists becoming increasingly concentrated among specialist providers. In the United States, for example, the sale of handguns was once so common that one could purchase a handgun in the course of one's regular shopping, or at least in mass-market sporting goods stores; today, however, handguns are mostly sold by small, specialized gun stores. At first glance, dynamics such as these are not only hard to justify based on economic considerations but also run counter to what existing theory would predict.

Therefore, in the following, we investigate the process by which stigmatized practices become concentrated into small, specialist firms through a study of the abortion provision in the United States. It is important to note that the question of how stigma itself arises lies beyond the scope of our work. Indeed, for most organizations, the stigmatization of a given practice often predates the decision to engage in that practice (see, e.g., Hudson and Okhuysen 2009, Vergne 2012, Helms and Patterson 2014, Piazza and Perretti 2015), as it is grounded in societal evaluations of what is moral. This is certainly the case for abortion. Our work is primarily concerned with the issue of how stigmatized practices are organized—and how their organization can change—at the category level, *given the stigma.*

Case Background: History of Abortion Provision in the United States

The stigmatization of abortion goes back centuries, and it is rooted in moral and religious concerns regarding the beginning of life. In the United States, there were historical periods in which abortion was legal and practiced by a range of providers, including homeopaths, midwives, and physicians (Mohr 1978). However, when physicians first organized into the American Medical Association in 1847, they led a concerted effort to establish a legal framework requiring that abortions could only be performed by physicians when judged by them to be medically necessary (Ginsburg 1989). From the late 19th century onward, therefore, *elective* abortions were outlawed in the United States, while those deemed "medically necessary" were carried out by physicians in their offices and in hospitals. By the 1960s, the combination of the limited availability of the service and an expanding view of women's rights led to a movement to legalize elective abortion that brought together an unlikely alliance of players, including the American Medical Association, Protestant clergymen, the YWCA, the American Civil Liberties Union (ACLU), and new feminist organizations such as the National Organization for Women (NOW) and Planned Parenthood (Ginsburg 1989). Their efforts initially resulted in the legalization of elective abortion in four states—California, Hawaii, New York, and Washington—plus the District of Columbia. In 1973, the question of the legality of "elective abortions" eventually reached the Supreme Court in the historic *Roe v. Wade* case. The court ruled that the constitutional right to privacy applied to a woman's decision to have an abortion, making the elective procedure legal across the country. The ruling came as a shock to both proponents and opponents, as most thought that elective abortions had little chance of national legalization at that point in time.

Upon legalization, it was unclear, however, where abortions would be performed; the path of least resistance would likely have been to perform most abortions in hospitals, as is the case in much of Europe and Canada. We know today that this turned out not to be the way abortion in the United States came to be organized, and, in the following, we trace how abortions

came to be primarily segregated into specialist organizations. In Table A1 of the online appendix, we provide a timeline of major abortion-related events in the United States.

Methods

We explore the issues discussed in the previous sections by means of a historical case analysis (Kieser 1994, Ingram et al. 2012, Vaara and Lamberg 2016) of the evolution of the stigmatized category of abortion providers in the United States in the decades following the landmark Supreme Court decision of *Roe v. Wade*. A historical case analysis approach is arguably best suited to analyze phenomena unfolding over long periods of time and characterized by a complex and interrelated set of causes, especially those for which we do not have strong priors (Kieser, 1994, Ingram et al. 2012, Leblebici 2014, Vaara and Lamberg 2016). Historical cases allow researchers to "look at the concrete details and actions of a particular situation to understand the larger systems of meaning reflected in them" (Hargadon and Douglas 2001, p. 480). Furthermore, from an analytical standpoint, this method helps us challenge and refine existing theoretical understandings through building theory from a single in-depth revelatory case.

Recently, a small number of management studies have advocated for not only utilizing historical and longitudinal *data* but in moving toward historical *methods* (e.g., Cattani et al. 2013, 2017; Argyres et al. 2020). We join in these efforts to integrate historical case analysis into management research. In particular, we follow the tenets of historical realism as outlined in Vaara and Lamberg (2016), as we aim to reconstruct historical events utilizing primary and secondary data sources, but we analyze them for our purpose of identifying structures, processes, and mechanisms related to the evolution of the abortion provision category over time.

Data

Our data include interviews, primary archival data, media articles, secondary data sources, as well as congressional hearings and court testimonies. In following the tenets of historical case analysis, wherever possible we prioritize primary sources, or those texts and media that were produced directly during the time period of study, over secondary sources. Table A2 in the online appendix outlines our sources and how they are used in our analyses. In our preliminary data-collection process, we first interviewed five prominent experts on the history of abortion provision in the United States to obtain an overview of the field, the actors who had been involved in it, and the organization of abortion over time. These semistructured interviews served as preliminary contextual guidance for understanding our case, providing structure and an underlying narrative to our primary data. We then gathered data that would enable us to understand the organization of abortion services in the United States over time. We collected statistics on the type of facilities where abortions were performed between 1970 and 2000 from the *Family Planning Perspectives* journal, which published the most reliable and consistent statistics on abortion providers (including hospitals and clinics) over time.[2]

However, the quantitative data on service provision did not offer any insight as to why changes to the organization of the practice had occurred, so we gathered additional data that would enable us to understand the historical changes of interest. At this point, we first gathered secondary data on abortion provision in the United States. As shown in Table A2, these secondary sources include 19 books by historians, sociologists, anthropologists, and journalists, as well as two biographies—one by an abortion clinic owner and one by an owner's son, recounting the details of clinic practices. Additionally, we collected all the articles from *Family Planning Perspectives* that mention the term "clinic," documentation from a U.S. Congressional Hearing on clinic blockades, as well as the archival data on the Supreme Court case of the *National Organization for Women (NOW) v. Scheidler*, which was the primary court case focused on anti-abortion groups' efforts to shut down clinics.

The secondary sources provided us with a historical overview of the players and events in the organization of abortion over time, and the two biographies provided first-hand accounts of abortion provision. However, we sought primary archival data on service provision to enable us to build the historical account of key players, events, and shifting meanings over time. Therefore, we gathered primary data from the two largest collections of archival materials on abortion provision in the United States—the Arthur and Elizabeth Schlesinger Library on the History of Women in America at Harvard University and the Wisconsin Historical Society Library.[3] In visiting these two archives, we collected hundreds of documents, including newsletters, posters, personal correspondence, clinic reports, speeches, and newspaper stories related to key organizations and individuals who worked to influence the organization of abortion.

Analyses

We engaged in multiple steps in analyzing our data, iterating between analysis and narrative, as is a standard approach in historical case analyses (Ingram et al. 2012). Without an existing theoretical understanding of how stigmatized categories might evolve to be populated predominantly by specialists, we first followed an inductive approach to our data analysis. However, as we began to identify the processes in our

case, we also recognized their relationship to existing theories and constructs from the literatures on stigma and categories. At that point, we went back to the literature to compare and contrast what we were finding in our case, following the tenets of abductive analysis, which purposefully iterates between data and theory—this approach has recently been advocated as being especially suitable for theory development and extension (Tavory and Timmermans 2014).

Timeline and Case History. First, we analyzed the statistics on the provision of abortion in the United States, paying close attention to the relative concentration of services in hospitals versus independent, or stand-alone facilities. By compiling the annual statistics from *Family Planning Perspectives*, we were able to observe the historical shifts in how abortion was organized over time. From this data, we saw that the general trend was an increase of the share of abortions performed in stand-alone facilities over time. We had originally learned about this shift from our interview informants, but these statistics allowed us to triangulate their accounts and pinpoint the changes to concrete dates. Additionally, the statistics also provided nuance to the main trend of increased concentration of abortion in stand-alone facilities, for example, showing that hospitals initially entered the field after *Roe v. Wade* and then exited later. After identifying these historical shifts, we sought to understand the main processes that contributed to them. We therefore followed the archival approach outlined by Ventresca and Mohr (2002) and read all of the secondary historical and biographical accounts of abortion provision in the United States that we had gathered, including the historical and sociological accounts, the biographies, and the issues of *Family Planning Perspectives*. To address our research question, we paid particular attention to the following areas: (1) who the primary actors working to affect the organization of abortion were at each point in time; (2) which individuals or organizations founded specialist organizations to provide abortions and what accounts they gave as to why they founded them; and (3) why hospitals reduced their provision of abortion services and what role they played in affecting how the stigmatized practice was organized over time. By analyzing the texts with these questions in mind, we were able to construct a narrative outline of actors and actions that propelled how abortion became organized into specialized clinics in the United States.

Identification of Relevant Processes. After outlining a historical narrative, we went to the primary archival sources to further illuminate the processes. We first focused on primary sources from actors who were centrally involved in the early years of structuring how the service was practiced, such as Planned Parenthood, the National Abortion Rights Action League (NARAL), the Women's National Abortion Action Coalition, and the Religious Coalition for Reproductive Choice, as well as prominent individual figures in the antiabortion movement. In assessing these accounts, we paid particular attention to the following: (1) what each actor's position was on how to structure abortion provision—and what justifications or concerns they presented for organizing it that way; (2) what tactics actors used to influence the organization of abortion provision; and (3) how actors attempted to influence abortion providers, both in terms of enabling them to carry out the service and attempting to disrupt their provision of it.

As we analyzed these documents, we were able to begin to fill in—and, where necessary, rearrange—our historical narrative with primary evidence from the archival data. The final step in our analysis was our examination of clinic records from the library archives. We analyzed the comprehensive records of two clinics, one established in rural Wisconsin and one established in Boston, Massachusetts. The records include newsletters, correspondence with local government bodies, speeches by the founders, court documents, photographs, brochures, internal documentation such as staff training manuals and job descriptions, correspondence with social movement organizations, and newspaper stories. Our primary goal in reviewing these materials was to look for disconfirming and confirming evidence of the wider historical trends that we had identified as to how abortion provision came to be concentrated in clinics. In analyzing the clinic documents, we considered the following: (1) who clinic founders were and what accounts they gave as to why they founded these organizations; (2) how clinics organized abortion provision in relation to other services; (3) who clinic operators were connected to, in their communities and nationally; and (4) what challenges or opportunities these specialized organizations faced in operating. These materials enabled us to look in-depth at two specific cases to see how they conformed, diverged, or added nuance to our historical case, and we made modifications to our case accordingly. Finally, we completed a qualitative analysis of *New York Times* articles from the period of study that included keywords related to abortion provision to examine how public discourse surrounding the organization of abortion shifted over time. In sum, the quantitative statistics enable us to identify key shifts over time in the structuration of the stigmatized category of abortion provision, while the primary and secondary accounts from a variety of central actors enable us to document the processes underlying these shifts.

Stigmatized Practice Segregation: The Case of Abortion Provision

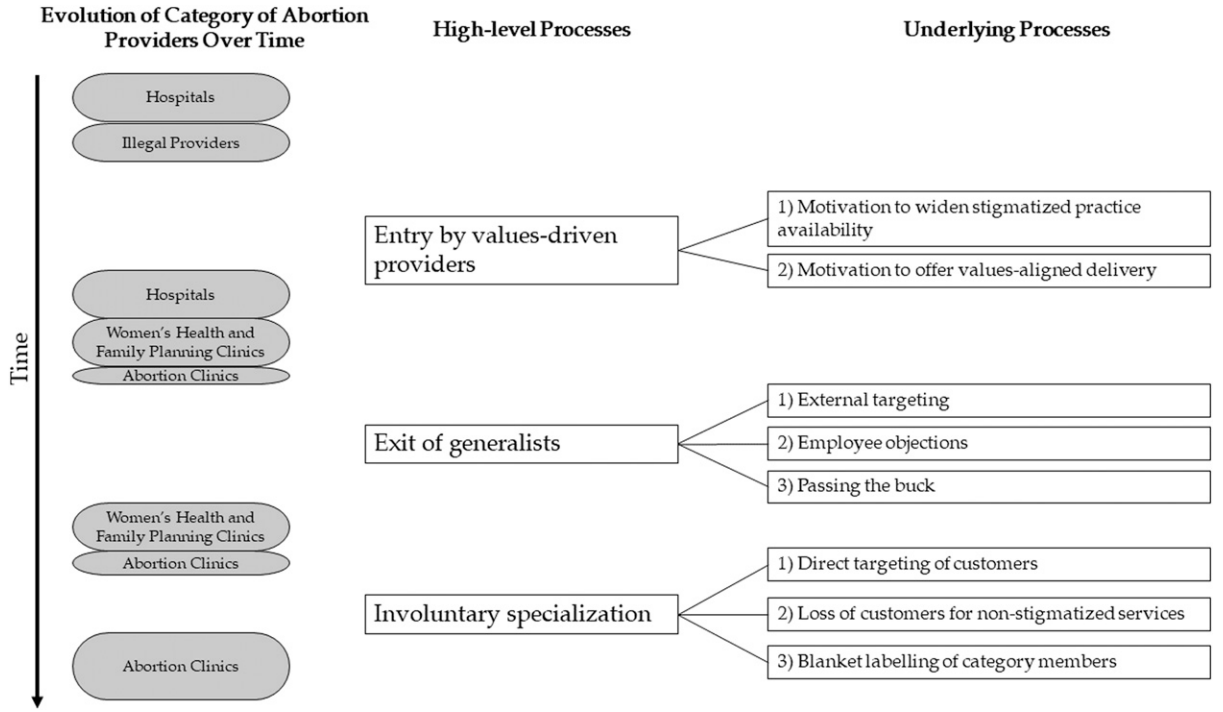
In the following, we describe our findings, which include the identification of three high-level processes as integral to the evolution of the abortion provision category in the United States toward practice segregation, namely, (1) entry by values-driven providers; (2) the exit of generalists; and (3) involuntary specialization. Figure 1 provides a summary that outlines the relationship between the high-level processes and their subsequent underlying processes and shows how each process changed the composition of the members in the category of abortion provision over time. Table A3 in the online appendix provides a summary of case evidence speaking to each of the theoretical mechanisms that we uncovered. In the following, we describe how each of these changed the category of abortion provision, eventually resulting in practice segregation.

Entry by Values-Driven Providers

Through our analyses, we found that values-driven providers were a key piece of the puzzle of how the category of abortion provision evolved over time. The historical evidence shows that these providers largely emerged from the movement to legalize abortion, and many had limited medical or business experience. According to our findings, their efforts were undergirded by two primary mechanisms. First, they aimed to widen the availability of the stigmatized practice. Second, they sought to offer a values-aligned approach to delivering the practice, which means that they aimed for it to be provided in a comfortable, supportive, and judgement-free environment to attempt to shield those seeking the service from stigmatization. The result of their efforts was the establishment of alternatives to the existing medical offerings for abortion services.

Motivation to Widen Stigmatized Practice Availability. One of the main drivers behind the entry of values-driven providers was a desire to widen the availability of abortion. Concerns about service availability were grounded in the reality that followed the passage of *Roe v. Wade*. Despite the American Medical Association's public stance toward abortion legalization, medical practitioners' reaction to *Roe v. Wade* was predominantly characterized by inertia. Although the 1973 U.S. Supreme Court decision established the right to have an abortion, it did not establish the right to *access* an abortion (Ginsburg 1989, Schoen 2015). Therefore, abortion proponents such as the National Abortion Rights Action League (NARAL)—an

Figure 1. Processes of Category Evolution in the Case of Abortion Providers



organization that largely grew out of the movement to legalize abortion—began voicing concerns that although abortion had been legalized, its availability would be limited.

In this regard, NARAL's proposed solution to the concern of availability could have been to propose legislation to ensure that generalist organizations, such as hospitals, would offer the practice. But the organization took a different approach. In fact, in 1973, NARAL fought proposed legislation in New York that would have limited abortions to hospitals, arguing that abortion would become "an unobtainable privilege" (Lader 1973). NARAL wrote that hospitals would charge too much, they would not give women the support that they needed, and they had limited space to provide the service in a comprehensive and compassionate manner. NARAL was successful, as the legislation was indeed struck down. NARAL also advocated for the founding of new, specialized facilities. Its leaders wrote that "the only rational solution was a network of freestanding, ambulatory clinics" (Lader 1973, p. 150) and that what was required was "a variety of abortion facilities . . . where they can reach women" and provide a setting "where the patient's dignity is paramount" (Lader 1973, p. 151). Although NARAL did not open clinics directly, the organization was a key voice in influencing how the practice would come to be organized.

One organization that took up the charge to provide these "freestanding" options was Planned Parenthood. Originally established in 1916, Planned Parenthood quickly became the most prominent birth control organization in the nation. In the first half of the 20th century, however, most birth control advocates—including the leader of Planned Parenthood—were morally opposed to abortion, hoping that providing women with access to birth control would eventually make abortion unnecessary (Reagan 1997). However, Planned Parenthood began to shift its position on the issue under Alan Guttmacher, who became president of the organization in 1962. A few years before *Roe v. Wade*, like NARAL, Guttmacher expressed concern that even if abortion were to be legalized, it would still likely be largely inaccessible to vulnerable populations, such as minority and poor women. He labeled these women "the victims of involuntary fertility" (Guttmacher and Pilpel 1970, p. 16) and shifted the organization's stance on abortion by arguing that these women should be given access to affordable and safe abortion services in case contraceptives failed (Guttmacher and Pilpel 1970). In the early 1970s, Planned Parenthood leaders began to discuss the availability of contraceptives and pregnancy termination services as two sides of the same coin, aligning abortion with Planned Parenthood's traditional mission of increasing access to birth control.

When it came to the question of how abortion should be organized, Planned Parenthood was an early proponent of the stand-alone facility model, which aligned with their existing approach of operating family planning clinics. The organization also advanced several arguments for why abortion should be separated from more mainstream medical services. Before *Roe v. Wade* was passed, Planned Parenthood publicly stated that it believed hospitals would not adequately meet the demand for abortions (Guttmacher and Pilpel 1970, p. 19). It published research that concluded that hospitals should not crowd "their already congested facilities with continuing services which can best be provided at neighborhood health centers" (Reynolds 1970, p. 22). Following the legalization of abortion in New York State in 1970, Planned Parenthood opened what they termed the first stand-alone "community abortion facility" in the country in Syracuse. In 1973, immediately following *Roe v. Wade*, the organization opened the first freestanding integrated facility providing abortions in Texas (Bader and Baird-Windle 2015) and expanded from there. Planned Parenthood would eventually grow to be the largest provider of abortion services in the United States.

But the founding of freestanding clinics was not exclusively carried out by Planned Parenthood. Through our analyses of historical documents, we find an entirely different set of values-driven providers, which was largely comprised of women who had been involved in the abortion legalization movement who decided to take it upon themselves to try to expand the availability of abortion provision. Although it is widely known that the feminist movement was central to the campaign for the *legalization* of abortion, the archival data reveal that the movement's legacy also played a central role in the *organization* of abortion after legalization. Prior to *Roe v. Wade*, networks of women across the United States had coordinated to help women seeking abortions arrange travel to states like New York, where the procedure was legal. After *Roe v. Wade*, we find that women from these referral networks expressed frustration that local options for abortion were slow to emerge, and some of them decided to found women's health facilities that offered abortion. For example, after legalization, women in Iowa City who had previously been active in referring women to underground or out-of-state abortion providers called local physicians to ask when they were going to start offering abortions and how much they would cost. "They virtually hung up on us," one recalled. "I mean they were just incensed that we had called because they had no intention of changing what they were doing" (Schoen 2015, p. 23). Frustrated with this response, these women decided to form a feminist collective and open their own facility.

There are similar accounts of foundings from across the United States. Many facilities reflected their feminist roots in their names, for example, the Chico Feminist Women's Health Center, founded in California in 1975, and the Aware Woman Center for Choice, founded in Florida in 1976. Before opening a center in Fargo, North Dakota, its founder helped local women seeking abortions find legal options. She recalled, of that time:

> I did a lot of abortion referrals. And one of the reasons I became so committed to opening something here was people would just call over the phone and say, 'Why isn't there something like this available in Fargo?' And the more I got those phone calls, the more I thought something has to be done about this (Ginsburg 1989, p. 80).

Another founder, Maggi Cage, described herself as "a feminist" and reflected on her role in helping women get abortions before legalization:

> I have been active in the pro-choice movement in Wisconsin since 1971. . . . Before 1973 legal abortion was available only in New York or outside the country, and I helped women make the necessary arrangements, find the money, and then I drove them to the airport.[4]

Cage was 26 years old when she announced that she would open a women's health facility in Wisconsin that would offer abortions. She told the local paper, "The alternative is for local hospitals or Planned Parenthood to assume the services, and to date these alternative facilities have no such program."[5] However, we found that values-driven founders were not only concerned with the availability of the service; they also expressed that their efforts were also driven by worries that the people seeking abortions within mainstream medical facilities would be stigmatized and not given the judgement-free care that supporters of the practice felt they deserved. Therefore, we have significant evidence that a second mechanism, around the aim to offer a values-driven approach to the service delivery, also underpinned these founders' decision to enter abortion provision.

Motivation to Offer Values-Aligned Delivery. We first see evidence of concerns with the way women might be treated in mainstream facilities in the discourse of the feminist organizations that were deeply engaged in the abortion debate. In examining the documents from these meetings and correspondences from these groups, we find the reoccurring theme that feminist organizations were concerned about not only abortion legalization but also the organization of legalized abortion. In these meetings, they argued that physicians' offices and hospitals were male-dominated spaces that did not provide adequate care for women. For example, two years before *Roe v. Wade*, in 1971, a feminist group published a brochure outlining these concerns:

> Although generally in favor of the liberalization of abortion laws, most health professionals feel that abortions should be performed by physicians in hospitals. Women's liberation, on the other hand, holds that abortion laws mean control of their bodies by the state and the medical profession. They want these laws repealed, and feel that paraprofessionals could safely perform an operation as simple as an abortion."[6]

That same year, another feminist group in Seattle echoed these arguments, writing:

> We must demand and campaign for widespread licensing and training of para-medics to perform abortions . . . . It will also free women from dependence upon the strong existing medical hierarchy and from subjection to the professional elitism of most doctors toward their patients. We would also favor having women perform abortions as a step to more concerned and sympathetic care.[7]

As illustrated through these excerpts, during the campaign for legalization, many feminist organizations saw the mainstream medical community as part of the patriarchal society that they sought to challenge. And they were rightly aware that legalizing the practice would not remove the stigma surrounding it; unless the service was offered in a setting that was purposely created to respect those seeking it, women would continue to suffer the consequences of stigma. Therefore, they wanted to ensure that legal abortions would be offered outside of hospitals and be performed by sympathetic (and primarily female) doctors or by "paraprofessionals." Aligned organizations that had supported the movement for legalization echoed these concerns. Planned Parenthood published a report calling for stand-alone facilities in part because hospitals "tended to overlook the social-psychological factors" of their patients (Reynolds 1970, p. 22). They advocated for counseling alongside the provision of the service. Additionally, the organization's leaders expressed the opinion that most doctors were hesitant to perform abortions, characterizing doctors as "conservative individuals who have been raised with the feeling that abortion is an illegal procedure," and they said that clinics could be staffed with "the thinking and caring doctors" (Guttmacher and Pilpel 1970, p. 23).

There is further evidence that these concerns then underpinned values-driven foundings in the category. For example, immediately following legalization, a group of women who had met through feminist organizations in Cambridge, Massachusetts, decided to open a facility called the Women's Community Health Center.

In their first annual report, they echoed earlier concerns from the feminist movement about where abortion would be organized, writing:

> We cannot allow the professional medical establishment absolute decision-making power about our health. . . . Hospitals are impenetrable bastions of the medical profession, the sterile, alien environment where we are stripped of our strengths and power.[8]

They described how their facility would offer a completely alternative organization and environment, describing it as "a feminist institution which seeks radical social change by implementing the concept of self-help; the sharing of skills and information so that women can regain control of our health care and our lives."[9] They also described their efforts by writing, "We see ourselves as a political force for change as well as an organization for providing services."[10] The women ran the clinic under collective decision-making rules and worked almost exclusively with female physicians. They noted that these women's health centers were "logical extensions" of feminist groups, and they offered an array of reproductive services as well as counseling, even though the records show that the majority of this facility's income came from abortion services.[11]

Although many founders did not have business or medical experience, some were physicians. Doctors who decided to establish an abortion facility often discussed their motivation to offer a supportive environment and make their expertise available to women, irrespective of economic considerations. Some even invoked their own negative experiences with abortion. For example, in an account of her years as an abortion provider, Wicklund (2007, p. 94) emphasized her values and philosophy as underlying her decision to found her own clinic in Bozeman, Montana:

> At the core, I was determined to make my patients' experience better than mine had been. A clinic facility that expressed my priorities, my values, and my style was taking shape in my imagination. . . . Within weeks of opening our doors there was already a handful of women whose experience and circumstance reaffirmed my philosophy. I had a business to run, and the financial burden kept me awake some nights, but I knew I was doing everything I possibly could to keep our patients both physical and emotionally safe.

As this evidence shows, the category of abortion provision was fundamentally changed by the entry of values-driven providers who expressed concerns both with the availability of the practice, as well as the environment in which it was offered. Organizations like Planned Parenthood and NARAL that were united in the movement for legalization alongside feminist movement actors articulated and defended the argument that abortion did not belong in traditional medical facilities. They also fought legislation that would have limited abortions to hospitals. Drawing on values from the movement to legalize the practice, as well as on networks and relationships that were built through this period of organizing, in the early and mid-1970s values-driven providers began to establish stand-alone facilities that were separate from hospital systems and specialized in women's health, fertility, and family planning, and also offered abortion in a judgement-free environment.

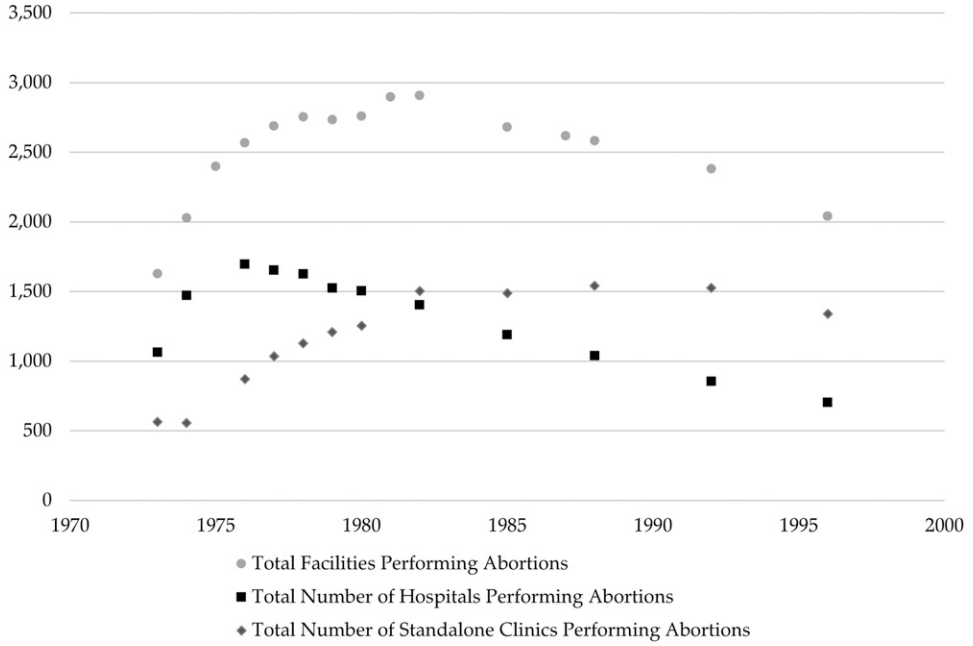
The Exit of Generalists

The second primary process that contributed to the evolution of the category of abortion providers was the exit of generalists—in our case, hospitals—from abortion services. This process was undergirded by three mechanisms. First, generalists were targeted by external groups who pressured them to stop providing the service. Second, employees of generalist organizations began to object to being involved in the practice. Finally, the generalists started to increasingly rely on the service being provided by specialist clinics, which enabled them to "pass the buck" by simply referring patients who wanted abortions to clinics.

Before delving into these mechanisms and illustrating how each contributed to the exit of generalists, it is helpful to show the trends that we find for the provision of abortion in hospitals over time. First, somewhat surprisingly, we find that many hospitals initially responded to legalization by incorporating the service. For example, in the first year after abortion was legalized in the state of New York, approximately 90% of the 215,500 abortions performed there took place in hospitals, with only 10% taking place in newly founded freestanding clinics.[12] Data from the New York Department of Health show that two years later, in 1973, there were 221 hospitals offering the service in the state, with only 18 non-hospital providers.[13] Additionally, as shown in Figure 2, immediately after *Roe v. Wade,* in 1973, and through 1976, the number of hospitals offering abortion services across the United States increased. However, the number of hospitals providing the service peaked in 1976, at 1,695, and steadily decreased afterward. By 1996, only 703 hospitals still provided abortions. Figure 3 further illustrates this shift, showing the percentage of abortions provided in hospitals versus stand-alone clinics from 1973 to 1996. As shown, there was a substantial increase in the proportion of abortions performed in clinics in the late 1970s. By the late 1980s, less than 10% of abortions were performed in hospitals, and this figure would continue to drop over time, reaching only 7% by 1996.

Overall, the historical evidence shows that the number of hospital abortions in the United States actually grew—albeit slightly—in the years immediately

Figure 2. Number of Abortion Providers by Organizational Form

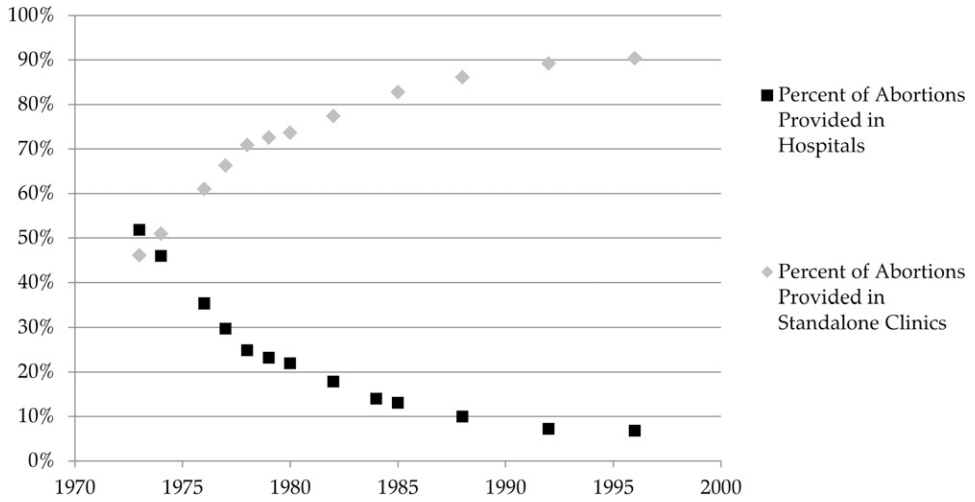


Sources. Abortion in the United States, *Family Planning Perspectives*, 1976, 1977, 1978, 1979, 1981, 1982, 1984, 1985, 1987, 1988, 1991, 1995, and 1996.

following *Roe v. Wade*, which indicates that initially many hospitals did view abortion provision as a logical extension of their existing services. Importantly, this shows that the explanation for the paucity of generalists in this category toward the end of our period of study cannot be attributed to the fact that they were never involved in the stigmatized practice. In the following, we describe the three processes that underpinned hospitals exiting the service en masse over time.

External Targeting. Although the legalization of abortion might have been expected to decrease (or even eliminate) the stigma associated with the practice, stigmatization nevertheless persisted in its wake. Not long after hospitals started to incorporate the practice, they began to face political and financial pressures from key stakeholders such as donors, politicians, and religious leaders, urging them to stop providing abortions. An example of early pressure from external

Figure 3. Percentage of Abortions Provided in Hospitals and Stand-Alone Clinics Over Time



Sources: Abortion in the United States, *Family Planning Perspectives*, 1976, 1977, 1978, 1979, 1981, 1982, 1984, 1985, 1987, 1988, 1991, 1995, 1996

stakeholders can be found in the notable case of the University of Arizona, whose medical center stopped performing abortions and providing abortion training in 1974 as part of a deal the school made with the state legislature in order to receive $5.5 million for the renovation of its football stadium (Myer 2000). In a similar vein, in 1976 the Catholic mayor of St. Louis issued an ordinance to forbid the public hospitals in the city from providing the service.

In the late 1970s, this type of pressure began to mount due to the increased mobilization of the antiabortion movement. Prior to this time, those who opposed abortion had primarily focused on attempting to reverse *Roe v. Wade*. However, when multiple legislative proposals failed in Congress, many grew weary of what they viewed as the tepid tactics that early advocates (often organized through the Catholic Church) had used to fight abortion up to that point (Ginsburg 1989). A more radical wing of antiabortion actors then became mobilized and focused on an expanded repertoire of persistent, direct action against providers.[14] A report by the Religious Coalition for Abortion Rights described how these activists worked to "create an atmosphere whereby hospital boards believe there is more to gain by eliminating abortion services than by continuing to serve the medical needs of women."[15] This can be illustrated through the case of a private hospital in Illinois that had provided abortions since *Roe v. Wade*, but discontinued the service in the early 1980s after it began to receive "a lot of comments from the community" about their abortion policy. The hospital's president stated, "We're a community hospital, responding to community needs."[16] Overall, we attribute much of the decision to exit abortion provision to the pressure that hospitals received from external stakeholders who disagreed that they should offer elective abortions. However, as described in the following, we also found substantial evidence that internal stakeholders, or employees of generalist organizations, also played a role in halting the service within hospitals.

Employee Objections. Historical sources show that pressure from internal stakeholders such as physicians, residents, and nurses was also a significant factor in hospitals deciding to stop offering abortions. In 1975, a public hospital in Minnesota wrote a letter to NARAL explaining why they would no longer be performing abortions:

> The Medical Staff unanimously agreed that they did not wish to have abortion services available to them in their hospital. The Hospital Personnel working in the surgery department, as well as the anesthetist employed by this hospital, have indicated in writing that they will refuse to participate in any abortion.[17]

Along similar lines, a newspaper reported that a public hospital in Texas "can no longer perform abortions except in medical emergencies because a majority of its nursing staff is unwilling to assist with the procedure."[18] A spokesperson told a local newspaper, "We simply have insufficient nurses to allow the procedure, because most people have declined to be involved."[19] The feelings of nursing staff on the matter were perhaps best captured by McDermott and Char (1971, p. 621) in their study of how hospitals reacted to the 1970 legalization of elective abortion in Hawaii:

> The nurses at one hospital felt the place was becoming identified as a slaughterhouse, an abortion factory in which patients were wheeled in and out on an impersonal assembly line. Others were upset by the abortion techniques and procedures themselves—the suction apparatus used in the operating room in one hospital was labeled the "murder machine."
>
> Their personal lives had been affected. They were jokingly called "abortionists" by their friends, who wanted to talk to them about the mysterious goings-on inside the abortion mecca. The nurses themselves felt that they had replaced the illicit underground abortionists in other cities, and, like them, they were personally involved in the slicing and chopping up of "babies."

The opposition of nursing staff often ended up influencing hospital policies: in 1982, an antiabortion organization reported that a "staff rebellion" at a private hospital in California ended the practice of abortions past the first trimester.[20] A 1980 study of hospitals in Maryland found that the determining factor in whether a hospital offered abortions was how vocal the staff and physicians were about supporting or rejecting abortion provision. The study concluded that "it is the attitudes and feelings of these individual private physicians that ultimately determine the hospital's role in abortion-service provision" (Nathanson and Becker 1980, p. 26). And while freestanding clinics could hire employees whose values were aligned with the cause of abortion rights, hospital were generally larger, less flexible, and more diverse in their staff composition, which made the provision of abortion services more subject to internal contestation. Facing conflicting demands from both internal and external constituencies, eventually many hospitals discontinued the provision of abortion services entirely.

"Passing the Buck." Finally, we find that, even when hospitals continued to offer the service, many doctors who worked in hospitals that allowed the procedure—even "pro-choice" advocates—began to simply refer patients to clinics rather than perform abortions themselves. This was likely due in part to the stigma facing doctors who provided them, oftentimes from

their colleagues, as exemplified in the following quote from an obstetrician:

> On the obstetrical service of every hospital, no matter how large the staff, there seem to be two or three doctors who do more than half of the abortions. And the rest of the staff regards these doctors with esteem not markedly higher than that previously reserved to the back-street abortionists. (Halfmann 2011, p. 108)

This reference to "back-alley abortionists" was a common label that conferred stigma on those who performed abortions, even as the practice became legal. For example, a 1971 New York State Department of Community of Health survey of physicians reported that a majority of physicians (65%) opposed abortions taking place in physicians' offices. The resultant survey report stated, "No doubt the smell of the back-alley abortionist helped to contaminate the office as a site for abortion and this effect lingers even now when abortion is legal."[21] The report continued, arguing that there could be a potential pathway of destigmatization if physicians would agree to routinize the practice into the existing medical establishment, writing that it would "help reduce the old stigma by its very routine nature as an acceptable office practice."[22] However, this incorporation of the practice into doctors' offices stalled. As one physician reflected on this state of affairs, "You can suddenly make something legal, but not moral" (Halfmann 2011, p. 109).

We also find evidence, however, that "passing the buck" can be attributed in part to the fact that clinics began to exist as alternative organizational forms. In a 1975 letter to NARAL, a physician described why his small Arkansas-based hospital "outsourced" abortions to clinics:

> The only thing that stops us from doing abortions here is that we believe it is better for the patients to go elsewhere. There are excellent abortion facilities near us, at cheap rates and with utmost privacy. These folks are specialists in that area and handle it very well. In the case of our little hospital, it is not the administration that decided we wouldn't do them here, it was the doctors.[23]

Others described a similar process, stating, "So if there's an abortion procedure that needs to be done, I send them to Planned Parenthood. It's not worth my time and effort to jump through the hoops of the hospital to make that happen for an elective termination" (Freedman 2008, p. 105). We find evidence of institutionalized "buck-passing" that contributed to fewer abortions being provided in hospitals over time.

Overall, we find that although hospitals began to offer abortion after legalization, many of them eventually faced pressure from multiple constituencies that led them to discontinue the service. This pressure came in part from external stakeholders, such as government officials and community members, and from internal stakeholders, who refused to perform the service and chastised colleagues who engaged in it. Even in hospitals where abortion could still be carried out, the stigma facing doctors who performed the procedure and the existence of an alternative organizational option, in this case freestanding clinics, enabled "buck-passing" of the stigmatized practice from hospitals to clinics. And through generalist exit, the category of "abortion providers" evolved further, increasingly becoming comprised of specialists.

Involuntary Specialization

The final process that we observe in the evolution of the stigmatized category of abortion provision is *involuntary specialization*, a process which—we argue—unfolded through changes in practices as well as meaning. The first underlying process that furthered involuntary specialization was that stand-alone facilities found themselves the easy targets of increasingly violent and disruptive forms of protest that exacerbated the consequences of engaging in abortion provision. Stand-alone facilities faced both material and cognitive consequences of this increased targeting. From a material standpoint, they lost customers for many of their other services, as those who were not seeking an abortion preferred to visit medical providers that were not involved in abortion. From a cognitive standpoint, even clinics that attempted to keep a diversified service offering by retaining other services besides abortion provision were increasingly labeled simply as "abortion clinics" in public discourse. Each of these processes is described in the following.

Direct Targeting of Customers. Whereas hospitals (as organizations) had come under stakeholder pressure to exit abortion provision, it was nearly impossible to know why women were coming or going from a hospital, which offered a diverse array of services. Conversely, because of their small size and core identity, freestanding abortion providers became a prime target for the antiabortion movement, with activists targeting not only the facilities and the doctors affiliated with them but their customers as well. At the time that many clinics were founded, their owners acknowledged that stigma might lead to minor inconveniences, such as delayed permits or the occasional heckler, but they did not foresee the coming intensification of the antiabortion movement. For example, Maggi Cage was quoted as predicting that the early controversy over her clinic opening in 1977 (which was mainly related to licensing difficulties) would die down in about a year.[24] The son of a prominent abortion provider in Buffalo, New York, reflected on their facility's early years in the mid-1970s, stating:

> There were no protestors outside. No one warned my father that physicians who performed abortions would be isolated from their colleagues. Nobody so much as hinted

> that doing so might be dangerous for the doctor. (Press 2006, p. 28)

However, when the antiabortion movement radicalized in the early 1980s, freestanding facilities and their clients became visible and highly isolated targets. In 1980, the first recorded blockade at a clinic took place, the first bomb threat occurred, and a man set fire to a clinic in Cleveland, Ohio, resulting in patients, staff, and physicians fleeing the scene (Schoen 2015). Between January 1983 and March 1985, at least 319 acts of violence were committed against 238 clinics (Bader and Baird-Windle 2015). During this time, hundreds of thousands of antiabortion protestors blocked access to clinics. They carried signs with photographs of maimed fetuses on them, chained themselves together, blared chants such as "Abortion is Murder" through loudspeakers, harassed physicians at home, called clinics incessantly to block phone lines, called in bomb threats, and in some extreme cases carried out arson and kidnapped and murdered physicians (Press 2006, Wicklund 2007, Bader and Baird-Windle 2015).[25]

Through all of this, specialist organizations were targeted more than generalists, even during the same year. At the height of these attacks, in 1985, 36% of hospitals performing abortions reported that they had been subject to "pressure from outside the hospital to restrict or limit their abortion services," while 61% of nonhospital facilities reported antiabortion harassment that same year (Forrest and Henshaw 1987). Even hospitals that performed a large number of abortions were targeted less than stand-alone facilities—41% of hospitals providing 400 or more abortions in 1985 reported that they had been subject to this pressure, while that percentage more than doubled—to 88%—for nonhospital facilities providing 400 or more abortions in 1985 (Forrest and Henshaw 1987). This was also around the same time that hospitals were exiting the provision of abortion, leaving clinics even more vulnerable.

In 1985, among stand-alone facilities that reported that fewer than 10% of their patient visits were for abortions, 68% of them still reported harassment (Forrest and Henshaw 1987). Evidence from court cases and congressional hearings shows that antiabortion protestors treated every client visit to clinics as if they were there for an abortion. Testimony from the court case *National Organization for Women, Inc. v. Scheidler*, which was focused on these attacks, illustrates what was going on behind these statistics:

> In Milwaukee, Wisconsin, protestors repeatedly banged on the car of a patient as she entered a health clinic parking lot, and grabbed at her arms and legs as she attempted to enter the clinic. "They surrounded me and my car. Telling me I wasn't a Christian, a baby killer. That I'm going to go to hell for this. Shoving pamphlets in my hand. Trying to stop me from making my way to the door of the building." The patient was visiting the clinic to receive her pap smear results and to receive her contraceptive medication.[26]

In a 1992 congressional hearing on clinic blockades, another woman recounted how she and her young daughter were harassed and prevented from seeing her doctor for prenatal care because the doctor performed abortions:

> I had a regular scheduled appointment with Dr. Michael Roth to obtain prenatal care for my impending birth of my baby. . . . But there were protestors in the elevator following it up and they pushed the stop button of the elevator so it would not go up. I then had several protestors come up to me and tell me that I did not want to see Dr. Roth because he was a baby killer. I told the protestors in the lobby again that I was not here to have an abortion; I was seeking prenatal care. They told me to go see someone else and then proceeded to give me pamphlets on free prenatal care and propaganda pictures that were disgusting of botched-up abortions. . . . Then I turned around to leave, not having seen the doctor or keeping my appointment, and the protesters pushed all around me so I couldn't leave.[27]

Protestors targeted anyone coming or going from the clinics. *National Organization for Women, Inc. v. Scheidler* found that 28 categories of people were victimized through clinic attacks, including patients, staff, landlords, neighbors, laboratory couriers, drug company representatives, repair people, and bankers.[28]

Loss of Customers for Nonstigmatized Services. The result of this harassment was that patients who would have normally visited these facilities for other services, such as birth control, prenatal care, counseling or disease screenings, stopped visiting clinics because they were targeted for performing abortions. As one physician recounted, "You lose a certain amount of patients that don't want to put up with the hassle of walking through a picket line" (Joffe 1996, p. 166). Clinic owner Maggi Cage decried the effects of violence and attacks on her clinic (which at that point had included fire-bombing, bullets through the windows, and daily picketing). She said that despite these attacks, *abortion* patient visits had not dropped. However, she reported:

> Our other services have. People tend to forget we are a full-service gynecological clinic and offer all kinds of other things there—pap tests, vasectomy care and so forth. The numbers seeking those services have fallen off. Why should anyone come for a pap test and try to cross the picket lines when it can be done in other places with much less hassle?[29]

Even though clinics tried to offer a full range of reproductive health services and counseling, which would have in theory reduced the stigma of the organization through their dilution with non-stigmatized services, they were forced to involuntarily specialize in abortion because of the loss of clients for other services.

In addition to driving away clients, the antiabortion movement also cost clinics time and money, which limited their ability to offer other services. By 1985, the annual professional meetings of clinic owners focused almost exclusively on "comparing notes on security systems, hand-scrawled bomb threats, and raspy-voiced midnight telephone calls" (Gorney 1998, p. 394). In response to these pressures, clinic owners often had to change physical locations because of damage to property or landlords that would no longer rent to them. Even if clinics continued in their existing locations, they incurred additional costs of hiring private security guards and installing alarm and camera systems.[30] By the mid-1980s, 80% of clinics lost their property and liability insurance, and the insurance they could access was often 10 times more expensive—the financial burden forced some to eliminate extra programs (Schoen 2015, p. 180).

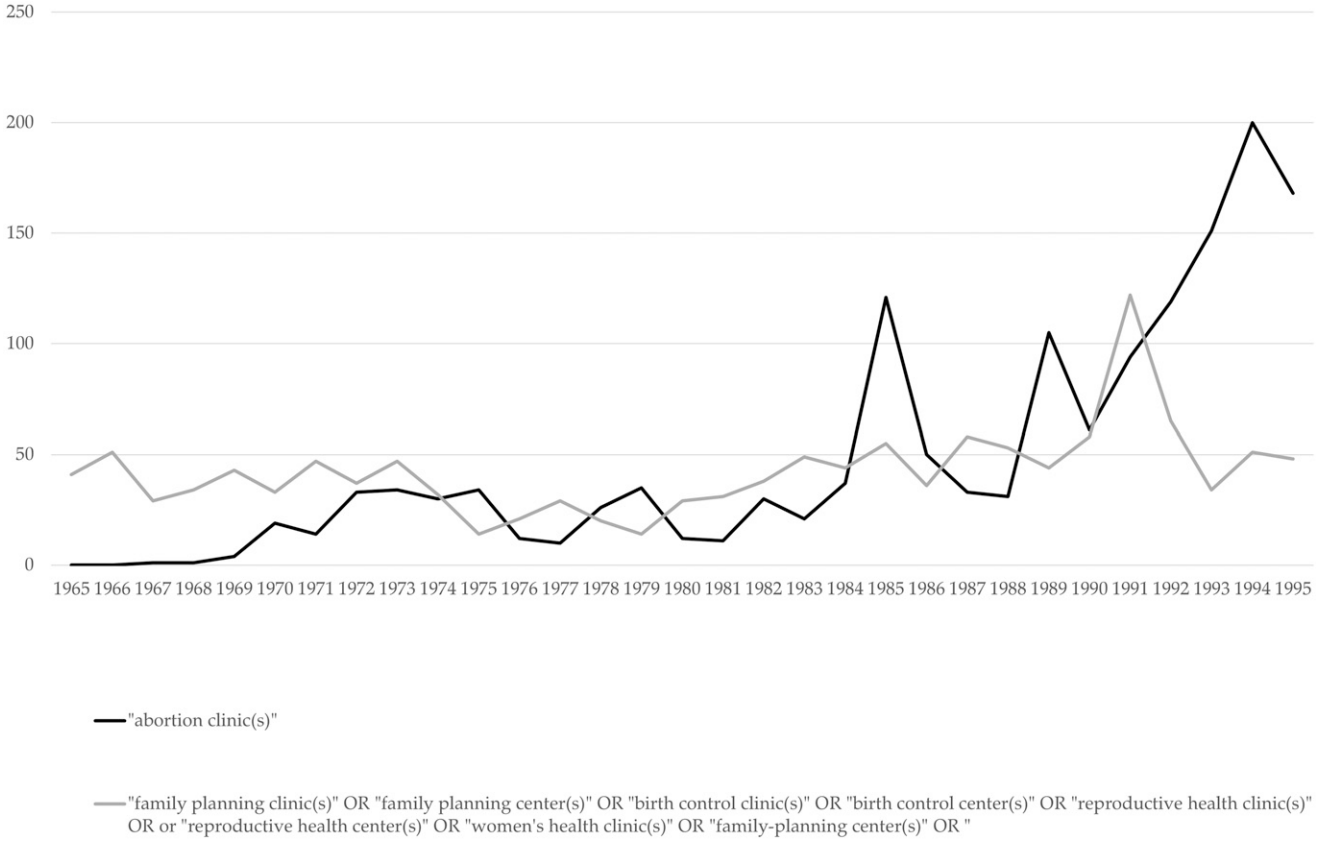
Over time, stand-alone facilities that had originated as multiservice women's health organizations were often left primarily performing abortions, despite their attempts to offer other services. By 1978, three-quarters of all abortions were performed in facilities that provided at least 1,000 abortions annually (Henshaw et al. 1981). The percentage of abortions performed at clinics where the *majority* of patient visits were for abortion services climbed from 56% in 1982 to 64% by 1988, and then to 70% by 1996.[31]

Blanket-Labeling of Category Members. Although a large part of the way that involuntary specialization unfolded was *material*, in that stand-alone facilities that offered abortions began to discontinue other services, we also find evidence that there was a *cognitive* change in the way that providers were increasingly labeled as "abortion clinics" over time. This reflects how the "mark of shame" of the stigmatized practice was applied over time to the non-hospital organizations that were engaging in the practice. When many clinics were founded, they aimed to offer a range of services, and they attempted to resist the label "abortion clinic," presenting their organizations instead as women's health clinics. Maggi Cage, the young feminist founder of the clinic in Wisconsin, first discussed her facility to the local press in the following way: "One of the points I would like to get across is that we will be a total reproductive care center, including prenatal care, pregnancy counseling, menopausal counseling, VD referrals and female sexual problems.[32] The Women's Community Health Center in Cambridge, Massachusetts, also emphasized that it provided a range of services, including self-help groups, gynecological exams, and pregnancy screening.[33] The PRETERM clinic in Washington, DC, described itself in a brochure in 1971 as a "non-profit, tax exempt medical, counseling, and educational facility."[34] However, we find evidence that the way that facilities such as these were labeled in public discourse changed in the decades following *Roe v. Wade*.

As shown in Figure 4, through our analysis of the origin and use of the term "abortion clinic" in the full historical archive of the *New York Times* from 1965 to 1995, we find that, early on, a range of commonly used terms for describing facilities that provided abortions—such as "family planning clinic(s)" or "women's health center(s)"—was utilized, but that over time the term "abortion clinic(s)" came to eclipse the use of these other terms.[35] In the decade following *Roe v. Wade*, the term "abortion clinic" was used at about the same rate as the other terms, but by 1985 it started to surpass the use of all the other terms (combined).

By examining the articles qualitatively during this transition, we see a clear shift not only in the number of articles using the term "abortion clinic," but also in how the term was being applied. When stand-alone facilities began to open that provided abortions, mentions of the term "abortion clinic" were used to refer to clinics that *exclusively* provided abortions; at first, the label was applied to those very few facilities that actually did specialize in the practice. However, in the early 1980s, the term "abortion clinic" began not only to be utilized to refer to abortion *specialists*, but it began to be used to refer to any facility that was being targeted by antiabortion activity. The label "abortion clinic" started to overtake the full range of alternate labels that acknowledged more diversified practice offerings when facilities began to come under visible attack for their engagement in the stigmatized practice. For example, in a 1984 article about the rise in violence against providers, the article oscillates between calling providers "abortion clinics" and "family-planning clinics"; using the terms somewhat interchangeably, it discusses, for example, "150 other incidents at family-planning clinics," but, in giving details on the incidents, refers to "blazes [that] ravaged three abortion clinics during one weekend in September" (Barron 1984, p. B15). In 1986, an article about an attack on a Detroit facility called "The Woman's Care Clinic" was titled "Michigan Police Disarm Bomb in Abortion Clinic" (*New York Times* 1986). The way that the label "abortion clinic" began to be applied during the mid-1980s indicates that the targeting of providers likely contributed to the wider

Figure 4. Frequency of the Term "Abortion Clinic(s)" vs. Other Labels for Abortion Providers in the *New York Times*



range of category members increasingly being blanket-labeled by their association with the stigmatized practice.

To understand this shift better, we examined articles about Planned Parenthood from the *New York Times* archive. We know that Planned Parenthood had largely worked to resist specialization in abortion provision, emphasizing that it was a full-spectrum family-planning organization that provided abortions alongside other services. In articles, we find that the organization emphasized its attempts at diversification, telling reporters that "of the 750 clinics operated by affiliates of Planned Parenthood, fewer than 50 perform abortions" (Pear 1987, p. 6). Because of this, we wanted to see how the label "abortion clinic" was applied in particular to Planned Parenthood's facilities over time, because even if they worked to resist practice specialization, if they were increasingly *labeled* as "abortion clinics," then the category of providers was evolving through discursive change as well.

Between 1965 and 1989, there were 177 articles published in the *New York Times* with "Planned Parenthood" either in the title or abstract. We coded these articles for the various ways that Planned Parenthood facilities were discussed and labeled over time. Again, we find that, early on, the term "abortion clinic" was used very sparingly, and predominantly to talk about abortion-only facilities. Until the mid-1980s, Planned Parenthood facilities were described as "birth-control clinics," "Planned Parenthood facilities," "family-planning clinics," "contraceptive clinics," or "reproductive health-care centers." In early articles, when Planned Parenthood was discussed as performing abortions, it was often clarified that this was only one of the services carried out by the organization. Between 1965 and 1984, the term "abortion clinic" only appeared six times, or in 4% of the articles about Planned Parenthood. Between 1985 and 1989, the term appeared in 29% of the articles about Planned Parenthood. Again, as with we found with the wider sample, around 1985 the term began to be utilized to refer to any Planned Parenthood facility that was under attack from antiabortionists.

Antiabortion activists certainly embraced this terminology and labeling. In 1985, one was quoted as saying, "We will continue our strong opposition to the abortion-on-demand philosophy which the proposed Planned Parenthood abortion clinic represents." In the same article, however, the term was not only used by protestors, but the journalist also used it to discuss violence against providers, writing, "Last year, according to law-enforcement officials, 24 abortion clinics were bombed or otherwise attacked" (Berger 1985). Another article, also published in 1985, focused on the case of two existing Planned Parenthood

clinics that provided other family planning services but had applied to also perform abortions at these facilities (Schmalz 1985). Despite acknowledging in the article that "the clinics have offered other medical services for some time," it also discussed the attacks and challenges on Planned Parenthood facilities as part of the wider attacks on "abortion clinics" and discussed how applications for "abortion clinics" are reviewed. Overall, we find that the process of blanket-labeling also played a role in category evolution, as even those providers who worked to resist practice specialization were increasingly labeled as if they were specialist providers of the stigmatized practice.

Examining Alternative Explanations

To increase confidence in our account of events, it is pertinent to consider and examine alternative explanations to gauge the robustness of the findings we have uncovered in our historical case analysis. We address what we believe are the main alternative explanations for our findings concerning the segregation of abortion provision into specialist clinics: (a) variations in stigma intensity surrounding the practice of abortion; (b) economic considerations concerning the pricing of abortion services; and (c) differential availability of trained providers for clinics and hospitals. We discuss each of these in turn.

Variations in Stigma Intensity. An obvious alternative explanation for our pattern of findings is that some of the dynamics underlying practice segregation, such as the exit of hospitals and the involuntary specialization of abortion providers, are actually due to the practice of abortion becoming more stigmatized over time. From this viewpoint, the increased stigmatization of abortion at a societal level could have accelerated the exit of hospitals from abortion services due to mounting societal pressure, leaving the most committed supporters of abortion—namely, values-driven clinic owners and operators—as virtually the only providers left. The available data on societal attitudes toward elective abortion in the historical period of interest, however, indicate that this is likely not the case. Opinion polling from Gallup—considered by many to be the "gold standard" pollster on socio-political issues in the United States—in fact suggests that, in the aggregate, attitudes toward abortion remained relatively unchanged, with only minor fluctuations, over the last four decades.[36] For example, in 1975, 54% of respondents nationwide indicated that abortion should be legal only under certain circumstances; this figure was virtually unchanged in 1995, with only minimal oscillations during the entire period. Similarly, the percentage of respondents indicating that abortion should be illegal in all circumstances—arguably the strongest stigmatizers at the societal level—was 21% in 1975 and dropped to around 15% by the mid-1990s.[37] Although these figures offer no evidence about state-level trends, which might arguably have been less homogeneous (as noted in Hudson 2008), they are nonetheless not suggestive of an uptick in abortion stigma.

Economic Factors and Pricing. A second alternative explanation that must be considered has to do with economic considerations surrounding the provision of abortion, especially as it pertains to pricing. Here, the main concern is that specialist facilities might have come to dominate abortion services primarily by undercutting hospitals on price, eventually resulting in the latter's decision to exit abortion provision. In her study of the availability and cost of abortion procedures, Lindheim (1979) reports that in 1976 the average charge for a first-trimester abortion at clinics was $165, while hospitals tended to charge between $195 and $280, depending on size and whether the hospital was public or private. Overall, this evidence suggests that obtaining an abortion at a clinic was cheaper and that price was probably a factor in explaining why many women chose clinics over hospitals.

At the same time, however, Lindheim (1979, pp. 288–289) also suggests that part of the reason that hospitals charged more was that they actively sought to limit the number of abortion procedures taking place there. In particular, although our analyses show that abortion was initially offered in a large number of hospitals, Lindheim (1979) notes that many hospitals might have been actively discouraging women from obtaining abortions from them by—among other things—charging higher prices, not offering outpatient services, artificially capping the number of abortions that they could provide, mandating long waits, and refusing to offer counseling and other supporting services. These measures have no apparent economic justification, thus suggesting that even before they received direct pressure from stakeholders, due to the stigma surrounding the practice, hospitals were likely attempting to balance their anticipated demands of external and internal stakeholders pertaining to abortion (which would later become an even more acute issue), while remaining nominally involved in abortion provision (albeit mostly ceremonially). These were, in other words, *strategic choices*. Viewed from this perspective, hospitals also had an incentive to maintain slightly higher prices, because doing so created a further barrier to access. Further evidence that high prices might have been part of a strategy to reduce abortion access is given by the fact that—as reported by Lindheim (1979)—a small number of hospitals chose to chart a path that was more similar to clinics in terms of auxiliary services and price. In other words, nothing about *hospitals as an organizational form*

prevented them from providing comprehensive abortion care mirroring that of clinics, at a competitive price, and, indeed, some hospitals opted to do so. Overall, our analysis suggests that, whereas price certainly played a role in abortion becoming concentrated in specialist organizations, it was far from being the only factor.

Availability of Trained Providers. A final matter of concern has to do with the availability of abortion training and whether hospitals' exit from abortion provision might have been a by-product of not being able to recruit obstetricians and gynecologists trained in the practice. In this regard, Joffe (1991, p. 51) notes that

> all obstetrical/gynecological residents, in theory, were given training in the completion of a 'spontaneous abortion' (miscarriage), which is similar, though not identical, to the commencing of an abortion procedure. Training in the latter, as well as training in the more technically challenging procedure of a later (second-trimester) abortion, was highly variable from program to program.

The fact that the vast majority of abortions fall into the category of earlier, more straightforward procedures, coupled with the fact that hospitals were already de facto performing the latter kind of abortions, which were more complex, suggests that the availability of properly trained physicians was likely not an issue for hospitals, at least initially. In fact, physician availability was likely more of an issue for clinics, as they had to either hire or contract with doctors with the appropriate training. However, with the exit of hospitals (and therefore teaching hospitals) from the practice, the issue of training was in a sense reversed, with clinics eventually developing an advantage as it pertains to abortion training—this happened much later in our period of study and was arguably more of a consequence of generalist exit than a precursor to it. Overall, for what pertains to our case, the availability of trained physicians is unlikely to have had any significant bearing on the segregation of abortion into clinics. On the other hand, if hospitals wanted to reenter abortion provision today, they would likely face challenges in doing so, because abortion training is increasingly less prevalent in U.S. mainstream medical education (Gordon 2015).

Theorizing Stigmatized Practice Segregation into Specialist Organizations

Since the findings in this study are based on a single qualitative analysis of a revelatory case, they are best suited for theory construction (Timmermans and Tavory 2007, Yin 2009); in this section, therefore, we develop a set of propositions to theorize from our findings. Following each one, we also briefly discuss the generalizability of our propositions, that is, how other stigmatized practices might have already progressed through, or could follow, each step in the process of segregation into specialist organizations over time. Our first proposition is based on the category entry dynamics that we observe in the abortion case.

Proposition 1. *Specialist organizations will be founded within a stigmatized category at a higher rate when the stigmatized practice enjoys movement support, as proponents from the movement will seek to engage in the practice in a values-aligned manner.*

This proposition is based on our finding that entry into abortion provision was frequently pursued by individuals who were connected through values and relationships that were developed within the movement that backed the legalization of abortion. Social movement actors have been found to be central to efforts to obtain greater marketplace representation for niche or controversial products through processes such as building cultural codes (Weber et al. 2008). We find that they can go one step further, becoming the very values-driven entrepreneurs who work to establish organizations where they can provide the product or service in an environment that offers dignity to their customers, especially if they are wary of the way generalists are offering the good or service. This finding resonates with Dioun (2017), who similarly found that an organized movement underpinned the foundings of marijuana dispensaries. Category entry, of course, also depends on standard factors such as barriers to entry (e.g., entry costs and regulations), but the presence of a movement backing the practice is an additional consideration that we find affects the process of entry of specialist organizations into a stigmatized category, thus becoming a key part of the overall process of stigmatized practice segregation.

In terms of the exit of generalists, we advance two propositions. The first is the following.

Proposition 2. *Generalist organizations within a stigmatized category will exit the category at a higher rate when they are targeted by stakeholder pressure.*

The exit of generalists from stigmatized categories based on stakeholder pressure echoes Hudson's (2008) argument, and we find empirical support for it in our case. We take this argument one step further in connecting it to how stakeholder pressure, and the ensuing exit of generalists, can shift the makeup of stigmatized categories toward specialists. This can be observed in other contexts, as well: for example, generalist retailers such as Wal-Mart and Dick's Sporting Goods have ceased selling assault-style guns and ammunition in the United States as a result of stakeholder pressure following mass shootings. In a similar fashion, tobacco products used to be commonly sold in

most American big-box stores, including pharmacies; however, major chains like Target and CVS eventually stopped selling tobacco, leaving small specialized retailers such as convenience stores and tobacconists as the main points of sale for cigarette products.[38] Beyond their generalizability to these and other contexts, our findings also highlight the importance of employees as a key stakeholder group, and we call for future studies to more explicitly look at the role of employees, who are sometimes termed "conscientious objectors," in organizations discontinuing the provision of stigmatized goods or services. We build on this baseline proposition with the following.

Proposition 3. *If a stigmatized practice has been established as a right, then the exit of generalist organizations from the associated category will be contingent on the presence of alternative providers.*

Here, we argue that if a stigmatized good, service, or practice has been established as a right (e.g., in the United States, this would include gay marriage, gun ownership, and, in some states, medical or recreational marijuana), generalists might be hesitant to exit the associated category, as in doing so they could be criticized for infringing upon individual rights. This is, however, less of a concern if there are other organizations within the category—whether specialists or generalists—who are willing and able to continue engaging in the practice. Under such conditions, we propose that there is a greater likelihood that generalists will make the decision to exit the category, thereby engaging in what we have termed "buck-passing."

We saw that, in the case of abortion, buck-passing was based in part on the idea that women had a right to obtain the service somewhere but also relied on the availability of alternatives, in our case specialists, who would provide the service. In the public debate in the United States, similar dynamics have arguably been at play in the case of other controversial practices that have been established as rights, such as same-sex marriage and, by extension, the business activities surrounding it. For example, a bakery's refusal to provide cakes for same-sex marriages was recently litigated in court, and some wedding photographers and in vitro fertilization clinics also refuse to cater to same-sex couples. Such disengagement is typically justified on the grounds that since plenty of businesses are willing to cater to same-sex couples, there is no *obligation* for any individual or organization to violate their moral tenets and do the same—a textbook example of buck-passing. Much in the same way, some pharmacies will not offer women the morning-after pill (Tanne 2005), some employers will refuse to cover contraception in the insurance plans that they offer, and some restaurants have been known to refuse service to owners of "assault-style" weapons (Lee 2014, Russell 2016).

Our final set of propositions are related to involuntary specialization, or when and why diversification in the pursuit of stigma dilution may not be achievable. The first proposition—of which we find significant evidence of in our case—is the following.

Proposition 4. *Organized opposition to a stigmatized practice will make stigma more salient, which in turn will exacerbate the consequences of stigma for the organizations within a stigmatized category.*

This proposition resonates with the arguments laid out by Hudson (2008, p. 258), who noted that the degree of stigma that an organization experiences "is also moderated, at least in part, by the number, size, and influence or power of the social audiences stigmatizing the organization." However, our case offers empirical evidence extending this argument in a more nuanced direction: as we have seen, public sentiment on the issue of abortion does not change substantially over our period of study, so this effect cannot be ascribed to variations in the degree of stigma. On the other hand, we find that the issue was brought to the forefront of the public debate (Hilgartner and Bosk 1988) through significant antiabortion movement activity beginning in the 1970s, thereby increasing the salience of abortion stigma. With this increased salience, the *consequences* of engaging in abortion provision become much more burdensome, especially for smaller specialist organizations. In this regard, our findings indicate, for example, that a much greater number of nonhospital facilities faced harassment as a result of abortion provision, relative to hospital facilities (Forrest and Henshaw 1987). Our final proposition is the following.

Proposition 5. *When the salience of stigma surrounding a practice increases, diversification into other, nonstigmatized practices will become more difficult for category members, as they become cognitively identified with the stigmatized practice to an increasing degree.*

Again, the basis of this idea was articulated by Hudson (2008, p. 259), who noted that "core-stigmatized organizations are also limited in their ability to operate in non-stigmatized domains because of the threat of transferring stigma from the core-stigmatized operations to new lines of business." The evidence in our case supports this argument, but, importantly, also uncovers the mechanisms underpinning *how* this process unfolds—specifically through both material and cognitive changes that lead to involuntary specialization. Although this dynamic is harder to observe "in the wild" without information on organizations' diversification strategies, we believe the generalizability of our argument extends to settings other than

abortion clinics. One may consider, for example, the debate surrounding the sale and availability of assault rifles in the United States, which is punctuated by the occurrence of mass shootings. Such traumatic events affect the saliency of stigma surrounding the sale of assault weapons, which might affect the diversification trajectory of gun stores. For example, as gun control activism flares up in the aftermath of a mass shooting, we might expect that gun stores would have trouble pursuing or maintaining diversification into both guns for hunting and military-style weapons, as potential customers of less controversial hunting guns may opt to go elsewhere, for example, to big-box retailers that have stopped selling military-style weapons. Indeed, there is some evidence that this may already be happening—for example, public leaders in Milwaukee urged "sportsmen and other law-abiding gun owners" to boycott a gun shop that was found to be skirting background checks – thereby dividing gun customers, and the stores they frequent, into "those interested in hunting" and those that are engaged in more nefarious activity (*Milwaukee Journal Sentinel* 2009).

Were the salience of the stigma surrounding assault-style weapons to grow further, therefore, gun stores might also experience involuntary specialization like what we observe in the case of abortion providers. We would also speculate that, under such conditions, organizations involved in stigmatized practices might be cognitively and collectively labeled simply based on this fact, with sporting retailers being labeled "gun stores," adult merchandise retailers "sex shops," and providers of smoking paraphernalia "head shops"; in turn, this labeling would compound the challenges of involuntary specialization.

Discussion

In this paper, we have conducted a historical case study of the evolution of the abortion provision category in the United States in order to contribute to the scholarly understanding of the prevalence and endurance of specialist organizations within stigmatized categories, given the inherent difficulties such organizations face. From our case, we identify how this process can occur and what the consequences are for stigmatized practices—namely, segregation into specialist organizations. Furthermore, we have advanced a number of propositions regarding how the mechanisms that we identify regarding category evolution toward specialization in our case might be best generalized to other settings. In the following, we outline the contributions of this work to the literature on stigma and its management, as well as the evolution of stigmatized categories over time, and we elaborate on the boundary conditions of our findings.

Specialists vs. Generalists in Stigmatized Categories

A primary contribution of our work is that of elucidating how specialist and generalist organizations might come to engage in, or disengage from, stigmatized practices. Whereas much work has focused on how stigma operates and is managed at the organizational level, we advance theorizing of how stigma affects the category-level organization of a practice and, by extension, the population-level dynamics of the organizations engaging in the practice. In this regard, ever since the work of Freeman and Hannan (1983) within organizational ecology, scholars have acknowledged that very different types of organizations engage in the provision of similar goods and services—organizations "large and small, generalist and specialist" (Carroll, 1985a, p. 1263). This body of literature has also elucidated under what conditions generalists (vis-à-vis specialists) are likely to thrive, based on factors such as the structure of the market, the configuration of the resource space, the presence of economies of scale or scope (Van Witteloostuijn and Boone 2006), as well as perceptions of identity and authenticity (Carroll and Swaminathan 2000, Swaminathan 2001). This work, however, has largely examined uncontroversial industries, such as newspapers and breweries. As a result, this literature offers limited insight regarding whether similar arguments concerning the relative advantages of generalist vis-à-vis specialist organizations might be applicable to stigmatized settings as well.

In this regard, in our setting we find that the stigmatized category of abortion provision came to be dominated by specialist organizations, that is, freestanding clinics that specialized in the procedure, over time. To the best of our knowledge, this is not due to freestanding clinics enjoying cost advantages. Indeed, if hospitals had made the strategic decision to offer elective abortion services, then hospitals might have enjoyed a cost advantage in the form of economies of scale and scope, inasmuch as simply adding elective abortion to the range of obstetric and gynecological services offered would have allowed hospitals to provide abortions in a fairly cost-effective manner by leveraging existing facilities and personnel. This stands in stark contrast with the substantial financial hurdles inherent to founding a new clinic. Yet, this cost advantage either never materialized or was never exploited: our findings highlight that most hospitals never made a real attempt to compete with specialists in the provision of abortions as a result of opposition from internal and external stakeholders, and, when they did, they continued to charge high prices while erecting barriers to the provision of the service. Eventually, at the same time that more and more clinics were founded, hospitals began to exit the practice.

Here, it is worth noting that existing work in organizational ecology has highlighted circumstances under which specialists might hold an advantage over generalists. In the case of the microbrewery movement, for example, Carroll and Swaminathan (2000) found that the success of microbreweries vis-à-vis large beer conglomerates could be ascribed to identity and authenticity mechanisms, as consumers held differentiated preferences for craft-like products. In our setting, clinic founders often did go out of their way to ensure that abortion services would be delivered in a values-aligned manner, as hospital providers were often perceived as indifferent to the plight of pregnant women. However, specialist clinics were hardly at an advantage when it came to clients, especially as stigma became more salient and its consequences intensified, inasmuch as the frequent picketing and the disruption created by antiabortion protestors often made women feel unsafe entering clinics. In fact, some pro-choice activists eventually advocated for a greater involvement of hospitals, showing that later proponents did not see clinics as a superior option (Caplan-Bricker 2015).

Overall, our case highlights how, in stigmatized settings, generalist-specialist dynamics are likely to play out in previously unexplored ways relative to the "unproblematic" contexts heretofore examined by population ecologists. Generalists, in particular, must weigh the upsides of practice engagement—financial or otherwise—with pressures from internal (McDermott and Char 1971) and external stakeholders toward disengagement (Piazza and Perretti 2015). Specialist organizations, on the other hand, are typically values-aligned—and thus more prone to resist this pressure—but when there is organized opposition to the practice these providers tend to face much harsher consequences as a result of stigma than generalist organizations do, as well as more challenges in managing or diluting stigma. We can also theorize that these factors might ultimately affect the failure rate of specialists. In fact, within the category of abortion provision after our period of study, this pressure, which has furthermore resulted in targeted regulation, has most likely contributed to abortion clinics going out of business at a record pace in the past decade (Deprez 2016, Joffe 2018). In any event, we believe further elucidating the category-level dynamics and the degree to which these categories comprise specialist versus generalist organizations in stigmatized vis-à-vis nonstigmatized populations to be a fruitful area for future research, and one that we hope scholars will consider tackling.

Stigma Management Strategies

A second contribution of our paper concerns the relative effectiveness of strategies for the management of stigma. Whereas recent accounts have underscored how organizations can reduce stakeholder disapproval by engaging in stigmatized and nonstigmatized practices simultaneously—a process that Vergne (2012) labeled "stigma dilution"—our findings concerning involuntary specialization suggest that this is not always possible. As the salience of a stigmatized practice increases, in particular, the consequences of stigma might make diversification into other areas impossible (Hudson 2008), as evidenced by the way in which freestanding facilities offering abortion became—both materially and in the eyes of audiences—simply "abortion clinics" over time. Our findings also have implications for other stigma management strategies that have been discussed in the literature—notably, boundary management and concealment processes (Hudson and Okhuysen 2009, Wolfe and Blithe 2015). In the presence of substantial stakeholder opposition or outright disruptive mobilization, in fact, maintaining a low profile might simply not be an option. In this regard, our findings have substantial implications for organizations seeking to operate in stigmatized markets (Shantz et al. 2019), because when disapproval is ubiquitous and the organizations' activities are openly contested, the options available to mitigate the fallout of stigma might be limited, even if organizations choose to avoid overt confrontation by pursuing a "stealth strategy."

Furthermore, our findings also point to the fact that the effectiveness of diversification as a stigma dilution strategy might not be universal. Whereas many clinics did in fact try to pursue diversification, in fact, they typically did so only in a limited manner, seeking to provide other services related to sexual and reproductive health such as PAP smears, birth control, and STD testing—services that are not without their own issues of stigma. Hospitals, by contrast, are characterized by less closely related forms of diversification, since only a small fraction of the services they provide have to do with sexual or reproductive health. When the antiabortion movement intensified, hospitals that performed abortions were less likely to face attacks and harassment than clinics performing a similar number of abortions. This shows that hospitals may have been more effective at diluting the stigma surrounding abortion provision. However, whereas our findings speak somewhat to this association, additional work is necessary to fully unpack how attempts at diversifying into offerings that are more or less related to the stigmatized offering might affect efforts at stigma dilution; this work would have important implications for scholarship on attempts at managing stigma.

Overall, although our study is not focused on organization-level strategies, we believe that our findings on involuntary specialization have implications for stigma management strategies, and, therefore, we hope

that they can contribute to sparking further research exploring the differential applicability and effectiveness of these strategies, with a view to understanding which strategies might be available to different types of stigmatized organizations in different contexts.

Boundary Conditions and Theoretical Extensions

A final point of discussion concerns the boundary conditions and applicability of our findings, as well as the opportunities that they open up in terms of future research. A good starting point here is perhaps given by the empirical observation that whereas stigmatized practices often end up taking place within specialist organizations, this does not always happen. Earlier in the paper, we noted that certain stigmatized practices—such as the sale of liquor and adult merchandise—initially took place in specialist organizations but were eventually taken up by generalist organizations, such as supermarkets and big-box retailers. This raises the question of what the boundary conditions of our arguments might be—that is, under what conditions would we expect to find stigmatized practices organized into specialist, vis-à-vis generalist, organizations. Whereas we provide an account of how this unfolded in the case of abortion provision, this issue is a difficult one to address empirically because the extent to which a certain practice is stigmatized varies over time, which can affect the organization of the practice at the category level. For example, the fact that the sale of alcohol and pornography was eventually taken up by generalist retailers might be ascribed—at least in part—to the fact that the sale and consumption of such goods is now much less stigmatized than it used to be at the societal level. Similarly, stigmatized practices becoming concentrated into specialist organizations might be reflective of a societal increase in the extent of stigma.

In this regard, our empirical setting offers two distinct advantages from an analytical standpoint. First, the extent of stigma surrounding abortion remained substantially stable throughout our observation window, which allowed us to observe category evolution without the confounding effects of changes in the intensity of stigma. Second, the fact that in most Western countries, other than the United States, abortion has largely been carried out in hospitals ever since it was legalized points to the fact that we cannot attribute segregation, in our case, to a feature of the *practice* itself—as we have many examples where the same practice was offered by generalist organizations, this lends credence to the idea that the practice could have been organized differently and, therefore, that the process we identify has explanatory power. As far as boundary conditions are concerned, the propositions that we formalized in the previous section point to the most likely conditions for our findings being (a) the presence of movement actors who support the wider establishment of the practice; (b) the extent of internal and external stakeholder pressure on generalists; and (c) the strength of organized opposition to the stigmatized practice. When these conditions do not materialize, one might expect generalists and specialists to coexist, and generalists might eventually come to dominate the category either as a result of the effectiveness of stigma dilution or of economies of scale, where these exist. In European countries such as France, Germany, and Italy, for example, relatively more lax attitudes toward abortion meant that hospitals were not under as much pressure to limit the provision of the practice (although, there is some evidence of employees exercising their "right" to not engage in the practice within generalist organization—through conscientious objection—which shows some of the same mechanisms at play).

A related question that is arguably just as interesting, and which we advocate should be pursued in future work, is the question of whether the involvement of generalist organizations in stigmatized practices leads to "normalizing" the practice, thereby contributing to its destigmatization (e.g., Siltaoja et al. 2020) over time. This is fundamentally equivalent to asking whether stigma dilution at the organizational level (Vergne 2012)—aimed at reducing stakeholder disapproval aimed at the focal organization—ultimately reduces disapproval aimed at the practice tout court. In the case of abortion, our informants appeared convinced that getting hospitals involved in abortion provision again would help reduce abortion stigma, and, across empirical settings, many proponents of stigmatized practices—such as the sale of contraceptives (e.g., Enright and Cloatre 2018)—similarly believe that situating such practices within generalist organizations is bound to normalize these practices and reduce the extent of societal disapproval directed at them. We have some evidence that shows that this might be the case, as in Western Europe, where elective abortion has been predominantly organized in generalist hospitals for decades (Outshoorn 1997), societal attitudes toward abortion have grown increasingly relaxed, although this could have been the result of a number of other distinct socio-cultural trends. And unfortunately, we are unable to draw firm conclusions on this point from the case of abortion provision in the United States, as we lack a suitable counterfactual—a rigorous test of this hypothesis would in fact require, at a minimum, for abortion to have predominantly taken place in hospitals in at least some locales in the United States consistently over time. Nonetheless, the fact that in the United States abortion has come to take place mostly in clinics does not appear to have amplified the extent of stigma—societal attitudes toward abortion have been virtually unchanged over the past four decades, at least at the

national level. Ultimately, due to the inherent endogeneity at play, answering this question in a definitive manner might require the use of an experimental research design (e.g., Negro et al. 2019); nonetheless, we hope that scholars will choose to take up this challenge in further research.

Conclusion

In conclusion, our analysis of the historical case of the evolution of the abortion provision category in the United States contributes to the scholarly understanding of category-level dynamics under conditions of stigma, in particular by illuminating how stigmatized categories can come to be populated predominantly by specialists and, in turn, how this can result in the segregation of stigmatized practices within specialist organizations. The processes that we have uncovered in this study, namely, values-aligned entry, the exit of generalist organizations from abortion provision based on stakeholder pressure, and, finally, the involuntary specialization of clinics, provide insight into the category-level organization of stigmatized practices over time. Our case not only expands existing thinking, but we hope that it will also encourage further work on revelatory cases that can contribute to a more nuanced understanding of the processes of stigmatized category evolution.

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Endnotes

[1] Examples of stigmatized categories include, for example, electric utilities involved in nuclear power generation (Piazza and Perretti 2015) and companies doing business with the Burmese military junta (Soule et al. 2014).

[2] The most recent statistics available, published in *Family Planning Perspectives* in 2000, refer to abortion procedures carried out in 1996, however, so we have no information on procedures carried out after 1997.

[3] In a search for the term "abortion clinic" in the Archive Grid database, the Arthur and Elizabeth Schlesinger Library on the History of Women in America at Harvard University and the Wisconsin Historical Society Library are listed as holding the highest number of relevant materials.

[4] Maggi Cage Papers, Wisconsin Historical Society Library, Court Papers, Box 1.

[5] Ibid. Carton 3: Press clippings.

[6] "Roots Underlying the Abortion Controversy: The Abortion Debate in the Light of Women's Liberation and Population Control," July 1971, Wisconsin Historical Society Library.

[7] "Seattle Abortion Project Proposal—Women's Liberation," September 1971, Wisconsin Historical Society Library.

[8] Women's Community Health Center Annual Report, 1975, Women's Community Health Center Archive, Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University.

[9] Ibid.

[10] Ibid.

[11] WHCH Organizational Analysis, 1975, Women's Community Health Center Archive, Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University.

[12] "The New York Abortion Story," Planned Parenthood, 1972, Women's National Abortion Action Coalition Records, 1969–1973, Wisconsin Historical Society Library.

[13] Abortion Facility Inventory, State of New York Department of Health, 1973, Women's National Abortion Action Coalition Records, 1969–1973, Wisconsin Historical Society Library.

[14] Religious Coalition for Abortion Rights Options Newsletter, February 1977, Women's National Abortion Action Coalition Records (WONAAC) 1969–1973, Wisconsin Historical Society Library.

[15] Ibid.

[16] "Illinois Hospital Stops Performing Abortions," *National Right to Life News*, March 13, 1986, Religious Coalition for Reproductive Choice Records, 1968 –2009, Wisconsin Historical Society Library.

[17] Records of the National Abortion Rights Action League, 1968–1976, Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University, 1975.

[18] Lee Hancock, "Fort Worth Hospital Halting Elective Abortions," *The News*, 1988, the Religious Coalition for Reproductive Choice Records, 1968–2009, the Wisconsin Historical Society Library.

[19] Ibid.

[20] "Staff Rebellion Forces Change in Late-Term Abortion Policy at California Hospital," *National Right to Life News*, September 30, 1982, Religious Coalition for Reproductive Choice Records, 1968–2009, Wisconsin Historical Society Library.

[21] "Performing Abortions in New York: A Physician Survey," Department of Community Health, 1971, Women's National Abortion Action Coalition Records, 1969–1973, Wisconsin Historical Society Library.

[22] Ibid.

[23] Records of the National Abortion Rights Action League, 1968–1976, Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University, 1975.

[24] "Area Abortion Clinic to Open in 3 Weeks," *The Post-Crescent*, September 22, 1977, Maggi Cage Papers, Wisconsin Historical Society Library.

[25] "Denying the Right to Choose: How to Cope with Violence and Disruption at Abortion Clinics (First Draft)," Records of the National Abortion Rights Action League, 1968–1976, Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University; "Fighting Back: Manual for Clinics (Draft)," Records of the National Abortion Rights Action League, 1968–1976, Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University; "In Defense of Freedom, A Summary of the National Abortion Federation Workshops, September 19, 1984," Maggi Cage Papers, Wisconsin Historical Society Library.

[26] *National Organization for Women, Inc. v. Scheidler*, 1992.

[27] "Clinic Blockades," Hearing Before the Subcommittee on Crime and Criminal Justice of the Committee on the Judiciary, U.S. House of Representatives, 102nd Congress, Second Session, May 6, 1992.

[28] *National Organization for Women, Inc. v. Scheidler*, 1992.

[29] "Clinic Director Tells of Violence," *Fox Cities: The Post-Crescent*, September 26, 1984, Maggi Cage Papers, the Wisconsin Historical Society Library.

[30] "Open by Choice: 99 Ways to Keep an Abortion Clinic Open in the Face of Harassment and Terrorism," National Organization of Women (NOW), Maggi Cage Papers, Wisconsin Historical Society Library.

[31] "Abortion in the United States," *Family Planning Perspectives*, 1976, 1977, 1978, 1979, 1981, 1982, 1984, 1985, 1987, 1988, 1991, 1995, and 1996.

[32] "Area Abortion Clinic to Open in 3 Weeks," *Fox Cities: The Post-Crescent*, September 22, 1977, Maggi Cage Papers, Wisconsin Historical Society Library.

[33] Women's Community Health Center 1975 First Annual Report, Women's Community Health Center Archive, Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University.

[34] PRETERM Brochure, Religious Coalition for Abortion Rights, Wisconsin Historical Society Library.

[35] The full list of terms that we used for comparison includes "family planning clinic(s)" OR "family planning center(s)" OR "birth control clinic(s)" OR "birth control center(s)" OR "reproductive health clinic(s)" OR "reproductive health center(s)" OR "women's health clinic(s)" OR "family-planning center(s)" OR "family-planning clinic(s)" OR "family planning services" OR "planned parenthood clinic(s)" OR "planned parenthood facility" OR "planned parenthood facilities."

[36] For a graphical depiction of levels of opposition to, and support for, abortion over time, see https://content.gallup.com/origin/gallupinc/GallupSpaces/Production/Cms/POLL/48ch2gccluqsapk432rnfw.png.

[37] Relatively less information is available about the pre-*Roe* period, except for a lone study by Sauer (1974, p. 64), which reports that "a 1969 Gallup poll revealed that 40 per cent of the adult public supported the legalization of abortion in pregnancies of twelve weeks' duration or less, and in 1972, 46 per cent approved of making any abortion legal under the same condition."

[38] Although convenience stores might be viewed as small generalist providers, in actuality, cigarette and tobacco products represent the largest product category in terms of their in-store merchandise sales (see https://www.statista.com/statistics/308783/us-convenience-stores-in-store-merchandise-sales-by-category/). Interestingly enough, this latter trend was exacerbated in part by regulatory efforts by cities and municipalities to restrict the sale of tobacco products that favored concentration in specialized stores: New York City, for example, limited the sale of flavored tobacco to tobacco bars, and several municipalities (such as Oakland, Denver, and Philadelphia) mandated that flavored tobacco be sold only in stores that get at least 60% of their gross revenue each year from tobacco sales.

References

Aldrich H, Fiol CM (1994) Fools rush in? The institutional context of industry creation. *Acad. Management Rev.* 19(4):645–670.

Argyres NS, De Massis A, Foss NJ, Frattini F, Jones G, Silverman BS (2020) History-informed strategy research: The promise of history and historical research methods in advancing strategy scholarship. *Strategic Management J.* 41(3): 343–368.

Bader EJ, Baird-Windle P (2015) *Targets of Hatred: Anti-Abortion Terrorism* (Macmillan, New York).

Barron J (1984) Violence increases against abortion clinics in '84. *New York Times* (November 5), B15.

Beneish MD, Jansen IP, Lewis MF, Stuart NV (2008) Diversification to mitigate expropriation in the tobacco industry. *J. Financial Econom.* 89(1):136–157.

Berger J (1985) Catholic bishop sues on abortions: Wins temporary court ban in Albany. *New York Times* (January 13), 1.

Carroll GR (1985a) Concentration and specialization: Dynamics of niche width in populations of organizations. *Amer. J. Sociol.* 90(6):1262–1283.

Carroll M (1985b) State permits closing of bathhouses to cut AIDS. *New York Times* (October 26), 1.

Carroll GR, Swaminathan A (2000) Why the microbrewery movement? Organizational dynamics of resource partitioning in the U.S. brewing industry. *Amer. J. Sociol.* 106(3):715–762.

Caplan-Bricker N (2015) Why are abortions performed in clinics? *Slate* (November 16), https://slate.com/human-interest/2015/11/why-are-abortions-performed-in-clinics-not-hospitals.html.

Cattani G, Dunbar RLM, Shapira Z (2013) Value creation and knowledge loss: The case of Cremonese stringed instruments. *Organ. Sci.* 24(3):813–830.

Cattani G, Dunbar RLM, Shapira Z (2017) How commitment to craftsmanship leads to unique value: Steinway & Sons' differentiation strategy. *Strategy Sci.* 2(1):13–38.

Davis LW (2012) Prospects for nuclear power. *J. Econom. Perspect.* 26(1):49–66.

Deprez EE (2016) Abortion clinics are closing at a record pace. *Bloomberg News* (February 24), https://www.bloomberg.com/news/articles/2016-02-24/abortion-clinics-are-closing-at-a-record-pace.

Devers CE, Dewett T, Mishina Y, Belsito CA (2009) A General Theory of Organizational Stigma. *Organ. Sci.* 20(1):154–171.

DiMaggio PJ, Powell WW (1983) The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *Amer. Sociol. Rev.* 48(2):147–160.

Dioun C (2017) Making the medical marijuana market. Beckert J, Dewey M, eds. *The Architecture of Illegal Markets* (Oxford University Press, Oxford, UK), 159–176.

Dioun C (2018) Negotiating moral boundaries: Social movements and the strategic (re)definition of the medical in cannabis markets. Briscoe F, King BG, Leitzinger J, eds. *Social Movements, Stakeholders and Non-Market Strategy* (Emerald, Bingley, UK), 53–82.

Durand R, Vergne J-P (2015) Asset divestment as a response to media attacks in stigmatized industries. *Strategic Management J.* 36(8): 1205–1223.

Elsbach KD, Sutton RI (1992) Acquiring organizational legitimacy through illegitimate actions: A marriage of institutional and impression management theories. *Acad. Management J.* 35(4): 699–738.

Enright M, Cloatre E (2018) Transformative illegality: How condoms 'became legal' in Ireland, 1991–1993. *Feminist Legal Stud.* 26(3): 261–284.

Forrest JD, Henshaw SK (1987) The harassment of U.S. abortion providers. *Family Planning Perspect.* 19(1):9–13.

Freedman L (2008) *Willing and Unable: Doctors' Constraints in Abortion Care* (Vanderbilt University Press, Nashville, TN).

Freedman L, Landy U, Darney P, Steinauer J (2010) Obstacles to the integration of abortion into obstetrics and gynecology practice. *Perspect. Sexual Reproductive Health* 42(3):146–151.

Freeman J, Hannan MT (1983) Niche width and the dynamics of organizational populations. *Amer. J. Sociol.* 88(6):1116–1145.

Ginsburg FD (1989) *Contested Lives: The Abortion Debate in an American Community* (University of California Press, Berkeley, CA).

Goffman I (1963) *Stigma: Notes on the Management of Spoiled Identity* (Prentice-Hall, New York).

Gordon M (2015) The scarcity of abortion training in America's medical schools. *The Atlantic* (June 9), https://www.theatlantic.com/health/archive/2015/06/learning-abortion-in-medical-school/395075/.

Gorney C (1998) *Articles of Faith: A Frontline History of the Abortion Wars* (Simon & Schuster, New York).

Guttmacher AF, Pilpel HF (1970) Abortion and the unwanted child. *Family Planning Perspect.* 2(2):16–24.

Halfmann D (2011) *Doctors and Demonstrators: How Political Institutions Shape Abortion Law in the United States, Britain and Canada* (University of Chicago Press, Chicago).

Hampel CE, Tracey P (2017) How organizations move from stigma to legitimacy: The case of Cook's Travel Agency in Victorian Britain. *Acad. Management J.* 60(6):2175–2207.

Hampel C, Tracey P (2018) Introducing a spectrum of moral evaluation: Integrating organizational stigmatization and moral legitimacy. *J. Management Inquiry* 28(1):11–15.

Hargadon AB, Douglas Y (2001) When innovations meet institutions: Edison and the design of the electric light. *Admin. Sci. Quart.* 46(3):476–501.

Helms WS, Patterson KDW (2014) Eliciting acceptance for "illicit" organizations: The positive implications of stigma for MMA organizations. *Acad. Management J.* 57(5):1453–1484.

Henshaw S, Forrest JD, Sullivan E, Tietze C (1981) Abortion in the United States, 1978–1979. *Family Planning Perspect.* 13(1):6–18.

Hiatt SR, Carlos WC, Sine WD (2018) *Manu militari*: The institutional contingencies of stakeholder relationships on entrepreneurial performance. *Organ. Sci.* 29(4):633–652.

Hilgartner S, Bosk CL (1988) The rise and fall of social problems: A public arenas model. *Amer. J. Sociol.* 94(1):53–78.

Hsu G, Grodal S (2020) The Double-Edged Sword of Oppositional Category Positioning: A Study of the U.S. E-cigarette Category, 2007–2017. *Adm. Sci. Q.*, ePub ahead of print April 22, https://doi.org/10.1177/0001839220914855.

Hsu G, Kocak O, Kovács B (2018) Co-opt or co-exist? A study of medical cannabis dispensaries' identity-based responses to recreational-use legalization in Colorado and Washington. *Organ. Sci.* 29(1):172–190.

Hudson BA (2008) Against all odds: A consideration of core-stigmatized organizations. *Acad. Management Rev.* 33(1):252–266.

Hudson BA, Okhuysen GA (2009) Not with a ten-foot pole: Core stigma, stigma transfer, and improbable persistence of men's bathhouses. *Organ. Sci.* 20(1):134–153.

Ingram P, Rao H, Silverman BS (2012) History in strategy research: What, why and how? *Adv. Strategic Management* 29(1):241–273.

Jensen M (2006) Should we stay or should we go? Accountability, status anxiety, and client defections. *Admin. Sci. Quart.* 51(1): 97–128.

Joffe C (1991) Portraits of three "physicians of conscience": Abortion before legalization in the United States. *J. Hist. Sexuality* 2(1): 46–67.

Joffe C (1996) *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade* (Beacon Press, Boston).

Joffe C (2018) The struggle to save abortion care. *Contexts* 17(3):22–27.

Jonsson S, Greve HR, Fujiwara-Greve T (2009) Undeserved loss: The spread of legitimacy loss to innocent organizations in response to reported corporate deviance. *Admin. Sci. Quart.* 54(2):195–228.

Kieser A (1994) Why organization theory needs historical analyses–and how this should be performed. *Organ. Sci.* 5(4):608–620.

Lader L (1973) *Abortion II: Making the Revolution* (Beacon Press, Boston).

Lashley K, Pollock TG (2020) Waiting to inhale: Reducing stigma in the medical cannabis industry. *Admin. Sci. Quart.* 65(2): 434–482.

Leblebici H (2014) History and organization theory: Potential for a transdisciplinary convergence. Bucheli M, Wadhwani RD, eds. *Organizations in Time: History, Theory, Methods* (Oxford University Press, Oxford, UK), 56–99.

Lee J (2014) It's not just Hobby Lobby: These 71 companies don't want to cover your birth control either. *Mother Jones* (April 2), https://www.motherjones.com/politics/2014/04/hobby-lobby-sebelius-contraceptive-for-profit-lawsuits/.

Lindheim BL (1979) Services, policies and costs in U.S. abortion facilities. *Family Planning Perspect.* 11(5):283–289.

MacMillan A (2017) Emergency contraception is supposed to be available on drugstore shelves—but it may not be as easy to find as you think. *Health* (September 25), https://www.health.com/condition/birth-control/morning-after-pill-pharmacy-availability.

McDermott JF, Char WF (1971) Abortion repeal in Hawaii: An unexpected crisis in patient care. *Amer. J. Orthopsychiatry* 41(4): 620–626.

Milwaukee Journal Sentinel (2009) Time to act: Felons should be banned from gun stores. But until a law is passed to do that, law-abiding gun owners should boycott shops such as Badger Guns (September 28), https://archive.jsonline.com/news/opinion/62443232.html/.

Mohr JC (1978) *Abortion in America: The origins and evolution of national policy, 1800–1900* (Oxford University Press, Oxford, UK).

Myer R (2000) UMC lost abortion procedure because of UA football stadium. *Wildcat Online News* (April 3), https://wc.arizona.edu/papers/93/127/01_3_m.html.

Nathanson CA, Becker MH (1980) Obstetricians' attitudes and hospital abortion services. *Family Planning Perspect.* 12(1):26–32.

Negro G, Koçak O, Hsu G (2010) Research on categories in the sociology of organizations. Hsu G, Negro G, Koçak O, eds. *Categories in Markets: Origins and Evolution* (Emerald, Bingley, UK), 3–35.

Negro G, Williams MJ, Pontikes EG (2019) Destigmatization and its imbalanced effects in labor markets. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3672008.

New York Times (1986) Michigan police disarm bomb in abortion clinic (December 5), A16.

Outshoorn J (1997) The stability of compromise: Abortion politics in Western Europe. Githens M, Stetson DM, eds. *Abortion Politics: Public Policy in Cross-Cultural Perspective* (Routledge, New York), 145–164.

Pear R (1987) U.S. aide to fight dismissal in abortion policy dispute. *New York Times* (July 4), 6.

Pfeffer J, Salancik G (1978) *The External Control of Organizations: A Resource Dependence Perspective* (Business Books, Stanford, CA).

Piazza A, Perretti F (2015) Categorical stigma and firm disengagement: Nuclear power generation in the United States, 1970–2000. *Organ. Sci.* 26(3):724–742.

Press E (2006) *Absolute Convictions: My Father, a City, and the Conflict That Divided America*. (Henry Holt, New York).

Pyatt RAJ, Horwitz S (1985) Tobacco firms step up efforts to diversify. *Washington Post* (October 6), https://www.washingtonpost.com/archive/business/1985/10/06/tobacco-firms-step-up-efforts-to-diversify/69d6348f-15f7-4e5f-ac64-c74175730682/.

Reagan LJ (1997) *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867–1973* (University of California Press, Berkeley, CA).

Reynolds J (1970) Delivering family planning services: Autonomous vs. integrated clinics. *Family Planning Perspect.* 2(1):15–22.

Rhee M, Haunschild PR (2006) The liability of good reputation: A study of product recalls in the U.S. automobile industry. *Organ. Sci.* 17(1):101–117.

Russell E (2016) Maine restaurant owner to assault rifle supporters: Take your business elsewhere. *Portland Press Herald* (June 15), https://www.pressherald.com/2016/06/15/maine-restaurant-owner-to-assault-rifle-supporters-take-your-business-elsewhere/.

Sauer R (1974) Attitudes to abortion in America, 1800–1973. *Population Stud.* 28(1):53–67.

Schmalz J (1985) Judge halts abortion plan of 2 clinics. *New York Times* (February 2), A23.

Schoen J (2015) *Abortion after Roe* (University of North Carolina Press, Chapel Hill, NC).

Shantz AS, Fischer E, Liu A, Lévesque M (2019) Spoils from the spoiled: Strategies for entering stigmatized markets. *J. Management Stud.* 56(7):1260–1286.

Siltaoja M, Lähdesmaki M, Granqvist N, Kurki S, Puska P, et al. (2020) The dynamics of (de)stigmatization: Boundary construction in the nascent category of organic farming. *Organ. Stud.* 41(7): 993–1018.

Soule SA, Swaminathan A, Tihanyi L (2014) The diffusion of foreign divestment from Burma. *Strategic Management J.* 35(7):1032–1052.

Suchman MC (1995) Managing legitimacy: Strategic and institutional approaches. *Acad. Management Rev.* 20(3):571–610.

Sutton RI, Callahan AL (1987) The stigma of bankruptcy: Spoiled organizational image and its management. *Acad. Management J.* 30(3):405–436.

Swaminathan A (2001) Resource partitioning and the evolution of specialist organizations: The role of location and identity in the U.S. wine industry. *Acad. Management J.* 44(6):1169–1185.

Tanne JH (2005) Emergency contraception is under attack by US pharmacists. *BMJ* 330(7498):983.

Tavory I, Timmermans S (2014) *Abductive Analysis: Theorizing Qualitative Research*. (University of Chicago Press, Chicago).

Timmermans S, Tavory I (2007) Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociol. Theory* 30(3):167–186.

Tracey P, Phillips N (2016) Managing the consequences of organizational stigmatization: Identity work in a social enterprise. *Acad. Management J.* 59(3):740–765.

Tyler M (2011) Tainted love: From dirty work to abject labour in Soho's sex shops. *Human Relations* 64(11):1477–1500.

Vaara E, Lamberg J-A (2016) Taking historical embeddedness seriously: Three historical approaches to advance strategy process and practice research. *Acad. Management Rev.* 41(4):633–657.

Van Witteloostuijn A, Boone C (2006) A resource-based theory of market structure and organizational form. *Acad. Management Rev.* 31(2):409–426.

Ventresca MJ, Mohr JW (2002) Archival research methods. Baum JAC, ed. *The Blackwell Companion to Organizations* (Blackwell, Oxford, UK), 805–828.

Vergne J-P (2012) Stigmatized categories and public disapproval of organizations: A mixed methods study of the global arms industry (1996–2007). *Acad. Management J.* 55(5):1027–1052.

Voss G (2015) *Stigma and the Shaping of the Pornography Industry* (Routledge, London).

Weber K, Heinze KL, DeSoucey M (2008) Forage for Thought: Mobilizing Codes in the Movement for Grass-Fed Meat and Dairy Products. *Adm. Sci. Q.* 53(3):529–567.

Wicklund S (2007) *This Common Secret: My Journey as an Abortion Doctor* (PublicAffairs, New York).

Wolfe AW, Blithe SJ (2015) Managing image in a core-stigmatized organization: Concealment and revelation in Nevada's legal brothels. *Management Comm. Quart.* 29(4):539–563.

Yin RK (2009) *Case Study Research: Design and Methods*, 4th ed. (Sage, Thousand Oaks, CA).

Zuckerman EW (2000) Focusing the corporate product: Securities analysts and de-diversification. *Admin. Sci. Quart.* 45(3):591–619.

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