



Resistance and vulnerability to stigmatization in abortion work

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ABSTRACT

The stigma surrounding abortion in the United States commonly permeates the experience of both those seeking this health service as well as those engaged in its provision. Annually there are approximately 1.2 million abortions performed in the United States; despite that existing research shows that abortion services are highly utilized, women rarely disclose their use of these services. In 2005 only 1787 facilities that offer abortion services remained, a drop of almost 40 percent since 1982 (Jones, Zolna, Henshaw, & Finer, 2008). While it has been acknowledged that all professionals working in abortion are labeled to some degree as different, no published research has explored stigmatization as a process experienced by the range of individuals that comprise the abortion-providing workforce in the USA. Using qualitative data from a group of healthcare professionals doing abortion work in a Western state, this study begins to fill that gap, providing evidence of how the experience of stigma can vary and is managed within interactions in the workplace, in professional circles, among family and friends, and among strangers. The analysis shows that the experience of stigma for those providing abortion care is not a static or fixed loss of status. It is a dynamic situation in which those vulnerable to stigmatization can avoid, resist, or transform the stigma that would attach to them by varying degrees within selective contexts.

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Introduction

Annually there are approximately 1.2 million abortions performed in the United States (Jones, Zolna, Henshaw, & Finer, 2008). Despite the frequency with which abortion is utilized, in 2005 only 1787 facilities that offer abortion services remained, a drop of almost 40 percent since 1982. While abortion is a legal right, it continues to be marginalized within medical settings through its omission from curriculum and limited clinical training opportunities (Eastwood, Kacmar, Steinauer, Weitzen, & Boardman, 2006; Steinauer et al., 2009). Clinicians who are trained may encounter formal and informal policies restricting or prohibiting abortion practice in their work environments (Freedman, Landy, Darney, & Steinauer, 2010). And even when there are willing clinicians and institutions, anti-abortion laws may significantly limit how and where abortions are performed (Weitz, 2009). Such structural manifestations of stigma serve to maintain the marginalization of abortion care (Freedman, 2010; Joffe, 2009).

Contention and social disapproval surrounding abortion both perpetuate and are perpetuated by stigma. Abortion stigma commonly permeates the experience of both those seeking this

health service (Major & Gramzow, 1999; Norris et al., 2011; Shellenberg, 2010) as well as those engaged in its provision. As such, abortion stigma creates an identified, and yet unmeasured disincentive for professionals, paraprofessionals and lay staff to become involved in abortion care. The stigma literature and the social science literature on abortion have yet to unpack the stigma experienced by those delivering abortion services or the ways in which such individuals resist stigmatization. Using qualitative data from a group of healthcare professionals doing abortion work in a Western state, this study provides evidence of how the experience of stigma can vary and how individuals manage their own vulnerability to stigmatization. We show that professionals delivering abortion care resist stigmatization by employing reframing, recalibrating, and refocusing strategies (Ashforth, Kreiner, Clark, & Fugate, 2007), and ultimately produce 'safe' spaces for the maintenance of a positive occupational identity.

Background

Erving Goffman (1963) defined stigma as a mark that reduces an individual "in our minds from a whole and usual person to a tainted, discounted one" (15). He asserted that the term "stigma" refers to an attribute that is deeply discrediting. For the past four decades, social scientists have taken up the study of many kinds of health-related stigmas, for example mental illness, HIV/AIDS, smoking,

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obesity, leprosy, and tuberculosis (van Brakel, 2003; Chapple, Ziebland, & McPherson, 2004; Corrigan, 2004; Kelly, 1999; Long, Johansson, Diwan, & Winkvist, 2001; Macq, Solis, & Martinez, 2006; Parker & Aggleton, 2003; Puhl & Heuer, 2009; Puhl & Heuer, 2010). The specific mechanisms of the stigmatization process have been interrogated and theorized as well (van Brakel, 2006; Herek, 2009; Link & Phelan, 2001). In a literature review, Link and Phelan (2006) found four principles consistent among a variety of stigmas that have been studied since Goffman's seminal work: 1) stigmas are used to define and label difference; 2) the label invokes a negative attribute; 3) the stigma allows the user to separate "us" from "them; and 4) discrimination and status loss result. Some of these themes have been present in analyses of abortion providers (Freedman et al., 2010; Joffe, 1995, 2009; Kumar, Hessini, & Mitchell, 2009).

Individuals who have had an abortion, performed one, or become embedded in abortion controversy are vulnerable to stigmatization because of the meanings that society attaches to abortion and how those meanings "disgrace" the individual. Thus, stigma can be experienced as the process by which a person becomes regarded by others as less than what is expected based upon their social role (Goffman, 1963: 3). However, the experience of stigma for those providing abortion care is not a static or fixed loss of status. It is a dynamic position in which those vulnerable to stigmatization can avoid, resist, or transform the stigma that would attach to them by varying degrees within selective contexts.

Abortion as 'Dirty work'

Goffman did not discuss occupational stigmas in much detail, and, with the exception of a few studies (Gandolfi, 2009; Horsman & Sheeran, 1995; Thompson & Jackie, 1992), occupational stigma has received only minimal attention in the literature. For example, several studies explore the experience of healthcare professionals and volunteers working with HIV/AIDS patients in the years following the disease's introduction to the United States (Durham, 1994; Snyder, Omoto, & Crain, 1999). Studies of stigmatizing work tend to fall within a relatively more developed literature that draws upon Everett Hughes' notion of dirty work, work defined by physical, social, or moral taint (1951). In the tradition of Hughes, we define dirty work as work that a society deems necessary but unsavory or somehow blemishing to the worker. Recently scholars, especially in the fields of organizational and management studies, have elaborated upon Hughes ideas and theorized about the nature of dirty work (Ashforth & Kreiner, 1999; Ashforth et al., 2007; Kreiner, Ashforth, & Sluss, 2006). Specifically, they suggest that abortion work is associated with all three subthemes, the physical (materially offensive or noxious conditions), social (contact with stigmatized others), or moral ("sinful") taint, whether through actual components of their work or an effective campaign to define them as such.

On the physical taint of abortion as dirty work, the perception that those who work in abortion care are in regular contact with materially offensive aspects is embedded in the way in which abortion work is understood in society, propagated through the widespread use of graphic images by the anti-abortion movement. Beginning in the 1970's with the fight over abortion reform in Michigan, the anti-abortion movement has used pictures of actual aborted fetuses to increase Americans' discomfort with abortion, calling upon the power of imagery as a mobilizing tactic (Halfmann & Young, 2010; Petchesky, 1987). In Halfmann and Young's (2010:2) analysis, these images are used as weapons, to "shock, harass, discomfort, and stigmatize opponents without necessarily changing their minds." Several physicians who perform abortions, particularly those who provide abortions in the second trimester,

acknowledge that death and discomfort with the handling of fetal body parts is part of abortion work (Harris, 2008; Hern, 1980; Kaltreider, Goldsmith, & Margolis, 1979). Many working in abortion care, including but not limited to clinicians, come into contact with fetal parts, death, and consequently physical taint. In cases of abortions for fetal anomalies or life-threatening medical circumstances the social and moral taint may be relatively less prominent, but the physical taint remains.

Noxious conditions, another component of dirty work's physical taint, are also an acknowledged part of abortion work. Anti-abortion violence and harassment (NAF, 2009) continue to be a concern for all members of the abortion care team (Joffe, 2009; Lyons & Lyons, 2005; Simonds, 1996). Furthermore, stigma and violence can be mutually reinforcing; the workplace hazards associated with anti-abortion violence is positioned as 'part of the job' whereas in other professional context these threats would be unacceptable (Todd, 2003). The stigma of abortion has helped perpetuate the social acceptance of public portrayals in which those working in abortion care appear as worthy targets of harassment and violence and a political climate in which political leaders' and law authorities' responses to such targeting is muted (Eviatar, 2009; Joffe, 2009; Pridemore & Freilich, 2007).

The social taint of dirty work, contact with stigmatizable others, applies to those that work in abortion care because they serve a population that is subjected to substantial social disapproval. Women seek abortion care for a variety of reasons, terminating both unwanted and wanted pregnancies. However, those who terminate unwanted pregnancies have been sexually active but reject motherhood (at least for this pregnancy), breaking with the dominant narrative of acceptable feminine behavior (Kumar et al., 2009; Luker, 1985). While stigma directed at women seeking abortion services is built on the assumption of an unwanted pregnancy, abortion stigma is also extended to those women terminating a pregnancy as a result of fetal anomaly (Chiappetta-Swanson, 2005). By offering the very medical care women are judged negatively for seeking, those who work in abortion are also labeled as 'tainted'.

Moral taint is perpetuated by the anti-abortion claim that abortion work is equivalent to murder. Joffe (1995) specifically examines how the label "abortionist" is sometimes derogatorily applied to those who perform abortions, invoking pre-legalization notions of morally deficient, profit-motivated, and/or technically incompetent 'back-alley' physicians. With the physical, social, or moral taint associated with dirty work all relevant to abortion work, literature from multiple disciplines have articulated a connection between the dirty work label and abortion care; however few have developed analysis around how the stigma associated with dirty work is experienced and managed (Ashforth & Kreiner, 1999; Chiappetta-Swanson, 2005; Joffe, 1978; Todd, 2003).

Stigma resistance: reframing, recalibrating, and refocusing strategies

Stigmatization is a process that can be actively resisted by people who are vulnerable to the stigma. As relatively powerful and collaborative agents, those providing abortion services also resist and transform the experience of stigma in a variety of ways. A degree of heroism is also part of the abortion work schemata in that the majority of Americans want abortion to remain available, albeit restricted and controlled (CBS, 2010). Those willing to withstand the challenging conditions of the work can and have been reframed as heroic by supporters. For decades abortion stigma has competed with the heroic public health and feminist framing of abortion work (Friedan, 1998; Joffe, 1995; Lader, 1973; Petchesky, 1984; Rosen, 2000; Tietze, 1975). Recent heroic framing of abortion providers

can be located in efforts to contextualize these individuals as Human Rights Defenders (“Defending Human Rights: Abortion providers facing threats, restrictions, and harassment,” 2009). While these positive narratives have yet to extinguish mainstream negative ones attached to abortion provision, they echo efforts to reframe the work at the individual and group levels among those supporting and providing abortion care, including the subjects in this study. Ashforth and Kreiner (1999) argue that individuals engaged in dirty work develop strong work cultures and learn to reframe (transform meaning), recalibrate (give more weight to some aspects of the work than others), and refocus (highlight more admirable features of the work) in order to cope with stigma and maintain a positive identity and self-esteem. These coping strategies are highly recognizable in our data; however, results do not suggest that all healthcare professionals doing abortion work necessarily view their work as inherently tainted, stigmatized, or dirty.

Methods

This study consisted of in-depth interviews with participants of a regional association of individuals involved in abortion care. This association was created in the late 1980's with the intent to unite the community of abortion workers, political supporters and advisors. The network included approximately 130 members in the spring of 2009 who perform the diversity of activities that comprise abortion care. Because workers performing any of these tasks may experience the stigma of abortion at some level, this study included respondents from different professional backgrounds and clinical roles.

Participants for this study were recruited by e-mail having been identified through their participation in the regional association. Invited participants were chosen from participant lists, with selection guided by an interest in having a professionally diverse sample. Eighteen individuals were selected on the basis of purposeful stratified sampling and invited to participate, of which fourteen were interviewed in late 2009 and early 2010; those invited who did not participate are not systematically different from those who did in terms of profession or demographics. In semi-structured interviews conducted by an interviewer who works in a nonprofit organization that supports abortion provision, participants were asked about their involvement in abortion care (specific care provided, training, initial interest in this work), vectors of support for their work (including professional networks) and their perceptions and experiences of stigma (overt social disapproval, social isolation, negative self-perception, and fear of disclosure). Participants were aware of the interviewer's nonprofit work, which likely facilitated report and disclosure of participants concerns. Interviews were conducted in person and by phone, ranging from 30 to 60 min. Interviews were recorded and transcribed verbatim. The interviews were coded and analyzed using Nvivo software. Coding and analysis relied on an inductive approach in order to generate findings from the data. The Harvard School of Public Health Institutional Review Board approved this study. In the analysis and presentation of the results, all participants are identified using pseudonyms, with identifying information removed to protect individual anonymity.

Fourteen respondents completed interviews (see Table 1). Respondents interviewed include seven physicians currently performing abortions, two physicians trained in abortion who intend to but do not currently perform abortions, two certified nurse-midwives who provide medication abortions, two registered nurses, and one social worker. Those individuals who did not directly perform aspiration/surgical or medication abortion are involved in peri-abortion care, which includes activities such as

Table 1
Respondent information.

Gender	Profession	Years of providing abortion care
F	Physician	0
F	Certified nurse-midwife	<3
F	Certified nurse-midwife	>7
F	Social worker	>7
F	Registered nurse	>7
F	Physician	>7
F	Physician	>7
F	Physician	>7
F	Physician	3–7
M	Physician	3–7
F	Registered nurse	>7
F	Physician	<3
F	Physician	3–7
F	Physician	0

counseling, ultrasound, and patient recovery. All but one respondent are female and their ages ranged between 30 and 81 years, all currently working as healthcare professionals. Given the small number of individuals involved in the study, ages are not provided for respondents to avoid identifying specific individuals. Respondents work in a total of seven different facilities that provide abortion care within the Western state in which the study was conducted and there are multiple respondents from the same facility in some cases. Estimated years of providing abortion care captures time after the completion of training, which typically includes performing upwards of 50 abortion procedures during residency (physicians who have not provided abortions as part of their post-residency practice are noted as having provided abortion for zero years, regardless of their training experience).

Results

If stigmatization is understood as a process wherein meaning is attached to individuals, individual experience with that process is dynamic. While abortion work is broadly stigmatized socially and politically, these data suggest that the vulnerability of healthcare professionals doing abortion work to stigma is variable. Encounters with abortion stigma as presented here are grouped within four different spheres: interactions with patients, with professional peers, with close friends and family, and with acquaintances or strangers. However, in each sphere, there is variation around the degree of vulnerability to stigma and the capacity to actively resist it in those moments. Overall, healthcare professionals doing abortion work minimize their exposure to stigma by producing and then existing within safe spaces as much as possible.

Interactions within the workplace

Among colleagues, the abortion care facility is reportedly a space that is relatively protected from stigmatization because workers in the facility tend to be like-minded about the need for abortion provision. The is homogeneity can facilitate bonding between coworkers over shared goals and struggles. Notes a female certified nurse-midwife working in an abortion clinic, “I think the most sustaining thing is probably the other people I work with. Because working in abortion, it draws really good people.” Many respondents regard their colleagues as “brave”. The pleasure of working with like-minded and courageous colleagues who create a supportive in-group work culture, an experience not exclusive to abortion work, is an often-referenced benefit of doing this stigmatizing work (Ashforth & Kreiner, 1999; CBS, 2010; McIntyre, 1987; Mulcahy, 1995).

Unfortunately, for some respondents, interactions with patients are less consistently positive than those with colleagues. Respondents report that their most frequent encounters of negative perceptions of abortion workers come from abortion patients who bring negative images of those providing abortion care into clinic with them. For many respondents, these interactions were an opportunity to resist stigmatization by correcting patient perceptions. A female physician who works one day a week at a clinic, explains, "People often say, with this tone of incredible surprise, 'You're so nice,' and I turn it around, I try and gently raise people's consciousness, and I go, 'Well, of course we're nice.'" Resisting and countering negative perceptions is a challenge a female registered nurse regularly poses to her staff in trainings. She warns them, "It doesn't matter how well you dress, how well you speak, how good you are; you always have to be better because abortion care is still seen as tawdry, as a little less than; you're dirty."

However, those doing abortion work are not always successful. Explains a female certified nurse-midwife, "I find it really stressful if patients are telling us how horrible we are. I can get support from other women I work with, and that does happen. But I think when you're working as hard as you can to give someone good service and they hate you, it's really hard." These types of interactions, when a patient stigmatizes the healthcare professionals who are providing her abortion care, are often demoralizing. Explains a female social worker,

It's very challenging for me professionally and it's been very hard for me to coach staff on how to respond, because I have the internal response of, "well, you can leave now." I focus on that there are so many messages to people that abortion is bad and you should be ashamed. They bring that with them. But it makes me think, "So why do I have this job that you don't respect?" ... So I feel a little devalued.

Her internal response, particularly the impulse to ask the patient to leave, is protective over herself and the space in which she works. Feeling "devalued" while serving a patient is a common challenge for individuals doing abortion work. However, an individual's vulnerability to this type of stigmatizing interaction may vary depending on professional status. Some respondents remarked that the clinicians performing the actual abortion are less likely to have patients express negative perceptions directly, which they attribute to the patients' desire not to jeopardize their access to care or the quality of that care.

Interactions within professional circles

While patient perceptions of abortion work as discrediting or distasteful are troubling for respondents, similar interactions with professional peers can further reinforce stigmatization. A female registered nurse describes an interaction with a medical professional, who incidentally became a patient. A doctor known to the nurse in medical circles directly conveyed her surprise at the 'cleanliness' of her abortion care experience:

We had a woman physician who was in practice in the center of the city and she'd come all the way to the clinic to have her abortion because she was too embarrassed to go to one of her colleagues ... So we did her abortion, and she comes to my recovery room, and I said to her, "I hope that everything has gone well for you," as I say to everyone. And she said, "Well, you know, it has," and she said, "You're all so professional and clean." And the minute she said it, she said, "Oh, I didn't mean that," and I thought, "Yes, you did."

While this is a perception the nurse had heard from patients before, the comment took on new weight when expressed by another healthcare professional. Disapproval from professional

peers was recognized by respondents in how peers tended to avoid discussing abortion work or imply that abortion work is 'distasteful.'

Aversion to discussing abortion work is noted as ranging from subtle to explicit. Respondents, especially those who provide abortion outside of a stand-alone clinic setting, come into contact with other healthcare professionals who implicitly bring a 'dirty work' frame to abortion work. A female physician who works in an educational institution, elaborates:

I have colleagues all the time who will say, "Nobody likes to do it, but thank God you're willing to." And I always respond by saying, "I actually like doing abortions." I like it. I think it's great. To me, it's kind of akin to doing a delivery, which I do general obstetrics and gynecology too. So it's this intense emotional experience in a woman's life, and you can be there for that transition.

These interactions create an opportunity to reframe the perception of abortion work, shifting it from undesirable to desirable. The physician connects abortion work with that of delivery, understanding both as intense transitions in a woman's life. In doing so, she collapses these two parts of her work into one space of 'being there' with a woman whether she is completing or terminating a pregnancy. By communicating her understanding of these interactions as similar, she simultaneously transforms these two experiences in a woman's life from a dichotomy to a continuum and reframes the work from an unappealing task to a privilege. The physician's description of her work resists the stigmatizing frame her colleagues offer, communicating that abortion is not distasteful but meaningful.

These interactions between those involved in abortion care and other healthcare professionals who intentionally distance themselves from abortion can make the former feel vulnerable to stigma, a reminder of the "otherness" of an individual's occupational identity. However, in the Western state where respondents resided, they found themselves more capable of building safe spaces for their work. Referring to the politically liberal climate of the state, they almost uniformly noted themselves as 'lucky.' Explains a female physician working in a clinic, "I'm respected in my field here. But I think if I lived somewhere else, there might be less of that." Many specifically acknowledged the network of those providing abortion in the immediate area, noting these specific professional communities can provide refuge from stigma by offering interaction with professionals for whom abortion work is normal and valued. In such a professional network, among colleagues doing similar work, individuals feel less discredited. The absence of such a network can be acutely felt. A female physician recounted an experience when she brought a colleague who performs abortions in another state to a larger national professional meeting for those involved in abortion provision:

To watch him all of the sudden realize that he had a community — he didn't know he had a community. He had no idea when he came to that meeting ... Because his experience with his colleagues in his city is, you know, they'd put up with him and that's about it... he just found this sense of relief that he was "normal" because there were hundreds of other doctors like him.

For her colleague, encountering a professional community that normalized his work was surprising and comforting. Respondents are quick to acknowledge their location mitigates their vulnerability to stigma. Several note that the presence of a local professional network of healthcare professionals doing abortion work is facilitated by the political climate; conversely, respondents connect a more conservative local political environment with an absence of the acceptance for their work.

Interactions within personal networks

Most respondents experience their network of friends and family as supportive of their work, but some respondents also discussed how they experienced limitations to that support. Disclosing the details of their work sometimes exposed an underlying discomfort with abortion that certain family members hold, and other times the discomfort may have been anticipated rather than directly observed. A female physician who has provided abortions in a clinic during residency and plans to integrate these services into her current primary care practice, discusses such discomfort within the family:

I was a little surprised that my husband would have such conflicted feeling about it, because he's always been pro-choice and he's socially liberal, and I didn't realize it would be as hard for him as it is to accept that I am an abortion provider ... I think ultimately it's distasteful to him, but he supports women's right to choose, and he supports my decision to help in that process; he just doesn't really like to hear about the details.

In the physician's case, her husband's discomfort was directly expressed by his unwillingness to engage about her work and his explicit requests to not disclose her work to his family. She explains, "Luckily, [the rest of] my family is all very supportive and understanding. And all our friends essentially share our political views about the subject. They don't always want to hear about [my abortion work], but they support me." However, this was not true for all respondents. A female registered nurse's strategy for avoiding stigmatizing interactions with family is to live across the country.

I remember thinking if my husband and I had come back to [a conservative Southern state] where we have family. I probably would not have worked in this arena because I think it takes a lot of courage ... I would not have the courage or the fortitude or whatever it would've taken to have bucked my family, the community, because it's hard enough here sometimes. You work at risk of loss of community; you work at risk of loss of friends and family.

Her physical distance from this disapproval reduces her vulnerability to stigmatization and loss of close relationships.

Interactions with strangers

Disclosure is a significant decision-point in stigma management by those doing abortion related work. Respondents employed judicial disclosure to manage exposure to disapproval and negative stereotypes, providing a measure of self-protection against stigmatization. In interactions with acquaintances or strangers, respondents reported relying on what one described as "fudging it" to avoid full disclosure. A female physician that provided abortion care during her residency explains, "I edit and omit, and I don't have a big problem doing that." The limited activity of anti-abortion protesters in the state where they work enables the avoidance of stigmatizing interactions with acquaintances and strangers, an avoidance that would not be possible if they were publicly 'outed' for their abortion work. All respondents described some sort of screening process through which they decided whether or not to disclose their abortion work.

In managing disclosure, often healthcare professionals considered not only their own exposure to stigma, but also that of their family. A number of respondents choose non-disclosure in order to protect their children. Discussing her policy on disclosure when her children were in elementary school, a female physician who performs abortions in an abortion clinic, explains: "If I was dealing with moms in their class, then I was more likely to say either, 'I'm

a family doc' or 'I do women's reproductive health'... It really is, 'are my kids going to get badgered and teased?'" A female physician who provides abortions a few days a month in an abortion clinic, rarely discloses her abortion work in her immediate social community for a similar reason – "I don't want [my kids] to ever have to worry about defending me." But limited disclosure, while offering clear protection from stigmatization, also has a cost for some respondents. For this physician, it comes at the expense of her ability to live openly:

It would certainly be easier if it wasn't a job I felt like I had to keep secret, that people would not approve of ... it's anxiety producing to feel like you have a secret. I am generally an open person and I try to do good in the world and I have integrity and I don't want people to disapprove of me. Having something in my life that I feel like I have to hide from some people, you know, it just doesn't feel like the way I usually live.

Other respondents enjoy the challenge of disclosure. Openly claiming abortion creates an opportunity to not only be honest about their work, but also counter to the negativity associated with abortion work. "Putting a human face to it," as one respondent described it, allows those providing abortion care to undermine stereotypes and confront social disapproval directly. This individual resistance to negative perceptions of abortion work and providers is empowering for some respondents, like a male physician who provides abortions once a month in a clinic. After the May 2009 murder of Dr. George Tiller, a well-known abortion provider in Kansas, the physician shifted his approach to full disclosure (all interviews took place after the May 30, 2009, murder). He explains:

Before Dr. Tiller got murdered, I would've probably just said, "I'm a family physician doctor," and just talk about that type of work. I wouldn't have mentioned the abortion work. But since then, I've been excessively open about the fact that I do abortions with people ... I wanted people to put a face they knew on abortion. They just hear things about Dr. Tiller. But if people didn't know that I did abortions, and they know me, and I'm just a normal guy who gets along just fine with everybody, and kids are in school and friends with other parents who I have social interactions with. I just want people to know that there are abortion providers everywhere that do good work and may need their support sometime.

This physician named this approach to disclosure as "coming out," invoking a strategy effectively used by the gay rights movement.

Strategies of resistance

Respondents managed their narratives of abortion work by reframing, recalibrating, and refocusing the conversation in order to resist stigmatization, especially in professional interactions and interactions with strangers. Some individuals who work in abortion shift the framing from an unappealing job to a privilege with particular emotional weight. Explains a female midwife who works in a clinic, "It's a chance to really share something intimate with somebody who's doing something really big in their lives." A female physician who works full time in a clinic, consistently resists the framing of her work as undesirable.

People say, "God, isn't it kind of depressing?" It's like, "No. This is an amazing way of watching people's inner strength, how they cope, their hopes for the future, their incredible ability to say, 'I can make something with my life and I need this to have that happen.'" I get to see some of the best parts of people, not the worst parts.

Reframing abortion work from a burden into a privilege is an effective strategy for those who provide abortion care, as is recalibrating, a strategy of more weight to positive aspects of the work. For example, several respondents emphasize the way their work maintains access to care for vulnerable patients, while deemphasizing the experiences they have with patients who do not appear particularly vulnerable and, in fact, may appear entitled and irresponsible. Many respondents refocus the narrative by highlighting redeeming qualities of abortion care such as the satisfaction of “fixing a problem.” In contrast to other aspects of medical practice, a female physician who works in an educational setting explains: “I find it very sort of defined procedure, where in such a short period of time, you can really help somebody. I like the fact that I have the ability to just completely turn their life around for them in five to ten minutes.” Another redeeming quality of the work reported by some respondents is the societal and individual value of enabling women to be better parents if and when they choose to do so. A female physician who provides once a month at a clinic, also echoes this sentiment, but continues on to make a connection between parenthood and the availability of resources:

I think having a strong belief that I'm doing a good thing for women, that I'm providing women with freedom to do what they need to do in their lives. I think as a mother I actually have a much deeper appreciation of mothers who need abortions because they feel like they're already stretched too thin with the children they have.

The physician's “strong belief” in the goodness of her work facilitates her ability to deflect stigma she might experience in her interactions.

Discussion

Studies of abortion physicians and facilities have documented the ways in which people delivering abortion care are labeled, harassed, or defamed. Common labels levied by abortion opponents, such as “abortionist,” “baby-killer” or “murderer,” separate those who work in abortion care from other healthcare providers. These labels are often applied to all individuals doing abortion work, regardless of clinical role. Despite the acknowledgment of how all professionals working in abortion are labeled to some degree as different, no published research has explored stigmatization as a process experienced by the range of individuals that comprise the abortion-providing community, either to explore commonality or difference between groups. This study begins to fill that gap.

For individuals involved in abortion care, abortion is understood not as simply a moral, political, or intellectual discourse, but as a lived experience. Their experience requires negotiation on a regular basis in interactions within the workplace and professional circles as well as during interactions with personal networks and strangers. In the abortion-providing facility, individuals find solidarity in their understanding of themselves as brave and performing important work. However, while the workplace is a safe space in general, interactions with patients that transmit stigma are particularly poignant for those working in abortion care.

As data from this study show, there is little space outside of the workplace for discussion of abortion care work as an occupational identity. An individual within the abortion-providing community often encounters avoidance of abortion work in general conversation, a mirror of the avoidance of abortion as work in the broader dialog. Still others feel obligated to intentionally conceal their involvement in abortion care, often at the expense of their own sense of who they are or how they usually behave in the world.

Respondents demonstrated the use of reframing, recalibrating, and refocusing strategies as articulated in the ‘dirty work’ literature to help manage stigma and mitigate its effects. These strategies are used in interactions at multiple levels: in the workplace, in professional circles, among friends and family, and with strangers. Reframing actively transforms the stigmatizing properties of dirty work. Respondents highlight abortion work as gratifying often by contrasting it with the provision of other medical services which are not as immediately gratifying. Recalibrating magnifies the redeeming qualities of abortion work and focuses on its role in vulnerable populations pregnancy occurs within a context of scarce resources. For many respondents, performing abortion is a way to use medicine to right injustices, as said above, to allow women the “freedom to do what they need to do in their lives.” Finally, refocusing avoids those aspects of the work that are labeled as negative by highlighting other aspects that are labeled as positive. The most consistent example of those was respondents’ focus on the pleasure of working with colleagues diverging from a focus on the abortion work itself. All had a strong sense that their work is in support of a ‘greater good’; however, resistance strategies serve to maintain that sense in the face of others who were not knowledgeable in abortion care or had negative perceptions of this work.

Respondents in this study are careful to acknowledge their individual successes in deflecting stigma are bolstered by a liberal political environment for which many respondents feel “lucky,” support from family and friends, and the strength of their local abortion-providing community. While all three factors are reiterated as important, the final component of the trio, professional community, is the most modifiable. A professional community creates “the normal” —in the case of this study's respondents, serving to normalize abortion work. In addition to or in the absence of a supportive local political environment and approval from family and friends, having a professional community that normalizes abortion care seems to make the work more attractive and sustainable for those engaged in abortion care provision.

Data from this study also suggest several areas for future research. As one respondent's husband's negative reaction to abortion work despite his support for the legal status of abortion illustrates, the taint of abortion stigma can coexist with pro-choice beliefs, speaking powerfully to stigma's ability to permeate how an individual *feels* about abortion work despite what he or she might *think about the legitimacy of abortion as a choice for women or in law*. The actual work of providing abortion care highlights the discontinuity between individuals' support for abortion work and their support for the legal status of abortion and might be a fruitful focus of inquiry to understand how stigma operates at the level of the individual.

Additionally, while the sample size limits a full exploration of how the experience of stigma might vary with role and status within abortion provision as well as by gender, race or age, the results are suggestive of several critical points. First, the experience of stigma is pervasive among those working in abortion care. Regardless of role, status or identity, respondents describe social disapproval consistently, though to varying degrees. Second, the cultures of different professional groups, particularly how much abortion factors into that culture, may magnify or minimize that stigma. For example, the acknowledgment of abortion as a recognized if inconsistently practiced aspect of obstetrics and gynecology might insulate physicians of that specialty from social disapproval to some degree. However, the less acknowledged place of abortion within the registered nurse professional community might mean a registered nurse experiences stigma more directly. Third, professionals, like physicians, that would be otherwise high status if not for involvement with abortion care can use that status to deflect social disapproval. Others whose role within the medical

community is not privileged with the same prestige might be more vulnerable to stigma. However, this study suggests that all who work in abortion care must commit some energy to managing stigma through the ways in which they disclose and, when they disclose, how they reframe, recalibrate, and refocus their experience.

Conclusion

Individuals in all aspects of abortion care work experience the process of stigmatization in and outside the clinical care environment and with those close to them as well as people they do not know. To manage these experiences, abortion workers engaged in a number of stigma management techniques. Most successful is the development of communities of support comprised of others performing this work.

Stigma at the individual level, however, can be understood to have macro-level consequences. Stigma nurtures the constant questioning of the legitimacy of abortion work. It creates a narrative that justifies the overregulation of abortion, establishing a frame in which the professionalism of those involved in the work is questioned. Stigma condones the omission of abortion at worst via the silence it projects, and the separation of abortion at best via its project of abortion work as “other.” It permeates policy and practice in medical education, making it difficult to learn abortion content and receive abortion training (Eastwood et al., 2006). Stigma solidifies the marginalization of abortion, justifying keeping abortion care separate from other aspects of healthcare as the containment of ‘taint.’ While stigma exacts a price on individuals within the abortion-providing community, it also taxes the integrity of the healthcare system. It not only labels those that participate in abortion care as “other,” but also calls into question any institution, payer, or entity that facilitates abortion services. In labeling this care as such, abortion is placed outside of mainstream healthcare and, because of that placement, outside the reach of some women who may need this care.

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