UNIVERSITY OF CALIFORNIA, IRVINE

# The Challenges of Modern Abortion Care

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

In Sociology

By

Kelly Marie Ward

Dissertation Committee:
Professor Francesca Polletta, Chair
Professor Nina Bandelj
Assistant Professor Rocio Rosales

2020

**DEDICATION**

To

Pam and Ken

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## ACKNOWLEDGEMENTS

To say that I could not have done this without the support of Professor Francesca Polletta, my advisor and committee chair, would be a gross understatement. She made it possible for me to complete the dissertation under unimaginable circumstances. I will forever be inspired by her intellectual curiosity and consider myself lucky to have her as a mentor.

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Finally, I'd like to recognize the clinic workers who are the subject for this dissertation. I was moved by their dedication to their patients and their efforts to provide safe abortion to all who need it.

**VITA**

# Kelly Marie Ward

Curriculum Vitae

## EDUCATION

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## PUBLICATIONS

### Peer Reviewed Journal Articles

In Press Polletta, F., DoCarmo, T., Ward, K.M., Callahan, J. "Personal Storytelling in Professionalized Social Movements." *Mobilization.*

2015 Ward, K.M., Zarate, M.E. "The Influence of Campus Racial Climate on Graduate Student Attitudes About the Benefits of Diversity." *Review of Higher Education* 38(4), 589 – 671.

### Book Chapters

2018 Zarate, M.E., Woods, C., Ward, K.M. "Nineteen years after Prop 209: Are Latino/a Equitably Represented at the University of California?" in *Hispanic College Students Move Forward: Policies, Planning and Progress in Promoting Access.* Alfredo De Los Santos (ed.) Tempe: Bilingual Press.

### Revise and Resubmit

Ward, K.M., "Dirty Work and Redirected Intimacy: Locating Medical Assistants in Abortion Work." *Journal of Health and Social Behavior*.

Ward, K.M., "Crafting the Conditions for Professional Membership: Women of Color Navigating Inclusion into Academia." *Sociological Perspectives.*

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## FELLOWSHIPS & AWARDS

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2019 Society of Family Planning Emerging Scholars Grant
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### University of California, Irvine

2018 Werner Fellowship, School of Social Sciences, UCI
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2019 Pitzer College, Claremont CA

2019 Advancing New Standards in Reproductive Health, University of California, San Francisco, Oakland, CA

2018 Sociology Department, California State Polytechnic University, Pomona, CA

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2018 Ward, K.M. (2018, August). *Logics at work: Reproductive rights and medicalization in an abortion clinic.* American Sociological Association annual meeting, Philadelphia, PA, August 11 - 14.

Ward, K.M. (2018, April). *Logics at work: Reproductive rights and medicalization in an abortion clinic.* Southern Sociological Society Annual Meeting, New Orleans, LA, April 4 - 7.

2017 Polletta, F., DoCarmo, T., Ward, K. M., Callahan, J. (2017, August) *Authenticity and Victimhood in Contemporary Storytelling.* American Sociological Association annual meeting, Montreal Canada, August 12 - 15.

Ward, K. M. (2017, August) *Institutional logics at work: An ethnography of an abortion clinic.* Society for the Study of Social Problems annual meeting, Montreal, Canada, August 11 - 13.

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2015 Ward, K. M., (2015, April) *Negotiating Inclusion: Women of color's resistance strategies in doctoral education.* Pacific Sociological Association annual meeting, Long Beach, CA, April 1 - 4.

2013 Ward, K.M., (2013, November). *Graduate student attitudes about diversity*. Association for the Study of Higher Education Conference, St. Louis, MO, November 13 - 16.

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2012 Ward, K. M., (2012, November). *The Influence of Schools' Racial Climate on Graduate Student Attitudes.* Association for the Study of Higher Education Conference, Las Vegas NV, November 15 - 18.

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2011 Ward, K.M., (2011, August). *Peer Influence and Postsecondary Education Enrollment.* Presented at Summer Research Symposium, University of California, Irvine.

## TEACHING EXPERIENCE

**California State Polytechnic University, Pomona**
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High School to College Advising (winter 2013)
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## RESEARCH EXPERIENCE

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| 2017 – 2018 | Digital Media and Learning Hub, UCI |
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| 2012 | DECADE Racial Campus Climate Survey, UCI |
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## PROFESSIONAL SERVICE

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**ABTRACT OF THE DISSERTATION**

Title

By

Kelly Marie Ward

Doctor of Philosophy in Sociology

University of California, Irvine, 2020

Professor Francesca Polletta, Chair

In years since Roe v. Ward abortion care has evolved in response to changes affecting healthcare more broadly (Halfmann 2012). Features of this newer model of healthcare provision, which is heavily influenced by managed care, include a strict division of job duties, practices that maximize efficiency and revenue, and organizational cultures that prioritize doctors' authority and expertise but also strive to meet the demands of insurance and state reimbursement structures. Scholarly and public attention have most often focused on the doctors who perform abortions. Yet one of the key changes wrought by the reorganization of medical care more generally has been the growing role of medical assistants in the provision of abortion. Medical assistants are increasingly being incorporated into healthcare as they provide less expensive labor than doctors and nurses.These workers, I find, do not have the prior commitment to reproductive rights that doctors and nurses have. Based on 18 months of ethnographic observation at a busy abortion clinic in Southern California, my dissertation addresses how institutional changes have shaped abortion work today and address the following questions: *How is abortion both similar to and different from typical healthcare? What are the implications for lower-status workers?*

I find the modern arrangement of abortion does little to recognize the diverse needs of low status workers nor does it account for the extra emotional work these workers do as they contend with the moral complexities of abortion. I argue that clinics' efforts to treat abortion as similar to other healthcare procedures ends up downplaying the undeniably politicized aspect of abortion. If we act as if abortion is like any other healthcare service without considering how abortion work is quite different from other forms of healthcare, then abortion work loses an important connection to the politics of abortion. It is a connection, I conclude, that may be particularly important for lower status workers as they make sense of their roles in abortion care.

# CHAPTER 1: INTRODUCTION

Stand-alone abortion clinics conduct the majority of elective abortions in the United States and serve the least advantaged women (Jones and Jerman 2017). Such clinics have increasingly come to resemble mainstream health centers rather than the feminist clinics of the 1970s. Yet persistent politicization and debate in the public sphere influence how care is offered and how workers engage in abortion work. Based on 18 months of ethnographic observation at a busy abortion clinic in Southern California, my dissertation addresses how institutional changes have shaped abortion work today. Scholarly and public attention have most often focused on the doctors who perform abortions. Yet one of the key changes wrought by the reorganization of medical care more generally has been the growing role of medical assistants in the provision of abortion. Low-skilled and low-paid, medical assistants, I find, do not have the prior commitment to reproductive rights that doctors and nurses have. And yet, they are critical to providing medical care that is highly stigmatized and even dangerous. I focus on how doctors, nurses, and medical assistants struggle to balance institutional logics of physician autonomy, patient-centered care, and market efficiency with a feminist logic of reproductive rights. The latter, I find, surfaces only occasionally in clinic work. But the fact that medical assistants do not have access to that logic—and that rationale for the emotional labor they are required to do—makes their work especially difficult. I begin this introductory chapter by recounting a surgical abortion in the clinic I studied. Doing so highlights the key changes in the provision of abortion since Roe v. Wade that I will focus on in subsequent chapters.

A TYPICAL APPOINTMENT

Dani is in the reception area sitting behind bullet-proof glass with a clear view of the security camera monitor to her right. She chats with coworkers sitting in the reception area about plans for the weekend. There has been a lull in patients arriving at the front desk. The first group has been checked in and will stay in the waiting room until they are called back. When a woman walks through the clinic door into the small vestibule, Dani turns to the bullet-proof window and motions for the woman to pick up the phone mounted on the side of wall. She picks up a receiver and takes the woman's information. Learning that she is there for an abortion, Dani asks the patient's name and confirms that she has a driver to pick her up after the abortion. She can expect to be in the clinic for several hours. Someone from the clinic will call an hour before the patient should be picked up. Dani tells the woman to let her driver know that the caller ID may show that the number is "unknown" or "blocked." After getting the driver's number on a sticky note, Dani pushes a button unlocking the door to the waiting room. She tells the patient to check-in on one of the iPads mounted on the waiting room wall. As part of the check in, the patient is asked to sign a form agreeing not to disclose information about the clinic or the visit. This is one defense against anti-abortion activists infiltrating and collecting information about the clinic. Staff from the clinic have been targeted by "antis" with undercover videos.

In the reception area, Dani has written some of the patient's information on the "face-sheet"; a laminated paper that is used to record the important information for the patient's appointment. Throughout the course of her visit, more information is added with a dry-erase pen by the different clinic staff the patient comes into contact with. Face-sheets come in two colors to indicate whether a patient has insurance. Dani places the face-sheet in a file holder that sits between her and her co-worker, Laura. Laura calls the patient over to another window and

motions for her to pick up a phone. First Laura takes the patient's payment and then hands her a set of laminated papers through a small opening under the window. The papers are held together by a metal ring in the corner and provide more detailed information on the abortion procedure, including the risks. Had the patient spoke a language besides English, she would have been offered the material in her native language. Laura tells her to read these carefully and bring them back when she is done. Once the patient brings the papers back, Laura signals that the patient is ready to be taken back for her appointment by putting the face-sheet in a colored plastic folder and placing that in a folder holder hanging on the wall near her head.

Chloe, a medical assistant (MA), has been checking that folder holder for the past few minutes. When she sees the folder, she looks at the face-sheet to see whether the person needs an interpreter. Luckily the patient speaks English one of the two languages Chloe knows. She accesses the patient's electronic file in the computer and clicks "MA start" signaling the beginning of her time with the patient and then opens the door to the waiting area and calls the patient's name. A woman gets up, says goodbye to her companion and walks through the door. "Hi, I'm Chloe, can you confirm your birthday please?" The patient confirms her identity via her birthdate and Chloe hands the woman a plastic cup with a lid, directing her to the nearby bathroom to provide a  urine sample. After the patient comes out of the restroom, Chloe records her height and weight, and then walks her to row of lockers on the wall. She instructs the patient to put her things in a locker and hands her some single-use thick cotton socks with rubber tread on the bottom. The patient asks if she can keep her phone, and Chloe says no. Chloe walks the patient through another set of doors back to the examination rooms. Once in a room, Chloe measures and records the patient's blood pressure, pulse rate, and temperature. She records this information on the face-sheet and in the electronic chart on the computer. Chloe instructs the

patient to get undressed from the waist down and to cover herself with the blue paper drape on the exam table. She clicks on “MA-end”, which officially records the end of her time with the patient, tells the patient that a nurse will be with her shortly and then leaves the room, hanging the folder in a holder on the outside of the door.

Once Naomi, a registered nurse, sees the medical assistant exit the room she gets the chart. She reviews the information on it as well as in the electronic chart on the computer. The patient is scheduled for a first-trimester procedure. If she ends up being further along and insurance won’t cover it, she will have to pay the difference. Naomi also checks to make sure what, if any, birth-control the patient’s insurance will cover. Naomi takes the chart and grabs and a blue plastic container with the items she will need for the assessment; needles, gauze, rubber bands, medical tape, wipes for cleaning, etc. She opens the door and says, “Hi [patient name]? Can you confirm your birthday?” as she hits a switch on the inside of the room that turns on one of three colored lights (red, yellow, and green) over the exam room door. Red means the RN is scanning and assessing the patient.

First Naomi conducts a vaginal ultrasound to determine the gestational age of the pregnancy. She turns down the lights in the room and instructs the patient to lay down on the exam table. Naomi pushes a button on the floor that raises the exam table and encourages the patient to relax. As she manipulates the ultrasound wand with one hand, she uses the other hand to scroll around, zoom, and take images with a special computer. She has to accurately measure the size of the fetus from different angles and look for anything that would make surgery dangerous. Naomi asks the patient if she wants to see the images, the patient declines. She prints out copies of the ultrasound images while the patient puts her clothes back on behind a curtain. During the assessment, the Naomi takes a full medical history, confirms that the patient hasn’t

eaten or drank anything in the last 12 hours, and screens for any medical risks. She also looks for indications that the woman is being forced to terminate her pregnancy or has been abused or raped. Naomi uses blood from a finger prick to check for Rh antibodies and hemoglobin levels; information from these tests is critical in assessing the risk for surgery. She asks whether the patient would like to start birth control and gives some information on the different methods while emphasizing the reliability and ease of use of long-acting reversible contraception, such an Intrauterine Device or implant. The patient decides to try an IUD. The nurse indicates that her insurance covers it and tells the patient that the device can be placed right after the abortion. Throughout this conversation the RN is taking notes on the face-sheet.

The nurse places an IV in the patient's arm and then starts a video on a portable DVD that explains the procedure and some of the risks involved with different types of abortions. As the video starts, Naomi takes the IV-kit and leaves the room. Altogether Naomi spent about 25 minutes with the patient. Naomi has just started doing ultrasounds on her own, so she is still unsure that she is reading the measurements correctly. She calls the ultrasound tech over and hands her the printed ultrasound images. The ultrasound tech looks them over while the RN says, "I have her at eight-two" She has determined that the patient is at 8 weeks 2 days, in the first trimester. The ultrasound tech agrees. Naomi walks over to one of the computers and starts entering all the information from the face-sheet into the electronic chart, makes sure the ultrasound images merge into the electronic chart, orders lab tests and medications, and makes general notes. While the patient watches the video, the nurse finishes charting and goes to the locked room holding the clinics medications to get the IUD. She opens the package, throws away the outer box and puts the contents of the box in the plastic folder. In a small paper bag she puts a tab removed from the box that has some basic information about the IUD, some documentation

on follow-up care, and a dose of the antibiotic the patient should take later. She also staples a business card to the bag with that has the date of the follow-up visit in a few weeks to check that the IUD is still in place. She places the plastic folder in the holder on the exam room door and says in the general direction of the MAs standing nearby, “Room 2 is ready.” She opens the door slightly and turns on the yellow light above the door, indicating the patient is ready for doctor’s consent.

The MAs had been chatting in the lab, waiting for a room to be ready. Mai, and MA, goes over to the room, gets the chart and scans the face-sheet. She takes sticky note off the chart and hands it to another MA, Sam, and says, “can you call driver?” Sam walks over to the phone and dials the number on the sticky note, “Hi is this [drivers name]? The patient will be ready to be picked up in one hour. Thank You” Meanwhile Mai has gone into the exam room and greeted the patient, “Hi, my name is Mai. I’ll be assisting the doctor today.” She covers a metal tray on a wheeled stand with a “chuck”, a thin absorbent pad with plastic lining the bottom, and tucks the edges under the rim of the tray so it’s secure. Mai looks in a drawer under the counter to find a bundle of instruments wrapped in a thin blue cloth, unwraps the bundle, and arranges the metal instruments it contains on the tray. She squeezes some lubricant on one corner of the tray. Mai confirms with the patient that she doesn’t have an allergy to shellfish as she pours some iodine in a small metal bowl. She gets disposable latex gloves and some scopettes (huge q-tips) and places them on the tray. Since this patient has decided to get an IUD, Mai also sets up another tray with the IUD and associated tools. While she has been setting up, the patient has changed behind a curtain in the corner. She undresses from the waist down and puts her clothes in a plastic bag labeled “patient belongings.” The patient wraps a paper drape across her waist and walks back to

sit on the exam table. MA-H tells the patient that the doctor will be coming in to talk to her and pulls up the electronic consent forms on a computer.

Dr. Cain has been sitting at the computer station while the other staff have been tending to patients. During this time she has been "charting" (adding or editing information to patients' electronic records), fielding calls from the hospital where she also works, and chatting with other staff. Mai comes out of the room and says, "room 2 is ready for consent doctor." Dr. Cain finishes typing, logs out of the computer, sanitizes her hands and walks into the room. She introduces herself to the patient with a warm smile. "Hi, I'm Dr. Cain and I'm going to be doing your procedure today. Can you confirm your birthday for me?" Dr. Cain sits down on a low stool at eye level with the patient, asks how she is doing, and after a brief friendly exchange, asks, "Are you sure you want to terminate the pregnancy today?" and "Is anyone forcing you?" She confirms that the patient wants to get an IUD and discusses its risks. Then she has the patient sign forms using the touchscreen on the computer consenting to the abortion and consenting to the contraception. Dr. Cain gets up to leave, pauses, smiles, and says to the patient, "we're going to take good care of you." She clicks the switch to turn on the green light above the door, walks out, and puts the chart back in the holder.

After she sees Dr. Cain leave the room Mai calls to the nurse anesthetist, Dave, "Room 2 is ready." Dave has been sitting in one of the chairs in recovery area, looking on his phone, and waiting for patients to be ready. Entering the room, he introduces himself to the patient, and tells her, "I'm going to help you take a little nap today." He explains the sedation process and has her sign a consent. Mai, who is also in the room, helps her to lay down on the table and scoot down to the edge. She rests the back of her knees on stirrups and her lower legs and feet hang down over the edge of the table. Velcro straps secure her legs. Dave attaches the IV bag to the port in

the patient's  arm, puts on a blood pressure cuff and attaches heart rate monitors to her chest, and puts an oxygen mask over her face. He begins the flow of fentanyl and Propofol. When the patient begins to lose consciousness, he pushes a button that rings a bell for the doctor.  When Dr. Cain walks into the room, CRNA says, "This is [patient's name], age X".  He has the face-sheet clipped to a holder near his head. Throughout the procedure, he monitors the patient's vital signs as they are displayed on the machine connected to the blood pressure and heart rate instruments and makes notes in the patient's electronic chart.

Dr. Cain sits down on the stool and pulls the surgical tray close by. She puts on her gloves. Mai stands behind her. She takes the speculum, puts lubricant on it and inserts it into the vagina. She opens the speculum and orients it so that she can see the cervix. There is a light on a long bendable arm attached to the side of the exam table that she uses to help see into the vagina. Without prompting, Mai hands Dr. Cain a couple of scopettes dipped in iodine, which she rubs around the cervix. She uses a clamp to hold the cervix in place. This patient has had a prior vaginal delivery and so is a bit easier to dilate than patients who have never delivered. The doctor dilates the cervix using  a series of plastic rods increasing in size. Eventually the cervix is wide enough to insert the plastic tube attached to the machine that removes the contents of the uterus. Mai has already turned on the machine and is holding the tube waiting for the doctor to reach back. The machine hums as Mai hands the doctor the tube. Dr. Cain moves the tube in and out and at different angles for about 20 seconds. The pregnancy tissue is transported through the tube to a glass jar with a mesh bag affixed to the top. Without turning to Mai, the doctor hands the tube back to Mai and she places the bloody end in a plastic bag tucked onto the side of the machine.

Mai brings the IUD tray closer to the doctor and opens the package completely so the doctor can take the handle that holds the IUD. The doctor places the IUD in the patient's uterus. After checking that there is no unusual bleeding, she removes the speculum.

Mai takes the jar with the products of conception into the adjoining lab. A few minutes earlier Blanca, the MA working in the lab that day, had poked her head into the exam room to see how much time was left in the procedure. Mai now hands Blanca the jar and says "eight-two;" then goes back into the room. Blanca empties the mesh bag into a fine strainer, rinses the blood and other fluid with water, and then empties the remaining tissue into a square glass dish resting on top of a platform with a light shining on it. She uses a pair of tweezers to move the tissue around and find the gestational sac. Once she locates the sac, she moves it over to the side in the dish so that the doctor can easily see it when she comes into the lab to confirm that the pregnancy has been removed from the uterus.

Back in the patient's room, the doctor leaves and Dave finishes entering information into the chart. Mai begins cleaning up. She takes all the tools from the surgical tray and IUD tray into the lab and drops them into a sink. Blanca will soak, wash, and air dry and then sterilize them. Mai disconnects the one-use plastic tube from the suction machine and puts it in the hazardous waste trash. She uses disinfectant wipes to clean any blood on the floor. Dave removes the blood pressure cuff, heart rate monitors and oxygen mask from the patient. Chloe, who knew the procedure was over when the doctor left the room, comes in with a wheelchair while Mai gently jostles the patient's shoulders and calls the patient's name, saying, "It's time to wake up. Your surgery is over." Chloe retrieves disposable underwear, shorts, a large, thick maxi pad and some sanitary wipes from a drawer under the counter. Seeing that the patient is waking up, Dave leaves the room. Chloe unhooks the patient's IV bag from the metal hook near the

exam table and lays it on the patient's belly. She uses cavi-wipes (medical grade disinfectant wipes) to clean off any blood, tissue or excess lubricant from the floor, exams table, ultrasound machine and other parts of the room. Mai uses the sanitary wipes to clean the patient's body and pulls the disposable shorts and underwear up to the patient's knees. The patient is still very groggy and keeps falling back asleep. Both MAs keep talking to her, "[patient's name] can you scoot back on the table?", "[patient's name] we are helping you get dressed; stay awake." The patient is disoriented and asks "Wait, is it done? Did I fall asleep?" Mai assures her the procedure is over and everything went fine. She takes the patient's legs out of the stirrups and tells her that she is going to have to sit up soon. Chloe positions herself on the patient's side while Mai instructs the patient to grab her hands and sit up. Chloe grips the patient underneath one of her arms for added support. The patient is having a hard time staying up and keeps leaning to the side and sliding off the table. Both MAs brace themselves, Mai takes the IV bag from the patient's lap, tucks it under her arm and says in a now loud voice, "[patient's name] do you see the wheelchair behind me? You are going to sit in this wheelchair." "One, two, three, strong legs," she says, instructing the patient to use her legs to support herself. When the patient stands up, Chloe pulls up the underwear and shorts so the woman is covered. Mai rotates the patient so she can plop down into the wheelchair. Chloe gets the patient's belongings and hangs the bag on the handle of the wheelchair. Mai opens the exam room door and uses her foot to wedge a rubber door stop into the bottom to keep it open. She grabs the patient's chart on her way out the door and wheels the patient over to recovery.

Chloe stays behind to finish cleaning the room. She throws away the used drape, the paper from the exam table, and the chucks that were on the floor. She uses cavi-wipes to further clean the exam table and equipment. She checks that there is no patient information left visible

on the computer or ultrasound machine. To prepare for the next patient, she pulls a fresh sheet of exam table paper from the roll and extends it over the table, puts two chucks (disposable absorbent pads) on the floor in front of the exam table, and places a clean folded drape on the table. As Chloe is finishing up, Neda, an RN, walks into the room with a chart in her hand, asking "is this room ready?" Before Chloe can answer, Neda sets up the ultrasound machine for the next patient. Sam walks over to the doorway and turns off all three colored lights, signaling the procedure is done and the room is open.

In recovery, which is a large room, the patient is in a large reclining chair. The IV bag is hung back up on a metal hook. Sasha, the RN scheduled as the recovery nurse for that day, has placed a blood pressure cuff and heart rate finger monitor on the patient to measure her vitals. The patient rests for 25 minutes while Sasha reviews her chart and enters her vitals periodically and monitors two other patients. Sasha asks the patient to sit up and tells her that it is time to check her bleeding. She places the IV bag on a portable hanger on rollers, helps the patient to the bathroom, and hands her a bag of maxi-pads. Pointing to a chart on the inside of the door that has images of maxi pads with different amounts of blood, she tells the patient to check her own pad to see how much blood she has. She can then get dressed. After a few minutes the patient comes out of the bathroom in her own clothes and pulling the IV holder. She is walking slowly and looks tired. Sasha has her take a seat in one of the chairs at the end of the recovery area, offers her a cup of apple juice and a package of saltine crackers and asks, "what did your pad look like?" The patient responds, "Number 1." Sasha quickly says, "Okay, that's normal," without looking up and removes the IV needle from the patient's arm. She reminds the patient to take her second dose of antibiotics and reminds her of her follow-up appointment. Then she walks away

from the patient back over to her station and calls up to the front desk, “can someone walk out a patient?”

Laura comes back to recovery, picks up the paper bag with the patient’s name on it and the chart and walks the patient back out to the lockers. As the patient is getting her purse and putting on her shoes, Laura tells her that her driver is waiting outside in the car. She walks the patient to the checkout counter and hands the paper bag to the patient and the chart to Dani. Dani confirms that nothing else needs to be paid for, reminds the patient that she can access information about aftercare and her IUD through the clinic website and asks the patient if she could fill out a brief survey on an iPad mounted on the wall. After the patient leaves, Dani places ultrasound images, label stickers with patient info, and sticky notes in the locked bin for shredding. She cleans the face-sheet and places that and the folder back in the stack for use with the next patient.

## RESEARCH AGENDA

Since Roe v. Wade, a significant amount of abortion work migrated from hospitals and private practices to stand-alone clinics and most abortion care now takes place in these outpatient clinics (Jones and Jerman 2017). Abortion care has also evolved in response to changes affecting healthcare more broadly (Halfmann 2012). Features of this newer model of healthcare provision, which is heavily influenced by managed care, include a strict division of job duties, practices that maximize efficiency and revenue, and organizational cultures that prioritize doctors’ authority and expertise but also strive to meet the demands of insurance and state reimbursement structures (Conrad 2005; Scott et. al. 2000). Another new feature of modern healthcare practice is the increase in lower status health workers; medical assistants are increasingly being incorporated into healthcare as they provide less expensive labor than doctors and nurses (Chapman, Marks,

Dower 2015; Chapman and Blash 2017). In this dissertation I address the following questions: *How is abortion both similar to and different from typical healthcare? What are the implications for lower-status workers such as medical assistants?*

To understand the experience of contemporary abortion provision and the challenges it poses, I draw on several literatures in addition to that on abortion provision. From the scholarship on organizations, I take the concept of institutional logic. Institutional logics are organizing principles that structure everyday activities, interpersonal dynamics, and beliefs about the organization's purpose and efficacy (Haveman and Gualtieri 2017; Thornton and Ocasio 2008; Thornton, Ocasio, and Lounsbury 2012). Researchers have shown organization members transposing and combining logics, but also struggling to conform to their conflicting expectations. I draw attention to the ways in which a reproductive rights logic comes into decision making only when the routine medical logic breaks down, and I suggest possible consequences of a waning reproductive rights logic in abortion care. From the scholarship on intimate and stigmatized work, I draw insights into the ways in which organizations disparately position workers to balance more unpleasant with more emotionally rewarding work. My research in turn contributes to that literature by showing how intimacy's purposes can be framed in ways that make it more or less satisfying. From the scholarship on professional identities I draw insights on how low status workers are able to frame their work in terms of different purposes. This allows me to contribute to scholarship on abortion stigma by identifying some of the ways in which that stigma can be combated.

THIS DISSERTATION

In the next chapter, I provide a historical account of the provision of abortion and describe my research site, questions, methods, and mode of analysis. In Chapter 3, I explore

clinic staff's efforts to manage institutional logics of physician autonomy, patient centered care, market efficiency, and reproductive rights in the various decisions they make about care. The concept of institutional logics helps to make sense of the normative pressures on staff decision making. I show that a politicized feminist logic centered on reproductive rights figured in decision making less commonly than one might expect. In Chapter 4, I consider how work is organized and allocated among doctors, nurses, and medical assistants (MAs) in the clinic. I use the literature on dirty work and intimate work to explore how occupational hierarchies shape workers' orientation to abortion work. I show that that the most stigmatized work was unevenly distributed, and in a way that withheld from medical assistants some of the satisfactions of abortion work provided doctors and nurses. As a relatively newer occupation, medical assistants now play a role that did not exist at the time of Roe v. Wade. These low status workers are now critical to the provision of abortion, yet we know little about their roles in and experiences with abortion care. In chapter 5 I highlight MAs' trajectories into abortion work and their reflections on the advantages and disadvantages of their jobs. Medical assistants tend not to have the prior commitment to reproductive rights that doctors and some nurses do, yet they perform some of the most stigmatized work. I find that they find satisfaction in their jobs by focusing on the medical and scientific parts of their work. I also argue, however, that MAs' occupational training, social and familial relationships, and the clinic's organization logics prevent MAs from developing potentially positive professional identities linked to the provision of abortion.

Together, the chapters point to some of the liabilities of the dominance of a modern medical logic over a reproductive rights one, especially for those workers who have little prior connection to a history of advocacy for the rights of women to control their own bodies. Reliance on a modern medical logic refocuses abortion provision toward a routinized and

efficient form of care and away from politicized care centered on reproductive rights. To be efficient abortion work is broken up into tasks, compartmentalized and allocated to different occupations. This arrangement of work certainly makes abortion care look more like other forms of healthcare, but it does little to foster low-status workers' solidarity around abortion. A reproductive rights logic may not structure how abortion care is organized and provided in the clinic but it does shape how clinic workers think about abortion and their patients. The logic dictates that workers be wholly uncritical of abortion. Being nonjudgmental and somewhat detached from patients' circumstances is part of the professional ethos for physicians and nurses but it is not the case for MAs, whose training consists mostly of the technical tasks related to their work. MAs are told not to judge patients but they are not given guidance on how to not judge. Nor are they given tools for processing their complicated feelings about abortion. Positioning abortion work as just like any other health care job may theoretically destigmatize abortion workers, but it also creates the conditions in which the consequences of emotionally laborious work are not acknowledged. Lower status workers have little opportunity to learn how to reframe their work as something admirable, cannot share their work with family and friends, and do not benefit from professional prestige. The modern arrangement of abortion does little to recognize the needs of these workers nor does it remunerate them for the emotional work they must do to contend with the moral complexities of abortion.

## CHAPTER 2: BACKGROUND AND RESEARCH DESIGN

Before going into detail on the rationale for the current study, it is important to understand abortion as a historical and social practice. It is a practice situated in women's bodies but with different actors recognized as experts over time. Abortion is not a new or modern phenomenon and at different stages in history abortion has involved different routine practices.

### FOLK REMEDIES IN ANCIENT TIMES

Abortion in some form has likely been a practice since people figured out how to terminate pregnancies. Individuals who dealt with birth were likely the experts who facilitated abortions. When women knew they were pregnant and wanted to terminate the pregnancy they used abortifacients (medicinal plants and herbs) or engaged in activities thought to induce a miscarriage such as strenuous physical exercise or hot baths (Devereux 1954; Gordon 2002; Himes 1936). This knowledge was passed down through healers, family, and friends. For example, in the United States, enslaved Africans terminated pregnancies, undermining the system of chattel slavery, and were ultimately sought out by white people to be a resource for pregnancy termination (Roberts 1999). This type of termination continued over time and likely continues to this day under certain conditions. Here the practice of abortion, like other aspects of reproductive health, was localized, with a few experts and accessed through personal networks. This type of pregnancy termination was only challenged when struggles to control the field of medicine used the legality of abortion as a political tool.

### QUASI-MEDICAL (LATE 1800s)

During this time women's reproductive health was still a private matter and largely centered on pregnancy and childbirth, with experts being known midwives. A woman who found herself pregnant and didn't want to carry until term might contact the midwife who had helped

deliver her previous child or might look to advertisements in newspapers for homeopathic herbs or medicine. While there was no law banning abortion outright, the general consensus was that early abortions were fine and later abortions (after quickening) were homicide. Abortion was unregulated, which meant that there was not set of medical "best practices" taught or tested methods. In all, pregnancy termination could occur through physically removing the pregnancy tissue with implements (entering the vaginal canal, cervix and then the uterus) or inducing termination through medicine (herbs or pharmaceuticals). At the time, trained doctors, "quacks", and the general public largely believed that retained menses was a health problem for women, even though one of the main reasons women did not get their periods was because they were pregnant. Practitioners would advertise remedies for "uterine" dysfunction or retained menses and would indicate that the medicine was not for "married women" as a way to communicate that the medicine would terminate pregnancies.

Over a period of years in the late 19th century, physicians attempted to distinguish themselves from "quacks." Abortion became one of the ways for doctors to professionalize, turning themselves into a skilled and exclusive professional group. The new profession wrested the provision of abortion from midwives and homeopaths and obtained a monopoly on the procedure; only licensed physicians now could perform abortions. Just as important, only physicians now could decide whether a woman could have an abortion. Rather than a personal decision about a non-medical issue that a woman could privately handle on her own, pregnancy termination was now exclusively controlled by the medical profession. While the list of acceptable reasons for a woman to terminate was long, thus offering great flexibility in how the law was interpreted, the medical profession was the gatekeeper for abortion. (See Beisel and Kay 2004; Gordon 2002 for an expanded history).

FULLY MEDICALIZED (1900 – 1950s)

By the early 20th century, states had adopted laws giving power to doctors to decide whether a woman could have an abortion and giving them the exclusive authority to perform abortions. With discretion to determine what qualified as a legitimate cause for an abortion, some doctors were more liberal than others in their assessment. During this time a woman who wanted to terminate a pregnancy could 1) hope that her doctor would find the abortion to be medically necessary or 2) find an illegal "abortionist." Advances in medicine meant that health conditions that had traditionally been contraindicators for abortion (e.g. tuberculosis, cardiovascular disease, etc.) were less common. Increasingly, doctors cited mental or social reasons for providing abortions. As more medicine was consolidated in hospitals, Therapeutic Abortions Boards were convened to make sure that doctors were following the rules and not overprescribing abortions. This meant a woman seeking a legal abortion had to convince a doctor and then a hospital board that pregnancy termination was necessary for her own health and safety. To circumvent this system, women sought out illegal abortions. People would share information through their social networks about how to get an abortion. In the late 1950s people began to argue for more liberal abortion laws.

POST ROE (1973 – EARLY 2000s)

After a series of legal battles, women gained the right to choose for themselves whether to have an abortion in 1973. Pro-choice activists, however, were not the only ones advocated for greater legal freedoms for abortion, doctors had a professional interest in legalizing abortion. Roe v. Wade freed up doctors from having to navigate the precarious legal standing of abortion. Prior to the Supreme Court's decision many doctors had to get approval from a Therapeutic Abortion Committee before each abortion to prove that pregnancy termination was medically

necessary. To protect themselves pro-choice doctors were creative in how they framed the reason for abortion because the only legal abortions were those approved by the committees (Luker 1984). Stand-alone clinics emerged as an option for women seeking abortions, as an alternative to turning to their general physicians. While abortion was legal it remained marginalized in mainstream medicine (Freedman, 2010). Marginalization was a result of two factors. First, feminist reproductive advocates wanted healthcare settings structured according to ideals of women's autonomy, reproductive freedom, and egalitarian practices. In other words, abortion clinics were purposefully set apart from traditional medical settings as a radical alternative. While feminist ideals led abortion providers to pull away from mainstream medicine, abortion was also pushed from mainstream medicine by the stigma it carried. The practice of pregnancy termination occupied a marginal status in reproductive healthcare as it was not a standard part of obstetric and gynecological training. There were many barriers preventing doctors from getting the proper education and experience to learn how to do abortions and obstacles to their practicing abortions once they had been trained (Freedman, Landy, Darney and Steinauer 2010). Joffe 1995 These obstacles deterred doctors from providing abortions. Additionally, the stigma associated with abortion transferred to the doctors who did practice abortion. So, while the practice was legal and safe, it was not widely discussed in the medical community (Harris, Martin, Debbink, and Hassinger 2013.). The pull and push away from mainstream medicine resulted in the proliferation of free-standing clinics. This new space for abortion created new occupations. It also created new workplace hierarchies.

Women with enough resources and a vision could open an abortion clinic. Doctors were contracted to work in these clinics, but the clinics were not centered on a purely medical mission (Halfmann 2012). Some clinics attempted to incorporate progressive ideologies emphasizing

egalitarian relationships among staff and recognition of power imbalances based on race and gender (Simonds, 1996). This made it possible for new lay (non-medical) staff to participate in abortion care and the abortion counselor emerged as a new occupation (Joffe 2013). These abortion workers were mission driven and were drawn to the work because of their belief in reproductive rights. The abortion counselor's job, in addition to getting informed consent and explain the details the procedure, was to provide time and space for the abortion seeker to process their decision and to offer resources and support either in groups or in one-on-one sessions (Joffe 2013). While some abortion counselors were trained as social workers, they were not necessarily medical professionals.

After some time, the vast majority of abortions were performed in free-standing clinics, which included large affiliated groups of non-profit clinics, such as Planned Parenthood, small independent non-profit clinics, and private clinics (Jones and Jerman 2017). While the technical aspects of terminating a pregnancy are largely the same regardless of where the abortion occurs, the practice of abortion may be different in these different settings. A larger network means greater resources and more shared, standardized practices for clinics like Planned Parenthood. Independent clinics have the flexibility and autonomy to have narrower missions and adhere to more radical notions of healthcare. Finally, for profit clinics must focus on generating revenue. Regardless of the setting, extreme violence and threats of violence have meant that clinics have had to increase their security and to be hyper-vigilant to protect workers and patients (Joffe 2010).

Abortion care's turn toward efficiency occurred largely during the period immediately after legalization. Stand-alone clinics quickly developed structures and processes to provide access to as many people as possible. This meant using space, personnel, and time efficiently.

Doctors were needed legally for their credentials and expertise but other non-medical staff were equally important in the clinics (Halfmann 2012; Simonds 1996). Concurrently, managed care emerged and marked a decline in physicians' authority in all aspects of medical care. During this time, physicians increasingly were employed by large health care organizations, which had an interest in the cost-effectiveness of the services offered to patients (Scott, Ruef, Mendel, and Caronna 2000). Though free-standing clinics are not part of big managed care systems, clinics are influenced by ideals and practices of managed care; both contexts often contract with doctors and other specialists (rather than hiring them as staff), seek to streamline care to reduce inefficiencies and maximize productivity and have to navigate complicated insurances reimbursement structures (Kavanaugh, Jones, and Finer 2011; Scott, Ruef, Mendel, and Caronna 2000).

## PRESENT NATIONAL AND CALIFORNIA CONTEXT

While abortion care is widespread and is routinized in the clinic setting, it has long been the subject of public controversy and point of concern for politicians. Continuous pressure from anti-abortion legislation and sustained aggression from anti-abortion activists means that the practice of abortion varies widely across the United States (See Guttmacher Institute's state by state analysis of abortion regulations). Targeted restrictions on abortion providers or "TRAP" laws have emerged as a tactic of anti-abortion advocates as a way of limiting access to abortion by setting strict medical-related requirements on the practice of abortion in certain states (Cohen and Joffe 2020; Mallampti, Simon, and Janiak 2017). For example, requirements related to the relationship between clinics and hospitals, the clinic's proximity to schools single out abortion care as different from other outpatient services and severely limit access to abortion in certain locations (see for example Leslie et. al. 2019; Mercier et. al. 2015; Roberts et. al. 2015). These

laws have been passed in more conservative states; however clinics nationally are influenced as they consider how best to protect themselves from similar legislation in their own states. The clinic under study is part of a nationwide federation of clinics organized into regional groups. While the smaller groups have some autonomy in deciding their own policies and procedures based on their state's legal context, there is some standardization across the federation.

In 2000 mifepristone, the "abortion pill," was approved by the FDA, providing a non-surgical option for terminating pregnancies in the first trimester (Schaff 2010). Pregnancy termination that makes use of mifepristone, or "medication abortions," was incorporated into some clinic's services, instigating new routines for care and (Clark, Gold, Grossman, Winkoff 2007). As a non-surgical option, mifepristone made it possible for abortion to be administered by healthcare providers other than physicians, such as nurse practitioners and physicians' assistants. The conditions for how mifepristone can be administered vary across the country; 27 states allow non-physicians to provide the drug and 18 states prohibit the drug being prescribed through telemedicine by requiring clinician be present during the procedure (Guttmacher Institute 2020). For methodological reasons, medication abortion (MAB) is not the focus of this dissertation. To maximize efficiency, MABs were not performed by doctors and were scheduled at clinics other than the one to which I had access. Unlike surgical abortions, MAB appointments were not concentrated on specific days but were dispersed throughout other types of appointments. Medication abortion represents a further move away from physician's authority and even clinics themselves as women can find these pills online without going through licensed healthcare providers. This may signal a return to self-managed pregnancy termination.

California is one of the states in the United States with the fewest restrictions on abortion. People who are pregnant have access to medication abortion up to 10 weeks and surgical

abortion up to 24 weeks (California Health and Safety Code 123464(d)). Non-physician medical professionals (e.g. Nurse Practitioners and Physician's Assistants) can perform medication abortions (California Business and Professions Code 2253(b)(2)). The Guttmacher Institute tracks abortion related laws and reports the following facts about California. There are no mandated waiting periods or mandated topics for discussion during abortion counseling with patients. Perhaps one of the strongest indications of the broad political support in the state is public funding for abortion; California is one of 16 states that pays for abortion with state funds. While efforts to restrict abortion have been unsuccessful at the legislative level, anti-abortion activists use other strategies such as protesting outside of clinics, crisis pregnancy centers (CPCs), and 'undercover' videos aimed at discrediting abortion providers. In addition to protecting access to abortion, California legislators have been proactive about prohibiting obstruction to clinics, threats, damage to property, and online harassment. The state also regulates CPCs requiring them to inform people of public funding for reproductive health care services including contraception and abortion. Altogether this relatively supportive and protective environment presents a best-case scenario for abortion care in the United States. Empirically, this study documents surgical abortion care in a context where clinics do not have to contend with combative legislative environments and thus can operate more like other surgical outpatient clinics.

The final factor to consider is the use of certified medical assistants in the clinic. This decision was made by the regional administers. All personnel who work with patients in the clinical setting have some kind of healthcare related credential. This may not be the case in clinics across the country or even in other areas in California, where laypeople interested reproductive healthcare and rights can be engaged in abortion work. While use of MAs may be

somewhat unique in abortion care, it is prevalent in healthcare more broadly. Medical assisting and other low-barrier-to-entry health occupations are some of the fastest growing occupations nationally and are projected to increase over the next 30 years (Bureau of Labor Statistics 2020). Use of MAs in the clinic acknowledges the medical and technical nature of abortion while also reducing doctors' and nurses' roles which reduces labor costs for clinics.

Considering the national and local contexts, the California case is an example of a best-case scenario for accessing abortion. People who are pregnant have easy access to both medication and surgical abortion throughout the majority of their pregnancy. With few TRAP laws creating hurdles to care, more clinics are able to easily provide abortion care. Given the polarization of views about abortion nationally it is unlikely that the country as a whole is moving to be more like California. But while California is unique within the country, it offers a glimpse of what abortion can be like when it is accessible and efficient and in doing so highlights some of the tensions in abortion care. Some of the protections on abortion's accessibility in California also make the procedure more efficient for providers. For example, without mandatory waiting periods or required counseling topics clinics have shorter and fewer appointments and are able to schedule more patients. Increased funding support and later gestational cutoffs means there are more abortions to perform. Clinics in California need to be more efficient and strategies offered by managed care become effective tools to help clinics meet increased demand. Additionally, California clinics are influenced by private insurance and state reimbursement structures and policies and so are not completely autonomous from managed care. While scholarly attention should be concerned with how excessive regulation affects abortion access and shapes the kind of care doctors and medical professionals can provide, we should not ignore

what abortion care is like when it is mainstream and accessible. In what follows I describe the methodology for this project.

## DATA AND METHODS

My work examines the institutional and social context of abortion work, rather than abortion as a discrete event (Almeling 2015; Timmermans, 2007). As social "phenomena cannot be analyzed divorced from their social and cultural contexts" (Atkinson and Pugsley, 2005 pg. 230), ethnographic methods are best suited in highlighting the process and complicated relationships present in abortion work. Ethnographic research is centered around a field site (e.g. an organization, social movement, social group, etc.) and requires the researcher to be embedded in the field site over a span of time to document social life in the contexts in which it occurs. Data is collected through observing activities, routines, behaviors, and social relationships, by interviewing members of the site, and may include analyzing documents or other artifacts produced within the field site. Ethnographic work in medical sociology has been essential in documenting how macro-, meso-, and micro-factors work together to shape healthcare (See: Becker, Huges, Greer, and Struass, 1961; Joffe, 1986, Reich, 2016; Trotter 2020). For the proposed research, observations in the clinic allow me to understand how work is organized, how staff from different occupations interact with each other and their work, and how staff respond to various organizational constraints.

The field site is a stand-alone health clinic in Southern California. The clinic provides a wide range of services related to reproductive and sexual health. Staff at the clinic include administrative medical assistants (front desk staff), management, medical assistants (who assist the doctors with procedures), registered nurses, nurse practitioners, certified registered nurse anesthetists, ultrasound techs, and doctors (see Table 1 for a brief description of staff positions). I

chose to observe surgical abortions rather than medication abortions because surgical abortions are more complex and require more staff. Surgical abortions are only offered three days a week and those days require the most staff on hand. On surgical days, the clinic has on average 20 patients scheduled. However, there are often no-shows, turn-aways, or referrals, which reduce the number of actual abortions performed on any given day. Patients are turned away if they are too far along in the pregnancy, if they seem unsure about their decision, seem under duress, or under the influence of drugs or alcohol. Referrals to a hospital happen when the procedure is deemed risky due to health factors (e.g. heart problems, low hemoglobin, etc.). This clinic has a referral partnership with a nearby hospital where some of the doctors from this clinic also work. The clinic is part of a large federation of clinics and health centers and while they have to adhere to state-level policies and procedures, they are also bound by rules and regulations set by the federation. In the following sections I will describe the clinic and my methodological approach to data collection.

*Table 1.1. Workers at the Clinic*

| **Position** | **Duties** | **Education/Training** |
|---|---|---|
| *Doctor* | Conducts the procedure responsible for all outcomes | M.D. required |
| *Management* | Operations and responsible for clinic outcomes | At least B.A. |
| *Front Desk* | Reception and insurance | H.S. (equiv) |
| *Nurse Anesthetist* | Sedation | Masters level |
| *Nurse Practitioner* | On surgical days same duties as RNs, can also give medical abortions | Masters level |
| *Registered Nurse* | Patient assessment and counseling | B.A. + credential |
| *Ultrasound Tech* | Conducts ultrasounds | H.S. (equiv) + certificate |
| *Medical Assistant* | Sets up and cleans up rooms, assists doctor during procedures | H.S. (equiv) + certificate |

## *The Clinic*

The clinic is in a mid-sized southern Californian city but serves the larger county population. The county has large populations of Latino and Asian immigrant communities and a large white population, and includes low-income, upper-middle class and extremely wealthy cities and communities. The clinic is part of a network of clinics and is housed in a building that also includes the call center that services all the clinics in network and the offices of upper management (e.g. executive directors, HR, program managers etc.) who oversee all the clinics. The building is highly visible due to its size and location on a busy street. Yet it is relatively difficult for protestors to access the site because the building is situated between an entrance and exit to a highway, without any neighboring lots. Protestors have to park a few blocks away and walk. The lot the building is on is surrounded by walls and fencing. A brick wall faces the street with an opening for cars to enter the parking lot and the wall is situated almost right up against the sidewalk which keeps protesters away from the entrance to the building. The remainder of the perimeter is surrounded by high chain-link fencing. There is a bit of this fencing on the front of the lot facing the street and occasionally anti-abortion protesters will tie signs or images to the fence. Security guards and facilities people are tasked with taking down these signs. The parking lot is long and narrow and is at times overly full. There is a very small garage underneath the building where the doctors and high-level administrators park and where some supplies and waste are stored. The garage remains locked throughout the day and one needs an opener or code to access it.

The building itself is unassuming, brownish with darkened windows. From inside the building one can see out but one cannot see in from the outside. The name of the clinic is high on the building in big letters but without any other signage or ornamentation. There a few planters with succulents near the entrances of the building and a bench for people to sit. There are a few

doors to the building but only two entrances. One entrance is for the clinic and the other is for the admin/call center side. There is an emergency exit that is used for dropping off blood and tissue samples in a little box to be picked up for testing by outside labs. The clinic went through a big remodel during my field work. What resulted, in addition to newer facilities, was a clearer separation between the rooms used for surgical procedures and the family planning side.

*Data Collection*

I collected data from July 2016 to February 2018. I gained access to the clinic via the medical director at the time. She was eager to have more social science research focused on abortion and she reached out to my advisor. My advisor recommended me for the project and so I began meeting with the medical director to discuss a possible research project. Gaining access from the top down has benefits and disadvantages when it comes to ethnographic work. On the one hand, approval from the top is absolutely necessary in a hierarchal setting and one that deals with patients and their health around a controversial topic like abortion. On the other hand, being introduced by the boss meant that staff were unsure of my role and my relationship to the clinic's management. While staff were used to having outside people come and observe (medical students, residents, etc.), my role as a researcher was different and my sustained engagement was also different.

Some people thought I worked for the clinic under the supervision of the doctor in an evaluator capacity. Others thought I was a MD who was learning more about family planning. The staff was used to people shadowing the doctors and so having a new person who was friendly with the doctors was not new to them. The doctors all understood my role as a researcher, though they were confused about what ethnography was as a research method. The nurses and medical assistants were less familiar with my role as a graduate student and lumped

me with other medical doctors in training. People occasionally asked questions about what I was doing or asked, "what is your paper about" and I explained that I was interested in how abortion clinics are run and how workers do their jobs.

To address my research questions I needed to document both *what people do* and *how people make sense of what they do*. This approach required that I observe organizational dynamics and staff behaviors in the context in which they occurred and that I talk to people about these dynamics and their perspectives on their work. Thus, I employed participant observation and interviews for data collection. Scholars have identified the tension in qualitative work using human subjects between what people do versus what they say they do (Jerolmack and Kahn, 2014). By collecting both observed and interview data I can begin to adjudicate between competing perspectives on people's actions and motivations.

*Participant observation*. After receiving IRB approval for the project, I began participant observation in July 2016. I ended my clinic observations in December 2017. On my first day of data collection, the office manager introduced me as a student researcher during the morning "huddle." The huddle is a daily meeting with all staff working at the clinic that day. The huddle lasts about ten minutes and during this time the office manager shares announcements and clinic updates. For the first couple of visits, I stayed close to the office manager or the doctors, both of whom I had already met before the project started. The office manager shared some ways I could be helpful; helping to clean rooms after a procedure and prep for the next patient, escorting patients from the waiting room to the procedure room, bringing warm blankets or magazines to patients who were waiting. My role in the clinic evolved to helping with flow facilitation, which meant monitoring the various stages of appointments and coordinating which patients would go

into which rooms, monitoring the order of procedures, knowing which staff were in which room and helping keep track of the moving parts of their complex system for appointments.

Over time, people got used to me being there, began to trust me with tasks, and in general were more open and welcome. I occupied a different space than most other observers. I was not a doctor in training, like the residents and medical students, and thus did not have any high-status markers attached to me. I believe this led the medical assistants to open up relatively quickly. I constantly deferred to them and tried to help them as much as I could. I had no medical expertise and so was in a position to be able to learn from all staff, regardless of occupation. As a graduate student, the doctors and to a certain extent the registered nurses could identify with my position as a researcher rather than simply as a college student. However, the medical assistants saw me as more of a college student.

On days that I was at the clinic, I spent approximately eight hours there (8am – 4pm). I started the project going two consecutive days a week and then after about nine months started going one day a week. Throughout the day I made notes on interesting or important events or conversations in a small notebook that fit into the front pocket of my scrubs. At the end of the workday I sat in my car and immediately recounted the events, conversations and anything else I could remember into an audio voice recorder. Then within a day or two I transcribed these field notes into a document. I used transcribed field notes for coding during analysis. Throughout the process of data collection and analysis I wrote analytical memos when possibly important themes emerged. I used these memos to inform my coding scheme for subsequent data analysis.

After I became more familiar with the site and the staff were comfortable with me, I started making more targeted observations. I identified which areas of the clinic, procedures, or occupations I knew least about and made sure to spend time observing those things. I also spent

some time observing the family planning side of the clinic, where abortions are not provided. By doing so I was able to explore whether the phenomena and relationships I observed were idiosyncratic to "surgical days" or that particular clinic itself.

*Interviews.* Interviews with clinic staff serve as a secondary source of data for this study and began in October 2017 and ended in February 2018. Interviews provided an opportunity for clinic staff to reflect on their experiences and explore their rationales for their actions and beliefs. I did not collect interview data to simply supplement observation data but to complicate the observational data and to explore the conflicts that arose when people attempted to make sense of their behavior. During interviews, I was able to 'test' my preliminary analyses of observational data and explore whether the themes I identified as important were salient for participants. Practically, interviews provided an opportunity to sit relatively uninterrupted with individual members of the staff and to get background information on certain topics. The clinic environment is fast paced with people focused on their job duties. While I did ask questions about the specifics of the work in the moment (e.g. What does this instrument do? What does "GCCT" mean?), it was not feasible or appropriate to ask more in-depth questions during work hours. Interviews gave me an opportunity to probe for more detail, ask follow-up questions, and collect systematic data.

Questions for the semi-structured interviews were developed after spending some time in the field. During interviews I asked about how staff came to be abortion providers and about their perspectives on abortion work, I collected data on respondents' backgrounds (e.g. education and training), professional experiences (eg. previous employment), and on the length of time they had worked at the clinic.

Another purpose of the interviews was to prompt respondents to reflect on times when they felt tension between organizational requirements and norms, on one hand, and their personal moral frameworks, on the other. Drawing on Grant, Morales, and Sallaz (2009), I asked them about relational aspects of their work as it pertained to interaction with other staff and networks outside of the clinic (e.g. family and friends). While I was able to observe dynamics between staff, in interviews I was able to tease out what staff thought of their relationships. My in-clinic observations did not provide much insight regarding the interplay between staff's organizational lives and personal lives. While people talked openly about their families in a day-to-day manner, little conversation occurred about the relationship between their work as abortion providers and their lives outside of the clinic. Interview data shed light on whether and how their personal lives and works lives collided.

All members of the staff at the clinic were eligible to be interviewed. I began recruiting for interviews in fall 2017. Due to my consistent presence and relative integration into the clinic, I anticipated a high response rate and hoped to collect at least 20 interviews. However staff did not respond readily and I ended up with 17 interviews. An email was sent out to the staff from the office manager letting people know that I was recruiting for interviews and giving them my email address. I also asked people when I saw them in the clinic. Interviewees were offered a $40 gift card from Target as an incentive. Even with the incentive and friendly personal connections with staff, recruiting was more difficult than I had imagined. I do not know exactly why staff were hesitant to be interviewed. It could be that they were simply too busy and did not want to make time during their days off from the clinic or that they were nervous about being interviewed. My personal relationships with staff was a factor as the those who I worked with most often were more likely to agree to be interviewed. It is possible that other staff were still

unsure of me, my research, and my role in the clinic. Interviews were between 1 – 2 hours long and at a time and place of the respondent's choosing. Interviews were audio recorded and transcribed.

*Analysis*

Transcribed field notes and interviews were uploaded into ATLAS.ti, a qualitative coding software. I used the concepts and events I had reflected on in memos to construct a foundational coding scheme. Analysis was an iterative process and somewhat specific for each of my substantive chapters. Each chapter included a process of initial coding, analytical memos and subsequent coding.

*Analysis: Chapter 3*

Data from this chapter primarily came from ethnographic observations. I was interested in how organizational priorities were made evident in clinic routines. The literature on institutional logics helped me to make sense of my observations. A clinic remodel and transition to a "patient-centered flow" occurred during my fieldwork, providing a useful example of how the clinic organized routine care. I also wanted to understand logics within the context of non-routine care and so I looked to instances of decision making around patient care that was not routine. In my field notes, I coded for "decision-making" and then analyzed the contexts of each of those decisions. I considered who was involved in the interaction, the rationales used for certain decisions, the outcome of the decision, and how actors felt about the outcome.

*Analysis: Chapter 4*

Data analysis occurred in multiple stages. First, I described in detail the routine for the average surgical abortion, from when the patient walks in the clinic door to when they leave with their driver. Based on that typical appointment scenario, I listed the specific tasks and processes

that made up the appointment, and which staff members were responsible for those tasks and processes. From there I went back to my fieldnotes and coded for these tasks and processes. For example, I had codes for examining products of conception, taking patients' medical history, obtaining consent, and cleaning rooms. Next, I applied the parameters for intimate work or dirty work to this sub-set of coded data, because not all work in the clinic falls under the categories of dirty or intimate. Finally, I considered these instances of intimate or dirty work in the context where they occurred. Knowing that these tasks were a part of the routine was different from understanding when, how, and under what conditions they occurred.

*Analysis: Chapter 5*

The data for this chapter came from one on one interviews with MAs outside of the clinic. I met MAs at coffee shops, parks, and even a bar to talk to them about their experiences with abortion work. In this chapter I use data concerning their educational and career trajectories, their perceptions on the advantages and disadvantages of their jobs, and their ability to talk about their jobs outside of the clinic.

*Positionality*

More so than one-off interviews, sustained participant observation at one field site brings up ethical considerations (Duncombe and Jessop, 2002). Participant observation provided increased opportunity for deeper relationships between participants and myself. During my time in the clinic I felt tension between my attempts to be a relatively unbiased and objective observer and to consider the interests of individual staff, the organization, and the pro-choice movement at large. It is important that I acknowledge my pro-choice stance. As I increasingly became part of the clinic culture, I had to ask myself: What data is fair game? When and how do I 'turn-off' my data-collection activities? How do I signal that I'm a researcher without setting myself too much

apart? In a practical manner, taking notes helped to remind people that I was a researcher. My interactions with the doctors also set me apart, as I had more friendly and less deferential relationships with two of the doctors than did other staff. After some time in the field I had to remind myself that I was a researcher. I got so caught up in my duties and being a part of the team that I forgot to make note of the goings on in the clinic. There were some days where I would be there for a few hours before I realized I hadn't taken any notes. The fieldnotes toward the end of my study were much shorter.

As noted above, clinic staff represent a variety of occupations with varied responsibilities. Associated with these occupations are different organizational and social statuses. It is unclear to me now how these varied statuses may affect the interview process or the data collected. Doctors are professional and social elites and thus interviewing them may pose certain challenges (Odendahl and Shaw, 2002). However, my educational background is more similar to doctors than to, say, the medical aides with whom I may have other types of demographic similarities. Either way, there are challenges associated with interviewing groups outside of the researcher's own social groups (Adler and Adler, 2002; Oakley, 1981; Reissman, 1987). This project offers an interesting juxtaposition as I will be included in and excluded from the social groups of different participants simultaneously throughout the course of the study. Being that some of my research questions concern staff and social hierarchies, I will take care to notice and acknowledge when my own position has the potential to affect clinic dynamics.

Finally, as the only Black 'worker' in the clinic I was highly visible to other staff and to patients. I cannot say how the "controlling images" and stereotypes of Black women shaped others' perceptions of and interactions with me (Collins 2000; Wingfield 2007). Before I started collecting data I was interested in exploring the experiences of Black patients and particularly

how ideas of motherhood and reproductive governance played out in their care. When started fieldwork, however, I found there were few Black women coming to the clinic. This could have been due to the geographic location of the clinic, there are very few Black people in the surrounding area, or maybe because Black women were going somewhere else for their abortions. Regardless of the reason, I decided to shift my gaze from patients to the workers. As with any space where I have been the only Black person there were moments when I felt isolated or marginal in some way. This has been my experience for much of academic and professional training. I have not fully explored how this has shaped my data collection, analysis, and conclusions but look forward to thinking through this in the future.

## CHAPTER 3: ROUTINES, DECISION-MAKING, AND A REPRODUCTIVE RIGHTS LOGIC

Abortion as a medical practice has changed in the decades since Roe v. Wade. Soon after this landmark decision, a significant amount of abortion work migrated from hospitals and private practices to stand-alone clinics and most abortion care now takes place in these outpatient clinics (Jones and Jerman 2017). Recently anti-abortion advocates have sought to limit access to abortion with Targeted Regulation of Abortion Provider (TRAP) laws, which have been particularly effective in conservative states (Cohen and Joffe 2020; Mallampti, Simon, and Janiak 2017). Much of the recent research on abortion provision in clinics has focused on the barriers created by these anti-abortion policies (see for example Leslie et. al. 2019; Mercier et. al. 2015; Roberts et. al. 2015). Abortion care has also evolved in response to changes affecting healthcare more broadly (Halfmann 2012). Features of this newer model of healthcare provision, which is heavily influenced by managed care, include a strict division of job duties, practices that maximize efficiency and revenue, and organizational cultures that continue to prioritize doctor's authority and expertise but also strive to meet the demands of insurance and state reimbursement structures (Conrad 2005; Scott et. al. 2000). Research on the effects of modern models of healthcare has studied the changes to healthcare workers' jobs. Morris (2018) found that nurses in obstetrics departments had to shift from being "patient-oriented" to "process oriented" as a result of the changes brought on by the Affordable Care Act. Efforts to serve as many people as possible while simultaneously reducing costs have pushed hospitals to implement protocols that maximize efficient use of staff labor, resulting in increased monitoring and specialization of duties (Reich 2016). Bridges (2011) demonstrates how one hospital's reliance on Medicaid and emerging technologies resulted in health workers becoming complicit in systems of racialization

and surveillance of "at-risk" pregnant African American women. Similar to these studies, I am interested in how healthcare is organized given current healthcare models. In particular, I am interested in how abortion providers balance institutional logics of contemporary health care with a reproductive rights logic from the women's movement.

I find that aside from the security measures, a reproductive rights logic is not much in evidence in clinical operations. I define a reproductive rights logic as one that prioritizes women's autonomy, normalizes abortion, and emphasizes the political nature of the abortion care. Earlier ethnographies of abortion clinics provided evidence for a reproductive rights logic in action; patients spent time processing their feelings with abortion counselors or in group sessions, non-medical staff were more integrated into the clinic, and efforts were made to incorporate a feminist praxis in clinic operations (Joffe 1986; Simonds 1996; Wolkomir and Powers 2010). In this chapter I discuss the challenges inherent in abortion care being routinized according to mainstream medical practices. First, I show how a modern medical logic (based on physicians' authority, demands from managed care, and attention to customer service) structures the routinized care in the clinic. In doing so, abortion comes to resemble other outpatient surgical care. Second, I show what happens when the routine breaks down and clinic staff have to make non-routine decisions with regard to patient care. Doctors at times intervene with a reproductive rights logic to justify their decisions but do so at their own discretion. I conclude this chapter with implications for what this means for abortion work and abortion workers; namely that the lack of a politicized logic as a strong organizer in clinic operations results in workers with differing orientations to the politics and provision of abortion.

Pregnancy termination, or abortion, and women's reproductive healthcare in general has always been politicized. Politics, however, are not the only factor shaping abortion care.

Emerging technologies, medical advances, along with shifting cultural norms and evolving legal contexts have resulted in authority over many aspects of women's reproduction being concentrated in the field of medicine (Halfmann 2012, Luker, 1984). At the same time, many healthcare organizations have increasingly embraced models for care which prioritize market-based efficiencies and customer service (Scott, Ruet, Mendel, and Caronna 2000). Influence from these diverse institutional spheres (e.g. medicine, law, managed care) surely affects how abortion care is provided. These influences along with the politics associated with abortion, converge to structure the conditions of abortion care.

## INSTITUTIONAL LOGICS

Institutional logics are organizing principles that create shared meaning, order hierarchies, allocate value, rewards, and punishment, and set criteria for evaluation (Haveman and Gualtieri 2017; Thornton and Ocasio 2008; Thornton, Ocasio, and Lounsbury 2012). Within an organization, institutional logics structure everyday activities, interpersonal dynamics, and beliefs about the organization's purpose and efficacy, among other things (Haveman and Gualtieri 2017). Institutional logics infuse broad institutional agendas and perspectives into organizational life and activities and are more expansive and far-reaching than organizational culture. Institutional logics operate within organizations and organizations may represent various institutional spheres (Friedland and Alford 1991; Thornton and Ocasio 1999). Take for example, a disciplinary department within a university such as psychology or history. This department may be part of multiple institutions including the university, the discipline, and higher education broadly. Each of these institutions may have different criteria for how the department should function and behave and have different assessments of success and failure. The clinic under study operates at the intersection of multiple institutional spheres of influence, all with their own

logics. Institutions of which the clinic is a part include health care broadly, community clinics, women's healthcare, medicine, nursing, and the massive federation of related clinics of which the study clinic is a member.

Scholars examining healthcare have documented social, cultural, and historical shifts in institutional logics (Haveman and Gualtieri 2017). Mainstream, western, medicine has shifted from logics centered on physician's authority and quality care to more bureaucratic and state affiliated models, and most recently to the market model that prioritizes privatization and efficiency (Scott, Ruef, Mendel, and Caronna 2000). Another documented shift has been to more "integrative" models for medical care, which promote more holistic and preventative approaches to health and position physicians as guides rather than ultimate authority (Heinze and Weber 2016). The field of women's reproductive healthcare, and abortion specifically, have also experienced historical shifts. With new technologies and the professionalization of doctors in the 19th century, abortion services migrated from the realm of midwives and naturopathic remedies to doctor's private practices and hospitals (Luker 1984). When abortion became largely criminalized later that century, abortion services moved underground until 1973 brought the legalization of abortion and with it a new space for abortion. Stand-alone family planning clinics, focusing on women's reproductive health, offered a third space different from the medical mainstream and the 'back-alley'. Legal and political fluctuations have determined which institutions lay claim to abortion work and in turn, the logics operating within abortion are surely affected.

When organizations operate within the context of multiple institutional logics some logics gain primacy over others (Besharov and Smith 2014). Acker (1990) argues a gendered logic undergirds all workplace organizations, preventing feminist or at the very least more

egalitarian organizing principles from emerging. Some logics are simply more powerful than others with "higher-level" and "lower-level" logics existing within a "nested hierarchy" (Haveman and Gualteri 2017). Ethnographic accounts of healthcare organizations have found that logics centered on bureaucracy and professionalism greatly influence organizational culture and structure regardless of organizational missions to promote other types of logics (Joffe 1986; Kleinmann 1996; Reich 2016). As logics shape the expectations for daily work, organizational actors strategically employ logics to achieve their desired goals (McPherson and Sauder 2013). Workplace hierarchies translate into some logics having more influence on organizational norms, processes, and decision-making as higher status workers elevate some logics over others (Besharov and Smith 2014; Heimer 1999). The transition from abortion care being mostly informed by a reproductive rights logic to a modern medical logic creates conflict.

Like medical practice in general, care at the clinic is structured in such a way as to standardized medical providers' decision-making through prioritizing evidence-based medicine, best practices, and systematic processes set forth by the medical community, insurance companies and other bureaucracies (Timmemans and Berg 2010). Most of the abortions at the clinic are mundane, monotonous and follow a predictable routine like the one in the introductory chapter. These routines are influenced heavily by rules, norms, and organizing principals created by the medical field and managed care rather than a logic of reproductive rights. Even when decisions have to be made when something unexpected happens, attention to reproductive rights or politics rarely plays a role. When, how and by whom decisions are made tell us something about organizational life. Take for example the clinics that emerged immediately after Roe v. Wade, where feminist ideals required different decision-making processes such as consensus building and intense consulting with patients. To understand how a politicized logic may or may

not play a role in abortion work we can look to both the routines and irregularities that make up abortion practice.

## CLINIC LOGICS AND ROUTINES

The opening chapter described a routine and uncomplicated appointment. This appointment makes tangible the institutional logics operating in the clinic. Safety measures are a result of a politicized logic that positions abortion work as dangerous and stigmatized. Conversations about insurance coverage emphasize the importance of reimbursement and concerns over service eligibility; a reflection of managed care. Counseling occurs in the exam room and is folded into the process of taking medical history, stressing the medical nature of the procedure. Staff take care to create and maintain routines in their day-to-day work. One day Mai and Sam were the MAs assigned to the surgical procedures. Usually Mai and Chloe were the main surgical MAs and Sam was a 'float,' meaning she worked in both the surgical and family planning sides depending on who needed help. This day Chloe was covering for Blanca in the lab and Sam was scheduled to work with Mai. Mai was proactive in the workplace. Some may say she is bossy. That morning right after the huddle she took charge with the more passive Sam, "If you see the lights on, set up the tray and call the driver." She then explained that they both should be aware of what was going on in the rooms and set up trays whenever necessary. The colored lights outside of the exam rooms signaled the stage of the appointment. When the yellow light came on it meant it was time to set up the surgical tray with the tools for the abortion. Mai wanted to establish a routine with Sam. Sam worked the surgical side less often and was less experienced. Mai and Wendy had a strong routine that included good communication and problem-solving. The MAs' routine was centered on supporting the doctors and moving the appointments along. Making the doctor's job easier increased efficiency and maintained doctors'

authority. Mai anticipated a breakdown in routine and wanted to ensure that things went smoothly. There were times when a manager initiated a return to the routine. The clinic had a relationship with a local teaching hospital with Ob/Gyn residents. Residents would come to the clinic to train in family planning and specifically surgical abortion. Residents were inexperienced compared to the doctors on staff and would take much longer to perform abortions. On days they worked, the nurses and MAs knew things would take longer and prepared themselves for longer-than-usual procedures. If they were getting too behind schedule the manager would ask the supervising doctor to do the next few abortions just to get things back on pace. The routine was a quick 5 – 10 minute procedure. Forgoing this routine for training was at times necessary but could only be tolerated for so long before it had too large of an effect on clinic operations and wait times for other patients. Attention to the patient experience created a new flow or set of routines and practices for the clinic. The rationale behind these changes to the clinic routines point to competing logics.

*Patient Centered Flow*

The clinic under study has recently undergone a remodel of the physical space and a reorganization of how abortion appointments are structured. This reorganization occurred in order to incorporate "patient-centered care" and specifically targeted the "flow" of patients through their appointments. Previously, patients would spend hours at the clinic and be shuffled from room to room for different aspects of their abortion appointment. For example, a patient might be called back from the waiting room to complete a urine test and have her vitals checked, then return to the waiting room. Later, that same patient would be called back to have an ultrasound, then moved to a different room for counseling and assessment. Then she might have to wait in a secondary waiting room for a couple more hours before meeting with the doctor and

having the abortion. This patient flow prioritized organizational efficiency since certain staff were responsible for certain tasks (e.g. urine test, ultrasounds, IV placement) and certain rooms were allocated for these tasks. However, this flow did not prioritize the patient experience. Patients were moved from room to room, and the order in which they received their abortions might not be the order in which they arrived at the clinic. Women were spending all day at the clinic.

The new "patient centered flow" prioritizes the patient's experience. When patients are called back into the clinic from the waiting room, they are for the most part attended to from start to finish. After their urine is collected and vitals documented, patients are in one room for the rest of their appointment. While there is still some division of labor, there are fewer staff members interacting with the patient throughout the course of the visit. As a result of consolidating tasks, registered nurses in the clinic have had to take on additional responsibilities such as administering drugs for moderate sedation and conducting ultrasounds to determine gestational age. As a result of increased tasks for nurses, staffing has been reduced in other areas. Ultrasound technicians used to scan all the patients, and there were two ultrasound technicians scheduled on days when surgical abortions were provided. With the new flow, nurses are doing most of the scanning themselves, and there is only one ultrasound technician scheduled. Now, this ultrasound tech primarily spends her time bringing patients back to the clinic from the waiting room, taking vitals, and helping the nurses with challenging ultrasound cases.

According to high-level administrators, a desire for patient-centered care drove the decision to reorganize the clinic both physically and procedurally. While arguably the clinic's flow of patients and appointments prior to the reorganization still provided quality healthcare, the goal of that flow was to make the most efficient use of staff time and clinic space. A patient-

centered flow prioritizes patient experiences and patient perspectives on their care (Oates, Weston, and Jordan 2000; Robinson, Callister, Berry, and Dearing 2008). While a move toward more patient centered care may be happening in a variety of health care settings, I argue that other factors were at play in the clinic. Ideals around the patient experience were also based on a customer service framework. Clinic staff, and administrators especially, want patients to be pleased with their experience as consumers of a service. Patients are regularly encouraged to fill out a brief survey as they are discharged. A small iPad is mounted near the checkout window and patients are asked to rate their experience. Additionally, patients are encouraged to fill out yelp reviews; in fact a yelp.com logo is included on the clinic's business card. This customer service framework is consistent with a market-based institutional logic. While organizations value efficient use and allocation of resources, they also need consumers to buy their products and services.

However, there may be an additional logic at play in the move toward patient-centered care. Pro-choice advocacy often calls for a destigmatization of abortion. Slogans that read, "Shout your abortion", "Everyone loves someone who has had an abortion", and the work of the 1 in 3 Campaign all aim to normalize and destigmatize abortion. These advocates point out that secrecy about abortion hurts pro-choice efforts. Combatting the popular belief that abortion is rare and something to be ashamed about, the pro-choice community is attempting to demonstrate how frequent abortion truly is and highlight the positive experiences most women have with abortion care. Patients from the clinic have first-hand experience with abortion and they may leave and share their experiences with friends and family. Ensuring customer satisfaction and positive abortion experiences could serve as a strategy for increasing support for a pro-choice agenda or at the very least support for the clinic itself.

While logics shape clinic routines they may be equally important, and more apparent, when routines fail. The clinic routines fail because people are complicated and unpredictable. People eat or do drugs before sedation or are further along in their pregnancy than they think. People have bad colds putting them at risk for sedation or low hemoglobin making surgery risky. People are late for their appointments. People have been raped or coerced into abortion. People can be unsure if they want an abortion. People change their minds. The medical practice of abortion can be routinized, but sometimes the individual circumstances of patients get in the way. Administrators attempt to control the clinic environment as much as possible, yet unexpected setbacks happen. Staff are sick and can't come to work or are stuck in traffic and are hours late. Equipment can break and a shipment of supplies doesn't arrive. Maybe the doctor on the schedule has little experience with 2nd trimester procedures or there is a particularly slow resident working the clinic. When things do not go according to plan what happens? How are decisions made? In the case of patient care there is often an alternate option or protocol in place; If A happens do B, if that doesn't work try C. Reschedule the patient who has eaten or done meth, refer the patient with low hemoglobin to the nearby hospital for the procedure. Depending on the type of problem, it is easier or harder to solve. For medical concerns regarding the patient, the doctor makes the final decision. Organizational and clinic-level problems are decided by administrators, usually the manager on duty. Logics are made tangible at the moment of these decisions. Staff draw from logics to make sense of the circumstances and create solutions to problems. The following vignettes are examples of appointments that do not follow the routine.

*Vignette 1*

I was standing at the opening of hallway with Linda the office manager and Dave the nurse anesthetist. It was the end of the day when the patients who needed a two-day procedure were scheduled. A patient walked by toward the bathroom. She was a white woman, tall with long dark hair in a ponytail. She wore loose sweatpants and a tight black tank-top showing her clearly pregnant belly. She was there the day before to start the first part of the two-day procedure to terminate her pregnancy. However, she was rescheduled for today due to recent drug use. Patients have to be meth-free for seventy-two hours before they can be sedated with anesthesia.

Yesterday there was discussion among the staff about whether she was too far along in the pregnancy for an abortion. There was a discrepancy between the gestational stages indicated by two ultra-sounds taken at different times. The one conducted at the clinic put her as beyond the 23 week and 6 day limit for a legal abortion. The patient had records from an ultra-sound from earlier in her pregnancy from a different clinic. The earlier ultra-sound indicated that she was within the legal limit to have an abortion. Sandy, the ultra-sound tech brought the most recent images to Dr. Roberts and said, “she is measuring too far along”. Dr. Roberts assured Sandy that earlier ultra-sounds are more reliable and that the patient should be rescheduled for today as long as the patient could abstain from meth.

Today there was a different doctor on duty, Dr. Cain. When the patient arrived for her appointment, Dr. Roberts happened to be in the clinic, observing a couple of Dr. Cain’s procedures. The office manager, Linda, purposely waited

until Dr. Roberts left to bring the patient from the waiting room to the clinic. As the patient walked by the three of us, Dave said, “I don’t know how I’m going to feel about that.” I mentioned to Linda that the woman did look really far along. By now I had been in the clinic for a couple months and was used to the variety in how people look while pregnant. Women’s bodies are different and carry pregnancy differently. Some people in the 2nd trimester show more than others. However, even I could recognize that this patient was showing more than usual.

With Dr. Roberts gone, Linda took the patient’s chart to Dr. Cain and told her that there was some disagreement about the gestational stage. Then she said, “when this patient comes tomorrow, [the doctor on duty] will be shocked.” Dr. Cain asked, “in a good way?” and Linda replied, “absolutely not.” Dr. Cain decided to scan the patient herself and took a visiting medical student and Sandy with her. The rest of the staff and I waited for the doctor to complete the ultrasound to know if there was going to be a procedure to prep for. Someone mentioned that that this was the patient’s 6th pregnancy and that she had had five abortions. Another passerby mentioned, “she looks too far.” Linda said, “yep, everybody is feeling the same way about it, but we have to leave it up to the doctor. “After about 10 or 15 minutes, Sandy left the ultrasound room and went to the front desk area. The med student came out of the room, found a box of tissues took it back to the room. The patient was crying, which most likely meant the pregnancy was too advanced to terminate.

Dr. Cain exited the room, walked by everyone, made a sad face and said, “Oh, that is a no.” Linda was relieved, “I wouldn’t have been able to sleep

tonight." Other than staff discomfort, as the office manager, Linda considered legal implications. "We could be shut down for that," she observed. "These are people's jobs."

*Vignette 2*

Raquel, the MA working in the lab, looked confused when the doctor told her the patient wanted to see the products of conception (POCs) after the procedure. Dr. Cain told Raquel, "rinse it off really well and put it in that silver dish" and went on to explain that the patient wanted to see the POCs because she had "ghoulish images in her head" of what they would look like. Then the doctor said, "it's her body," indicating that the patient should be able to view the POCs. Raquel prepared the POCs and put them aside so the patient could see them when she fully recovered consciousness. Linda, the office manager, and another MA wandered over to the doorway of the lab and Raquel told them what had just happened. She asked the office manager, "do we even do that?" Raquel had not questioned the doctor at the time. Now there was some back and forth about whether this had happened before and whether there were any specific rules regarding letting patients view POCs. Linda said, "I don't think we should" but conceded the doctor had the final say.

To some degree it makes sense that doctors have the most authority. After all, they are ones who will be held accountable for any negative medical outcomes. However, the vignettes above describe decision making that involved more than a consideration of medical factors and risks. In the first vignette, there was a legitimate case for the gestational age being within the legal limit for the state. All the patient's ultrasound images were stored and documented in the

patient's electronic chart, including the ultrasound from the other clinic. Two doctors, both equally experienced, had different perspectives on the issue. Ultimately the doctor on duty made the decision. Had Dr. Roberts been the one doing abortions that day, things might have gone differently. In the second vignette the doctor asserted authority over an issue that had no medical basis. This is different than a doctor drawing from their authority to deny an abortion on the basis of potential medical or legal risks.

In both vignettes, proper protocol was ambiguous and doctors were clear in their assessment of what should be done. Some staff expressed personal discomfort but not directly to doctors. In the second vignette, Dr. Cain believed the patient should be able to view the POCs and invoked a reproductive rights logic-- "it's her body"--to justify her decision. The doctor's desire to put the patient's mind at ease by dispelling the "ghoulish" image is consistent with a customer service logic that prioritizes patient satisfaction *and* a reproductive rights logic that aims to destigmatize abortion (both are discussed more in-depth below). Had the gestational stage been advanced to the point that recognizable fetal parts could be discerned, I do not think the doctor would have allowed the patient to see the POCs. In that case, the patient's beliefs in "ghoulish images" might have been validated. In the first vignette, Dr. Robert also relied heavily on a pro-choice logic. When given two valid yet differently interpreted data points, she made an argument for the option that would allow the patient to receive an abortion. She justified her decision by giving more validity to the earlier ultrasound: "earlier ultrasounds are more accurate." In this vignette, the office manager, who was responsible for the clinic as a whole rather than only individual patient outcomes, could have made a stronger case for denying the patient an abortion. However, Dr. Roberts was the medical director for the entire clinic and was in a supervisory position over clinic staff, while the other doctors just worked there. Linda was

able to be strategic and circumvent Dr. Roberts to get the outcome she, and the majority of the staff, were more comfortable with.

In both of these cases the doctors asserted authority and invoked a reproductive rights logic in situations where they were not the only staff in the clinic with expertise to make a decision. They were not making medical decisions that only they were qualified to make. The ultrasound technician in vignette 1 was extremely experienced and was the lead trainer for ultrasound scanning for the system of clinics in the region. Normally her assessment of a scan was accepted by doctors without question, and on occasion doctors sought out her opinion on difficult cases. Staff were unwilling or unable to invoke alternative institutional logics in these cases. Their attempts occurred away from the doctor and were timid in nature. In the discussion over the POCs, there was no apparent competing logic that staff could point to. As the office manager, Linda had a great amount of authority and discretionary power. She felt responsible for the clinic as a whole and yet even she did not assert a competing logic. Instead, she chose to circumvent the issue. Interestingly, staff objections, whether voiced or hinted at, seemed to stem from uncertainty and personal discomfort.

*Vignette 3*

> At the end of the day a woman came in who was at 17.4 weeks. She had been given an incorrect appointment for her gestational stage. She was scheduled for a 2-day abortion but was not far enough along in the pregnancy for that procedure. At her stage she should have been scheduled for what the staff call a "cyto" or "lam and tab same day" where the patient comes in early in the day, gets dilators placed in her cervix, takes some misoprostol, then waits a few hours. Over time the misoprostol and dilators soften and open the cervix. Because this

patient was scheduled as a 2-day procedure her appointment was later in the day and there was not enough time to wait for dilation. Charlotte asked Dr. Cain about rescheduling the patient. Charlotte often talked through her rationale for making certain decision with other staff. She felt it helped them understand all the things she had to consider. She had limited the following day's schedule to certain types of procedures; there would not be any abortion scheduled between the gestational stages of 15.6 to 18 weeks. I asked why and she explained that she restricted the schedule because of the doctor working that day. The doctor did not do abortions very often; maybe once a month or so. Charlotte explained that the last time the doctor had worked at the clinic she had perforated a patient's uterus and the patient had to be transferred via ambulance to a hospital. Charlotte said, "It's not her fault, she just doesn't do these procedures often." According to Charlotte, the mid-range abortions were more difficult; first trimester procedures were easy because they largely relied on suction and the 2nd-day procedures were easier because the POCs were larger and easier to remove. Charlotte decided to reschedule the patient for the following week and Dr. Cain agreed: "yeah that is probably a good idea."

Charlotte's decision pushed the woman's abortion into a completely different category of procedure. By waiting an additional week, the woman would be at 18.4 weeks, which turned the abortion into a 2nd day procedure bringing elevated risk. While the patient had originally anticipated the 2-day procedure when she came to the clinic, she would now have to make arrangements again for transportation, possibly time off work or childcare. Additionally, the woman would have to remain pregnant for additional week, which is not what she had planned.

The people scheduling appointments in the call center used their best estimates of gestational stage to schedule appropriately. They based these decisions mostly on women's recollection of the first day of their last period. In most cases, the ultrasound at the beginning of the appointment confirmed the gestational stage and thus what type of procedure to perform. Instead of scheduling the patient for the following day, which would mean a less complicated, cheaper, and technically lower risk procedure, Charlotte thought it better to wait a week because she considered it riskier to the patient to have a less experienced doctor. In addition to patient safety, Charlotte was also concerned with clinic operations. The last time the doctor was there, the flow of appointments came to a halt as the doctor and other staff were busy taking care of the bleeding patient. Ambulance transfer also required extra paperwork, communication and coordination with the receiving hospital, and follow-up with the patient. All of this disrupted clinic operations during the event and caused extra work for the clinic manager, nurses, and doctors in subsequent days. Rather than consult with the patient and determine what they wanted, Charlotte made the decision for her. Without denying the need for patient safety, a reproductive rights logic would have considered the woman's autonomy and incorporated the patient in this decision. The patient still had the option to terminate the pregnancy but managing risk was the most important factor in this situation.

## DISCUSSION

If the abortion clinics after Roe v Wade reflected the commitments of the reproductive rights movement, today's clinics reflect the political economies of the current state of healthcare. Moving toward the mainstream means that abortion clinics have increasingly shed radical and feminist logics and adopted logics that stem from medicalization and managed care, posing a conundrum for abortion care. Is abortion care routine and like any other medical procedure? Or

is it a political act that must be treated differently? Abortion care is both. Relying on modern medical logics is very effective in structuring routinized care. The logic also pushes abortion care to conform to other outpatient surgical health care settings. The reproductive rights logic has become less influential in shaping care and more of a tool that can be used by some in making decisions about individual patients' care. The rise of the modern medical logic and the decline of the reproductive rights logics has two implications; one for abortion work and one for abortion workers.

When occupational compartmentalization and a chain of command are features of care, as is required in the modern medical logic, the tasks associated with abortion work are precisely delineated and distributed among the staff. The medical logic prioritizes the technical aspects of the job that facilitate the pregnancy termination rather than the interpersonal work that is valorized in a reproductive rights logic. Additionally, a medical logic emphasizes hierarchical occupational structures. In the past, some abortion clinics attempted to diminish physician's authority in favor of a more egalitarian organizational model. In the clinic I studied, doctors' status was elevated and they were able to draw from multiple logics to justify their decisions.

A medical logic may be structuring care, but a reproductive rights logic is not wholly absent from the clinic. It is present when staff come to work and have to be buzzed in through a security door. The reproductive rights logic in some ways undergirds a medical logic; because abortion is so stigmatized and unlike other types of medical care, clinic administrators want abortion care to resemble and feel like any other surgical outpatient setting. This may legitimize abortion to patients. However, it may also exacerbate occupational inequities among clinic workers. In subsequent chapters I demonstrate, 1) how a modern medical logic allocates the most stigmatized work to low status workers and 2) that a reproductive rights logic makes workers

aware of the politicized nature of their work but is not integrated enough into clinic operations to ameliorate the negative effects of the politicized character of their work.

## CHAPTER 4: THE REWARDS AND LIMITS OF INTIMACY

In this chapter, I compare the work that doctors, nurses, and MAs do at the abortion clinic to show that the potential rewards of stigmatized work are not evenly distributed among staff. Abortion care requires a great deal of emotional labor from all involved. Researchers have been concerned with how doctors and staff manage the emotional labor associated with highly stigmatized work. Abortion providers rely on a "repertoire of responses," such as distancing and boundary setting, when interacting with patients (Wolkomir and Powers, 2007). Additionally, staff and doctors at abortion clinics have sophisticated and malleable beliefs about the appropriateness of abortion in different contexts (Simonds, 1996; Joffe, 1986). These earlier studies, however were conducted in clinics that incorporated feminist and reproductive rights ideologies into their organizational structures. Less is known about intimate work in the context of modern abortion provision.

Scholars have shown that jobs requiring either physical or emotional intimacy with clients may also be a source of satisfaction for workers, even as those jobs may be highly stigmatizing. Ashforth and Kreiner (1999) argue that relative prestige is important when considering work that carries stigma. Those in high-status positions benefit from a "status-shield" that can buffer potential negative consequences of unsavory work (Hochschild 1983). For example, doctors in an abortion clinic remove the pregnancy tissue from the patient's body, but this work may not be as repugnant as the task of disposing of the pregnancy tissue. Organizations may be structured to protect high status workers by allocating the most unpleasant tasks to lower status workers (Stenross Kleinmann 1989). Low-status workers have also developed strategies to manage potentially stigmatizing work. Domestic workers, for example, develop "deep alliances" with their elderly clients to bolster their professional identities as helpers. Detectives frame their

emotional labor as necessary for fighting crime and thus prefer working with criminals as opposed to victims of crime (de la Luz Ibarra 2010; Stenross and Kleinmann 1989). I find that unlike domestic workers and detectives, the MAs in the clinic have less flexibility and leeway to reframe the benefits of their stigmatized work. In the clinic under study, hierarchies and the compartmentalization of duties combine to make abortion work disparately rewarding.

All staff are not equally responsible for all tasks in the clinic, as a modern medical logic dictates that clinic duties are allocated among staff to ensure efficiency and minimize labor. I use dirty work and intimate work to make a conceptual distinction between the types of the work MAs, nurses, and doctors do and to highlight how workers are differentially stigmatized. Different staff in the clinic are responsible for the different aspects of intimate work required in the course of an abortion appointment. Staff must tend to the emotional needs of patients, foster trust, collect and protect sensitive information, and communicate a pro-choice message. I find that doctors benefit from the emotional intimacy they build with patients and from being the moral face of the reproductive rights ideology. Nurses are able to reframe their intimate work as highly skilled and necessary for the safety of the patients and the clinic. MAs, who do the most stigmatized work in the clinic, engage in intimate work that is not linked to abortion and in their duties there are few pathways to kinds of work that promotes a positive professional identity.

## DIRTY WORK AND INTIMATE WORK

Surgical abortion[1] meets Hughes' (1951) definition of dirty work as work that includes physical, social, or moral taint. Surgical abortions in clinics require that staff touch and handle patients' bodies and bodily products. Staff remove, handle, examine and dispose of blood, urine, and pregnancy tissue. Patients' genitals are central to the procedure, making abortion work and gynecology in general particularly dirty, as women's genitals and reproductive organs have historically been considered unclean (Bolton 2005). Abortion is also socially tainted in that

abortion workers come into contact with stigmatized people. People with undesired pregnancies are often perceived as irresponsible or immoral (Abrams 2015; Allen 2015; Luker 1984). Finally, abortion is very polarizing, with both sides of the debate offering moral arguments for and against terminating pregnancies. Thus, abortion work is also morally tainted, as some believe abortion is morally wrong, evil, and a form of murder.

Scholars have linked the physical, social and moral taint associated with abortion to stigma (See O'Donnell, Weitz, and Freedman 2011 for a detailed discussion). Abortion is highly stigmatizing for both abortion workers and those seeking abortions (Hanschmidt et. al. 2016; Kumar, Hessini, and Mitchell 2009; Norris et. al. 2011). Stigma affects abortion providers' legitimacy in the broader field of medicine (Harris et. al. 2013), their professional training and career trajectories (Freedman 2010; Joffe 2010; Smith, et. al. 2018), and their perceptions of their work (Harris et. al. 2014). Providers use different strategies for managing stigma (O'Donnell et. al. 2011) and connecting with other providers is an effective tool for reducing the negative effects of stigma (Harris et al. 2011).

In this study, I define intimate work as the close interpersonal work required to provide a service. Intimate work requires workers to manage people's emotions (Hochschild 1983), to develop trust, and foster vulnerability among their clientele (Zelizer 2005). Collecting "specialized knowledge" about a person is also a feature of intimate work as workers collect information that is potentially damaging to the client or consumer in order to provide a service (Zelizer 2005). Intimacy in abortion work can be observed in different areas. Patients are vulnerable physically; they are sedated, half-naked with their genitals exposed. Patients may also be vulnerable emotionally, requiring abortion workers to tend to their emotional states. Clinic staff are required to collect specialized knowledge from patients to perform the procedure

effectively and safely. Patients share intimate details of their lives, describing their romantic and familial relationships, drug and alcohol habits, mental health, and instances of sexual assault. Trust plays a major role because patients must trust staff to keep their personal information confidential, and trust that staff are qualified to perform the abortion. Previous research has emphasized the role of the abortion counselor, a non-medical clinic employee who is assigned a large part of the intimate work in an abortion appointment[2] (Joffe 1986; Simonds 1996; Wolkomir and Powers 2007). Over time, however, this counseling work has been largely integrated with the more medical parts of the appointment rather than being the responsibility of a person in a separate position. Again, this is due to stand-alone clinics becoming more medicalized (Halfmann 2012). Accordingly, in the clinic under study, there was no abortion counselor position.

Neither dirty work nor intimate work in abortion care have been static across time or populations. Physical taint in surgical abortion work has been relatively consistent over time: the body parts and bodily products have not changed, though new tools have been introduced (Paul and Stewart 2009). Social and moral taint, on the other hand, are sensitive to public perception and legality (Luker 1984). Like medical practices in general, intimacy in abortion work has changed, reflecting developments in who performs abortions and the organizational environments in which they are performed (Joffe 2013). While intimate work and dirty work are not mutually exclusive concepts, they are helpful in providing a framework to understand the various duties of abortion workers and how these duties are organized in the clinic.

## THE ALLOCATION OF ABORTION WORK

Clinic staff engaged in varying degrees of intimate work or dirty work depending on their position. Clinic duties were organized around occupations and Amy[4], the assistant office

manager, explained to me that administrators allocated tasks to workers according to the limits of workers' credentials and licensure. To maximize labor, the clinic needed workers to do all the labor they were trained and authorized to do—but not if there was a cheaper worker to do it. For instance, testing a urine sample could be done by any of the types of workers employed in the back-clinic: MAs, RNs, NPs, MDs, etc. It only took a few seconds to dip a small paper strip into the urine to test for pregnancy hormones. However, the cost of those seconds to the clinic depended on who was completing the task. A doctor's time was more expensive than a nurse practitioner's time, which was more expensive than a registered nurse's, and so on. The clinic wanted to pay the doctor to do only tasks that only a doctor could do, and the same was true for the NPs and the RNs. At the bottom of the hierarchy, MAs spent their time doing work that other staff could do, but having MAs do that work was cheaper for the clinic.

Each occupation's duties were more or less closely associated with intimate work or dirty work. Appendix A includes a list of the work activities for the workers represented in this study. In the clinic, intimate work and dirty work existed on a spectrum. These spectrums are relational: there are no quantitative measures of this work. Movement on the spectrums is based on frequency or intensity and purpose of the work. For example, RNs spent the most time with the patient compared to other staff and did intimate work more frequently, though the purpose of their intimate work was to gather information. Doctors, on the other hand, spent little time with patients but were largely responsible for managing patients' emotions. Both doctors and nurses placed high on the spectrum of intimate work, but the amounts and purpose of their dirty work were different. I found that a relationship between dirty work and intimate work was made evident by these different arrangements. In the following, findings are organized into three analytical categories and correspond to the different occupations in the clinic, 1) dirtiest work

and redirected intimacy, 2) honored dirty work and emotional intimacy, and 3) diluted dirty work and expert intimacy. Each theme exemplifies a relationship between intimate work and dirty work and I draw conclusions about what it means for workers whose work falls under those categories.

*Dirtiest Work and Redirected Intimacy*

MAs performed the dirtiest work in the clinic. By the "dirtiest work" I mean, when compared to other staff, MAs performed the tasks characterized as particularly tainted (e.g. handling pregnancy tissue) and a larger proportion of their duties consisted of dirty work. MAs handle blood, tissue, urine, dirty linens and instruments, empty sharps containers, and are responsible for cleaning and sterilizing clinic spaces. They handle and dispose of the tissue removed from the uterus also called products of conception (POCs). MAs' proximity to this physical taint was exacerbated by their position in the occupational hierarchy. Many aspects of their work evoked servitude: getting down on hands and knees to clean blood off the floor, cleaning patients' bodies, and protecting the clinic, staff, and patients from the physical taint associated with abortion work.

Much of this dirty work happens in the lab. The lab is a small room with equipment to clean and sterilize tools and storage for surgical tools and supplies. The door to the lab was supposed to be kept closed at all times, separating the space and the worker from the rest of the clinic and sparing patients and other staff from being exposed to the dirty work happening in the space.

> Blanca is quick and methodical as she picks through the contents in the Pyrex dish. She uses a small pair of tweezers to separate and examine bits of tissue under a bright light. Her job is to confirm that the doctor removed all the

pregnancy tissue from the uterus. Dr. Cain peered over her shoulder occasionally commenting “what about that?” and “that could be something”. Both Blanca and Dr. Cain were having a hard time finding evidence of pregnancy tissue for the early gestational stage.

Blanca was 73 years old and had worked at the clinic as an MA for over 15 years. She told me that years ago they used to send the POCs to an outside lab for analysis but now they confirm the abortion is complete in-house. The lab was an integral workspace for the MAs and also served as a place where they could socialize. During slow work periods, the MAs tended to gather in the lab to chat. Nurses and administrators only went in the lab if they were looking for an MA and doctors went in briefly after an abortion to confirm the POCs. While the closed door separated the dirty work happening in the lab from the rest of the clinic, the closed door also protected MAs from being surveilled by other staff. MAs took the opportunity to check their phones, chat about their personal lives, and sneak the occasional snack.

MAs duties required them to be responsible for handling physical taint in the lab and in the surgical rooms. They were in the clinic to clean up the messes.

I went in the exam room after a procedure to help Alex dress the patient and clean the room. The patient still had an oxygen mask on and was coughing a lot. The patient wasn’t waking up and she vomited some clear liquid a few times into her oxygen mask. The nurse responsible for sedation was trying to wake the patient and used a suction tool, like dentists use, to remove the fluid from the mask. Alex and the nurse were serious and focused rather than chatty like they usually were. Chloe came in the room to help out. Alex, Chloe and I turned the patient over on her side while the nurse monitored her vitals and continued to loudly call her name

to rouse her. I was standing near the patient's head and shoulders, but Alex directed me to switch places with her so that I was near the patient's feet. After the patient woke up and was transported to recovery Alex confided that she switched places with me because she didn't want me to be vomited on.

Alex decided it would be inappropriate for me to come into contact with vomit, while it was acceptable for her. She did not switch places with me due to politeness; had another MA been in my place Alex would not have insisted they move. As an MA, Alex's job was to handle vomit and she put herself in a position to best do her job. Other staff also determined the appropriateness of tasks for MAs based on their responsibility for dirty work. When chatting with Sam, an MA training in the lab, Charlotte, the office manager, mentioned "You have a 16-weeker coming up, that'll be good for you." Charlotte wanted to make sure Sam got experience handling the instruments and POCs in a 2nd trimester procedure. Coming into contact with and examining the pregnancy tissue and removed fetus was "good for" the trainee, because it meant she would acquire the necessary skills and experience to do her job.

MAs' one-on-one time with patients, when taking their vitals and immediately before and after the procedure, are opportunities for intimate work, but division of labor tempers intimacy with patients. The purpose of face-to-face encounters was not to build a relationship and get to know the patient, but to streamline the appointment and prepare the patient for the nurse's assessment, then the abortion with the doctor. Organizational features of abortion work in the clinic encouraged MAs to redirect their intimate away from patients to focus on the needs of the doctors.

The clinic appointment structure places MAs with the patient during the most vulnerable time in the appointment; immediately before and after the abortion. During pre-procedure prep,

there were opportunities for chatting and I observed that conversation between patients and MAs was reduced to relatively superficial topics, like complimenting patients' personal appearance (e.g. tattoos or manicure) or asking the patient where they were going to eat after the appointment. These interactions might have helped pass the time and lessen the feeling of awkwardness while waiting for the doctor. However, whatever intimacy was developed during these brief encounters was weakened when MAs avoided or refused to answer direct questions about abortion from patients. Their position in the clinic allowed MAs to avoid or escalate more intimate work associated with discussing sensitive topics and answering questions about patients' abortions.

> Mai poked her head through the open exam room door and looked around for the doctor. She had already prepped the patient for the abortion and had been waiting for a few minutes. She stepped out of the room and shut the door and said, "she is asking too many questions." The patient had asked "How many abortions do you do every day?" and "How do you feel when people say you are killing babies?" Mai had avoided those questions and responded with "I'm going to see if the doctor is ready for you know".

Other staff presumably had strategies to avoid uncomfortable situations with patients, but only MAs were low enough on the clinic hierarchy that they could easily redirect patients to a staff member with higher status. Mai was able to ignore the patient's questions because according to the division of labor she was not primarily responsible for doing that kind of work with patients. Her job was to do the work that kept the flow of appointments moving and the work that made it easier for RNs and MDs to do their jobs.

After sedation patients were most vulnerable; they were partially nude, half-awake, confused, and often incoherent. Many patients did not immediately recover full control of their physical movements, so MAs had to help them sit up, get dressed, and transfer from the exam table to the wheelchair. I observed that patients often asked questions about whether the abortion had happened, whether the doctor "got it all out," how much blood there was, what they could expect in terms of recovery, what medications they could take to manage post-abortion pain, or side effects of birth control. MAs gave vague, boilerplate answers or told patients the nurse or doctor would answer those questions later. Instead of confirming that the doctor, "got it all out" MAs would confirm to patients that the surgery was "over,". They also told patients there was a "normal amount" of blood, regardless of how much bleeding the patient actually experienced. Any questions about post-surgery expectations or medications were escalated to RNs and MDs. One day, after a procedure, a patient sleepily asked Chloe, "How far along was I?" and Chloe responded by asking, "the nurse or doctor didn't go over that with you?" When the patient said, "no," Chloe continued to dress her and replied, "Okay, we'll have someone talk to you about that." Chloe was quite aware of gestational age; she had relied on that knowledge to set up the surgical tray with the appropriate equipment, and she communicated that information to Blanca when she brought the POCs to the lab. Even if she had forgotten, the gestational age was also on the patient's chart in the room. Chloe declined to provide the information because it was outside the scope of her position: an MA is not authorized to discuss details from the patient's chart or medical file. Thus, a potential point of intimacy between herself and the patient was ruptured, and the MA stayed within her role as a dirty worker.

While MAs could provide moral support immediately before and after the abortion, they could not answer specific medical questions from patients. The purpose of their work was to

move the procedure along, rather than tend to the emotional needs of the patient specifically. When MAs hugged crying patients immediately after the procedure it was an intimate act; however, it was unlikely that patients would remember these encounters because of the effects of sedation. Abortion appointments at this clinic were structured with the aim of minimizing the number of staff members and different exam rooms the patient encountered; a patient usually remained in one room and saw only one nurse and one doctor. However, I noted little consideration for how many different MAs interacted with the patient. One MA might bring them back from the waiting room, but they might have a different MA to prep them for the procedure and yet another MA present when they wake up. Tellingly, when patients said their goodbyes as they left, they often directed their attention and gratitude to the nurses and doctors, rather than the MAs. Nurses and doctors were tasked with developing intimacy with patients and the clinic relied on their intimate work to minimize risk and tend to the emotional needs of patients.

While the clinic did not depend on MAs to build intimacy with patients, they were required to perform intimate labor for the doctors. MAs' attachment to the doctor started at the beginning of the shift during the morning huddle. After general announcements, office manager would list all the staff working that day and when it came to time to list the MAs on duty, would say "Mai and Chloe are with doctor." From the start of their shift MAs' labor is tied to the doctor.

For abortion appointments to efficient, the MAs needed to know each doctor's preferences and anticipate their needs. A collection of laminated sheets indicating doctors' preferences was displayed on the wall underneath one of the cabinets in the lab. Each sheet was labeled at the top with the doctor's name, (e.g. "Preference sheet for Dr. Roberts") and listed the

specific tools the doctor preferred. Doctors had specifications, for the type and size of speculum, number and types of gauze, scopettes, curettes and even preferences for where things would be placed on the surgical tray.

> Later Blanca came out of the lab and looked at the doctors' schedule which is posted right above the computer where the doctors do their charting. Blanca said, "Dr. Caine is back Friday. I have to get the packs ready". I asked what she was talking about and she explained that Dr. Caine likes to use a smaller speculum. I was surprised and said, "the doctors like different things?" Sam commented, "Yeah, they like different sizes [of tools], different gauze, different amounts of iodine …"

The lists specified each doctor's preference for first trimester, second trimester and 2-day abortions. Though each list was typed and laminated, MAs had added handwritten notes to the sheets to revise the lists. When new MAs were trained for the surgical appointments, they had to learn all of these preferences, and MAs shared tips about what different doctors liked. When Chloe was training Sam on how to use the ultrasound machine, she commented, "the hardest part is learning what the different doctors like." The importance of these preferences to the MAs' jobs was highlighted when two doctors were performing abortions on the same day.

> Dr. Cain and Dr. Roberts were both in the clinic because they each had to observe each other's procedures as part of the clinic's evaluation process. Dr. Cain was officially on the schedule but Dr. Roberts came for part of the day to do abortions. Confusion arose because they did not clearly communicate which of them was doing the abortion before the start of procedure, so MAs did not know until the last second which tray to set up in the room. The MAs working that day did not

ask for clarification before setting up for the surgeries, they just tried to anticipate which doctor they needed to set up for and then made changes at the last minute. They were clearly flustered as they asked each other in hushed voices which doctor was doing the abortion and quickly made adjustments as needed.

In addition to being part of their job duties, tending to the needs of MDs was a source of pride and was part of the social life of the clinic. MAs consistently brought food and small gifts for the doctors, and would do small favors for them, like having a pair of clean scrubs ready for them when they arrived in the morning.

*Diluted Dirty Work and Expert Intimacy*

Registered nurses' work in the clinic was characterized by high levels of intimate work and lower levels of dirty work compared to other staff. The information they gathered as result of their work was incredibly valuable, as it identified both the parameters for the abortion and potential risks. Registered Nurses (RNs) had three main roles in surgical abortion: 1) they conducted the pre-abortion ultrasound and assessment, 2) they monitored patients after the abortion in recovery, and 3) they dispensed the various medications and drugs used over the course of the abortion appointment. The ultrasound and assessment together made up the bulk of the abortion appointment; thus, RNs spent more time with the patient, about 30 minutes, than other clinic employees. I call their dirty work "diluted" because RNs had the least involvement with the pregnancy termination or contact with pregnancy tissue. Their intimate work with patients was incredibly important because it allowed the nurses to identify major risks, determine the gestational age of the pregnancy, and was part of the formal consenting process for the abortion. This intimate work required technical expertise in the areas of pregnancy, physiology, contraindications to surgery medications, and policies and regulations.

After the MA brought the patient back from the waiting room and recorded their vitals a nurse conducted an "assessment". During this time the nurse performed an ultrasound to confirm gestational age, collected blood for tests, placed IVs, recorded the patient's medical history, consulted on birth control, explained the surgery, and answered questions. There were usually 2-3 RNs assessing on surgical days and they were often the busiest in the clinic, with less downtime than the other staff. In addition to assessing abortion patients, they were also responsible for stocking and keeping track of all the medication in the clinic and follow-up phone calls with patients.

The main purpose of their work was to collect specialized knowledge about the patient to determine what type of abortion to perform (e.g. first vs. second trimester), what types of drugs could be used, and uncover any contraindications to surgery or sedation. RNs recorded this information in patients' electronic charts and alerted doctors when anything unusual or alarming came up. Risks might be identified due to physiological issues making the abortion and sedation dangerous. For example, low hemoglobin, cold related congestion, using certain drugs too close to the time of the procedure, c-section scars, or bicornuate uterus were all factors that could complicate the procedure.

> I asked Stacy, and RN, about a patient who she had recommended be referred out to a hospital for the abortion. Stacy explained the patient had very low hemoglobin which was a reason to refer her out. The scaring on the uterus from a prior C-section was another reason to refer the patient to the hospital. She explained "there is a lot of vascularization on the placenta" and "the C-section scare is weaker and more prone to tearing than other tissue. It's like ripping off a Band-Aid and if for any reason something gets nicked you can have a lot of

> bleeding." Stacy went on, "she has taken iron pills her whole adult life, she has had a blood transfusion, these are all high risks". When the doctor had a moment to come chat about the patient Stacy explained the details of the case, the doctor glanced at the chart and said, "Oh yeah, refer her out".

Without Stacy's expertise and specialized knowledge the patient and the clinic would be at risk. The doctors relied on the nurses to catch any contraindications for sedation or surgery. The division of labor made it more cost-effective for nurses, rather than doctors, to do this work. In addition to risks associated with physiology, nurses were responsible for identifying more social or emotional risks. RNs determined a patient's ability to consent to the procedure. Patients could not be under the influence of drugs or alcohol, nor experiencing mental illness symptoms that would limit their decision-making. Additionally, RNs screened for coercion to make sure the patient wanted the abortion and was not being forced by someone else to terminate the pregnancy.

While the clinic RNs always provided quality and compassionate care, they were less likely than other staff to express emotional responses regarding patients. RNs' formal training teaches them to maintain appropriate boundaries with patients; a certain degree of emotional distance is required as nurses engage in so much intimate work which can be emotionally taxing and cause burnout (Allan and Barber 2005; Erickson and Grove 2007). While other staff simply gleaned information from a patient's chart, RNs had to collect the information directly, and in doing so heard every patient's story. They knew the circumstances around each abortion. While the circumstances around most patients' abortions were not traumatic, when there was trauma, the RNs were the staff members who knew all the details. In an interview Naomi recounted one memorable patient.

> Oh, there was a patient like one time for example that like, came in and she was like full of bruises all over, she was getting domestically abused, two-day procedure, you know all these things, they were trying to find her, her son had to drop her off, like we checked with the police there were warrants out for her boyfriend's arrest because he was beating her, (unintelligible) and I offered to pay for a hotel room across the street for her because she didn't qualify for the things, and then like all these things, we had to send her out in our scrubs because she like bled in [her own clothes] so we were giving her our scrubs like doing all these things for her. We ended up like calling around and finding shelters for her to live at the next day and that was what I just – like her whole story like I've never actually cried with a patient before and I cried with her.

Naomi had worked in the clinic for 5 years and heard a lot of patients' stories but for most of these cases maintained an emotional boundary and did not cry with patients. She talked about how she felt her position as a nurse allowed her to connect with the patients more than other staff, "I think that sometimes spending more time with [patients] when you really do have that connection, you feel that you've really made a difference in someone's life and they're gonna remember you for helping them through a hard time and that makes me feel really good." She acknowledges the work of helping people through "a hard time" and she values that work. RNs tempered the emotional work they did with patients. In my observations the RNs were less likely to dwell on a particularly sad or difficult case, they shrugged it off and kept working. Appointments were scheduled with the assumption that RNs would take about 30 minutes for the ultrasound and assessment and the nurses had to keep a steady pace in order for the schedule to remain on-time. The time with the patient had to be spent collecting the necessary information

for a safe and effective abortion rather than spend too much time managing patient emotions. I am not suggesting RNs did less emotional labor than other staff but rather claim information gathering, technical expertise, and tempered emotional engagement was an essential part of RNs' intimate work.

While RNs' dirty work at the clinic was in service of surgical abortion, they were not involved with terminating the pregnancy nor handling pregnancy tissue. The dirty work RNs performed during the abortion appointment included placing an IV needle; drawing blood to test for RH antibodies, hemoglobin levels, and pregnancy hormones; and conducting ultrasounds. These activities were a standard part of appointments at the clinic but are not unique or special to abortion care. RNs working at Ob/Gyn offices or fertility clinics perform the same tasks, but for a different purpose. The "recovery nurse" monitored patients' vitals and post-surgery bleeding as the effects of anesthesia wore off. If after about 20 minutes the recovery nurse felt the patient was alert enough, she sent them to change back into their regular clothes, removed the IV, provided reminders regarding aftercare and any follow-up appointments, and then sent the patient to the front desk to check out. The RNs in the clinic rotated being assigned this position. The work performed by recovery nurses was similar to the tasks they might have handled in other outpatient surgical facilities, like monitoring patients after a colonoscopy or wisdom teeth removal. MAs and MDs also do dirty work that also happens in non-abortion healthcare settings, however I find MAs' and MDs' dirty work to have dealt more closely with pregnancy termination than RNs' dirty work. This distinction provides a lens for comparison between occupations in the clinic. RNs, comparatively, were not performing the dirtiest of the dirty work in the clinic. They did not regularly come into to contact with pregnancy tissue and aborted

fetuses, and thus were somewhat shielded from the more gruesome aspects and moral taint associated with abortion work.

Ultimately, the nurses had a different orientation to abortion work compared to other clinic staff. Nurses' training and expertise allowed them to make assessments regarding the patient's medical history and socioemotional state. Rather than primarily a source of emotional support, nurses' intimate work with patients was focused on gathering information that would protect the clinic and patients from risk. Nurses' dirty work garnered information that was used to determine the parameters of the abortion, but they did not directly participate in terminating pregnancy nor did they handle POCs thus their dirty work was diluted in comparison to MAs and doctors.

*Honored Dirty Work and Emotional Intimacy*

The doctors' involvement in the dirty work of abortion was straightforward. They removed the pregnancy tissue from the body and examined the POCs to confirm everything had been removed. They came into contact with blood, tissue, and genitalia. The physical taint associated with these tasks is clear and for doctors the moral taint may be more salient than for other workers in the clinic because they are ultimately responsible for terminating the pregnancy. Intimate work with patients was less consistent and varied according to patient circumstances. Doctors spent very little time with the patient and so had less opportunity to build intimacy, yet the intimate work they did was a primary source of emotion management for patients. Furthermore, the doctors' elevated status in the clinic, combined with the clinic ethos regarding the morality of abortion, positioned them as exemplars, martyrs, or the ideal abortion worker. Although they are associated most closely with the moral taint of abortion work, they are positioned to reap the benefits of relationship building in intimate work and self-sacrifice inherent in choosing a career in abortion work.

In a routine appointment the doctor spent very little time with the patient before sedation, often just a few minutes. The doctor obtained consent for the procedure and for birth control if necessary. During this brief meeting, the doctor asked one last time if the patient was sure they wanted to terminate the pregnancy and confirmed that the patient understood the chosen birth control method and possible side effects. At this stage in the appointment, there was little organizational need for doctors to perform intimacy associated with collecting specialized and confidential information, as a nurse had already done this work. For the doctor to spend time talking to patients and taking a medical history would not have been cost-effective for the clinic. However, the meeting between the patient and doctor was not without intimacy. To build trust with the patient and convey support of their decision to terminate the pregnancy, doctors performed micro-intimacy work through their body language, tone and gestures. Instead of rattling through a script like RNs and MAs, doctors were a little slower with their questions and left more space for a patient's own questions. They sat facing the patient and made eye contact, rather than facing the computer. Dr. Cain would say "we are going to take good care of you" when concluding the surgery consent protocol with patients. This short, reassuring phrase communicated to the patient that the doctor wanted her to feel safe, that the staff as a team had the patient's best interest in mind, and that the patient deserved quality and safe care.

There were occasions when a doctor was more involved with a patient due to complications, the patient having a lot of questions, being nervous, or when the pregnancy was too advanced to be terminated.

> The patient had a big friendly smile on her face as Dr. Cain and I walked into the exam room. Dr. Cain greeted the patient, introduced me and sat down. She asked the patient whether she was sure she wanted to terminate the pregnancy and the

> patient started crying. She said, “I can’t afford a baby. We can’t take care of it. My boyfriend wants me to keep it but I really don’t.” The doctor exuded warmth and concern in her tone as she said, “are you sure you want to do this today? You don’t have to do this today.” The patient said, “Yes I am sure.” And Dr. Cain replied with, “This doesn’t mean you can’t have kids in the future. When you are ready to be a mom you are going to be a great mom.” After the patient calmed down a little, the doctor left to get the MA to start setting up the room. Later Dr. Cain commented on that patient as she was on the computer doing some charting, “You saw how smiley [the patient] was? Sometimes the ones that are really smiley are the ones that are having a really hard time because there is more dissonance.

Dr. Caine had been performing abortions for about 15 years and her reflection about the patient were based on her experiences observing and managing patients’ emotions over the years. As the last person to confirm the patient is sure about terminating the pregnancy, doctors in the clinic paid close attention to patients’ emotional displays.

Doctors also spent more time counseling and tending to the patient when it became apparent that the gestational age was too advanced for a termination. In these cases, the patient was taken from the exam room to another smaller room, which both freed up the exam room for another patient and provided a more intimate space for the doctor to break the news to the patient. The doctors took their time explaining options and allowed the patient to ask questions, cry, and say whatever they needed to say. The doctor asked about whether the woman had any support from friends or family, and whether it was safe for her to go home. When patients at this

clinic had a hard time emotionally or needed extra counseling, it was most often the doctors who filled that role.

Doctors are responsible for terminating the pregnancy and they are most closely associated with the moral aspect of abortion. The physician's dirty work is the entire purpose of the appointment. In a space where abortion is accepted, doctors receive the highest honor, not just because of their professional prestige but also because they are the heroes doing the hard work. Doctors at the clinic had been personally targeted by anti-abortion efforts, including being outed as abortion providers in their neighborhoods and the subjects of illegal 'sting' videos. While all clinic staff voluntarily worked there, doctors made a deliberate choice during their residency training to select gynecology and obstetrics as their field of practice and furthermore decided to be trained in the sub-field of family planning and abortion. Their dedication to reproductive rights and support for abortion was evident in the clinic. Doctors discussed current events that pertained to abortion (e.g. supreme court decisions, legislation restricting abortion access in other states, the 2016 presidential election, etc.) in the clinic. Perceived attacks on abortion rights were framed by doctors as the reason why the work everyone did was important. When "40 Days for Life", the annual international anti-abortion event, brought protestors to the sidewalk in front of the clinic, doctors gave encouraging comments during the morning huddle. Doctors were the moral and morale leaders of the clinic.

Doctors who provide abortions, particularly those that work at clinics, are what most people envision when they think of abortion providers, although abortion clinics have many other staff members helping to perform the abortion. The doctors are valorized *because* they chose to do this work when they could be doing other things; their dedication to reproductive

rights is apparent. Their roles as the moral center of abortion work in addition to their occupational prestige provides a degree of privilege not offered to other staff.

## DISCUSSION

In this chapter I have shown that the type, frequency, and purpose of dirty work and intimate work are key sources of variation and argue that this variation creates different opportunities to reap the rewards of intimate work. In the clinic understudy, MAs engage in the dirtiest work and their intimate work is directed toward doctors rather than patients. Nurses' intimate work is necessary to mitigate risk, but their dirty work is tempered as it is the least associated with the distasteful aspects of abortion. Finally, doctors are freed up to the bearers of emotional labor and hold a special place on the dirty work spectrum due to their occupational prestige and support for abortion in the clinic.

I have illustrated the tiered nature of stigmatized work within one organization and offer a mechanism for understanding how prestige affects these workers differently. One's work (especially stigmatizing work) can be a strong rallying point for group cohesion and collective identities resulting in positive self-identification (Ashforth and Kreiner 1999). However, in organizations like the clinic under study, it may be difficult for lower-status workers to rally around a shared identity when they are required to do dirty work that is substantially different from the labor performed by their co-workers. Additionally, a strict and hierarchical division of labor may impede potential group cohesion.

This study contributes to what we know about health work and the reproduction of inequalities. Managed care and medicalization require that work in health settings be divided and allocated hierarchically and in the most efficient manner. In the case of abortion, this leaves the dirtiest work to the lowest-status workers. Given what we know about the role of race and

ethnicity, gender, and class in shaping educational and career trajectories, it is not surprising that in the clinic under study, the MAs were all Latina and the MDs were white. However, this study further shapes our understanding of how organizations exacerbate these inequalities. The point needing exploration is not simply a matter of Latinas doing MA work because that is what they are qualified to do as a result of their educational opportunities; rather, we must examine how dirty work becomes racialized. Further research is needed to investigate how race/ethnicity, gender, and class shape abortion work and fashion certain types of abortion workers.

## CHAPTER 5: LOCATING MEDICAL ASSISTANTS IN ABORTION WORK

This chapter explores MAs' relationship with abortion work and reveals barriers to their developing positive professional identities linked to abortion provision. I start by describing MAs' trajectories into abortion work, followed by how they talk about their work to family and friends, challenges they experience doing abortion work, and what they like about their jobs. MAs did not come to work at the clinic to be involved with reproductive healthcare or support reproductive rights. They have to evaluate people's stances on abortion before disclosing their work to them and are careful when talking about their work with family. Not unlike abortion counselors in the 1980s (Joffe 1986), however, MAs in this study liked their jobs because they perceive abortion work at the clinic to be more interesting and requiring greater skill then work in other clinical settings. Yes, MAs struggle with managing and making sense of their emotions, especially their conflicting feelings about abortion. This requires them to do unremunerated and unrecognized emotional labor.

In the previous chapter I demonstrated that MAs perform some of the most stigmatized work with the least opportunity for intimate work with patients. In this chapter I argue that the effects of this arrangement of work is further exacerbated by the clinic ethos to not judge patients. While the reproductive rights logic may not much shape clinic care, it certainly does shape how workers are instructed to relate to patients. A reproductive rights logic emphasizes women's autonomy and normalizes abortion; thus abortion workers have to accept patients' choices without question. Judging patients for their actions or choices implies that some abortions are more acceptable than others. A reproductive rights logic treats all abortion as equal regardless of patient circumstances. Additionally, the focus of the reproductive rights logic is on the patient and does not articulate a role for workers. In medical and nursing education there are

opportunities for student doctors and nurses to recognize potential cleavages between their own values and patient care and they are encouraged to develop professional identities around nonjudgmental and compassionate care (Curtis, Horton, and Smith 2012; Maze Martino 2005; Rhodes, Cohen, Friedman, and Muller 2004). When MAs are trained to work at the clinic, they are instructed to be nonjudgmental and provide quality care but they do not receive training that encourages them to process or even acknowledge complicated feelings about abortion. The modern medical logic, for its part, leaves little time or space for this kind of work.

## A NEW OCCUPATION

Medical assistants, who are instrumental in many clinical settings that offer reproductive healthcare, have been largely overlooked in research on abortion providers. While the literature has examined the roles of physicians (Freedman 2010, Joffe 2010), counselors (Joffe 1986), nurses (McLemore and Levi, 2011), and ultrasound workers (Kimport and Weitz, 2015), among others, researchers have not focused on the increasing, unique, and integral role medical assistants (MAs) play in abortion care. Healthcare related occupations have been increasing at a rate of about thirty percent over the last few decades and are projected to trend at this rate for the foreseeable future (Bureau of Labor Statistics 2019). Medical assistants (MAs) are 13$^{th}$ on the list of fastest-growing fields (Bureau of Labor Statistics 2019) and offer an important group for study because they represent a new demographic of healthcare workers. Unlike doctors, MAs more closely reflect the racial, ethnic and socioeconomic demographics of the communities in which they work (Chapman, Marks, and Dower, 2015). Medical assistants have a low barrier to entry compared to other healthcare professions; only a high school diploma or equivalent and a certificate are needed. Medical assisting certification programs are short (6-9 months) and are often provided by private corporate-run schools. Low barrier to entry and short training periods position medical assisting as a feasible option for those without a college degree who are looking

for a stable career. Finally, from an organizational perspective, MAs are cheap and valuable sources of labor for clinics striving to maximize revenue and reduce costs.

MAs fit into a broad category of health worker but without an established professional identity to draw from. Professional identities are derived from a combination of training, credentialing, and sociohistorical factors (Larson 1979). Take for example, doctors and nurses. Both professions require significant training, have cultural and historical narratives regarding their evolution and importance in society, and are recognized as honorable careers. Nurses and doctors have well-developed and positive identities related to their professions which may be particularly useful in managing the stigma associated with abortion work (Ashforth and Kreiner 1999; Langendyk, Hegazi, Cowin, Johnson, and Wilson 2015). Medical assisting, on the other hand, is a relatively new occupation, requires little training, and does not enjoy elevated social status; nor is there a collective social perception of what it means to be a medical assistant.

## THE MEDICAL ASSISTANTS AT THE CLINIC

The MAs in the clinic had not intended to work in abortion or even reproductive healthcare when they decided to become medical assistants. The route to working in the clinic was very similar for most MAs; they wanted a job in healthcare and completed an MA certification program, then either through the school they attended or a friend, was connected to the clinic. The following are profiles of some of the MAs in the clinic and describe their career trajectories, what they did and did not know about abortion, reproductive healthcare and the clinic prior to working there and what they think are the benefits of their jobs.

### *Chloe (5 years at the clinic)*

I asked Chloe what made her get a medical assisting certificate and she said, “my kids.” She explained, “Well, I was a stay at home mom for a couple years with my first son and then I

went back to college and got my associate's degree. At first I wanted to be a teacher and then I wanted to get something fast because I needed a job because I wanted to make money. So I [became a] medical assistant." She had a job with an endocrinologist and then in pediatrics for a couple years but was looking for a change. She read the job description at the clinic and thought, "I want to do that … it seemed like something I wanted to do." Chloe was largely unaware of the types of services offered at the clinic. She recalled reading the job description, "I read about birth control, when it said like 'women's choices,', like birth control, like... I never knew nothing about birth control until I started working at [the clinic]." When I asked her what made the job different from her previous work she said, "Like helping other women and you know. I didn't know pap smears... Like I didn't know how important that was until I started working there." She liked working there because she got to "be there for the patient, to make sure they know that there is somebody there for her. Not to judge them for what they are there for." While she liked "being there" for patients she admitted her job was easier than nurses' because she didn't "have to sit there and talk to them as long as the nurses do. And find out their whole life story and stuff." She didn't have to hear every patient's story which made it easier not to judge patients. She went on, "I am not here to judge anybody. I mean there's times where I, for example, where they've been there like 6 times or 7 times I kinda get a little judgmental like how come they didn't get birth control? But I mean I'm not in their shoes, I don't know what they are going through."

I asked Chloe what she thought the most important part of her job was and she said, "being there for the doctors if they need anything. I think that's important. To give it to them right away." She liked working with doctors and liked the surgery aspect of her job. In addition to abortions, Chloe liked assisting doctors during more advanced gynecological procedures like

colposcopies, cervical biopsies, and sterilization procedures. Chloe and I had the following exchange:

> Me: What about the surgical days and the LEEPs and the [colposcopies], what about that is more appealing to you? Why do you like that more?
>
> Chloe: Like the LEEPs?
>
> Me: Yeah, like the more advanced stuff? Why do you like that?
>
> Chloe: I like to see when they take out the piece of the cervix, I just like the biopsy that they do. I like to watch.
>
> Me: The more medical stuff?
>
> Chloe: Yeah. It's interesting. And the Essure, how the doctor puts the camera in.
>
> Me: I want to see that so bad!
>
> Chloe: I think that's awesome. It's like a whole different world in there

She also liked that her job at the clinic didn't involve a lot of paperwork or more administrative duties. MAs in other settings have to do things like insurance authorizations, follow-up phone calls to patients, and dealing with referrals. She liked that she was always busy doing the more clinical duties and that she had learned so much. Chloe was up for a promotion at the time of the interview; she was being considered for a lead surgical MA position. She wanted the position but didn't like the feeling of competing with her coworkers and friends, "I don't like working like that. Like to be competing. Like, I'm just happy I work, and I have a job, and I have a check."

Like all of the MAs in the clinic Chloe was careful about how she talked about her job outside of the clinic. The next exchange is from when I asked whether she talked about her job to her friends and family:

Chloe: I don’t really tell people about where I work unless they ask me. Like my sister, I let her know where I work and she like "oh, isn't that where they do abortions?" and I'll just explain to her you know... we do pap smears, we do biopsies, anything that has to do with women reproductive [health], we do it and also with males but it's more for women. And we do terminations but only 6%, a certain percentage, not a lot.

Me: So then the people in your extended family know that you are a medical assistant but don't know where you work?

Chloe: Yeah. My mom knows and she doesn't really care where I work as long as I work but my in-laws are religious so they are against it. I think my sister-in-law told them and for a while they stopped talking to me and they somehow brought it up but I just changed the subject because I didn't want drama in between the family. I just don't talk about my job or any work when I am around them.

Me: Oh okay. What about your husband?

Chloe: He knows. I'll tell him how my day is or what I did. He is okay with it.

Me: Do you share when things were particularly hard, or like stressful or something?

Chloe: Yeah, I'll tell him and he is just like "it’s fine". He doesn't know what to say. He doesn't like to hear it. When I talk about the abortions and stuff. He doesn't like to hear it.

Me: What does he do for a living?

Chloe: He is in construction. He got his license [to be a] contractor. A contractor's license.

Me: When is the job difficult for you emotionally? Like when is it really hard or emotional or stressful?

Chloe: Like personal stories from patients?

Me: Yeah, or whatever you think is hard.

Chloe: I gets emotional when I hear some of their stories like if they were raped or... or like the second [trimester] when they’re bigger because the bigger cases those are a little still; I don't really pay much attention to it. It doesn't bother me it's just like "why did you wait so long?" when patients just don't care. When they are like "oh I knew but I didn't know" and they wait so long to decide. But I know sometimes they don't know, but sometimes they do know, and they just don't care.

I asked how she gets through the emotional stuff. She reminds herself that "okay, I am here for the patient. She doesn't have anywhere else to go. There is a reason they have to get this done."

Chloe was the ideal MA at the clinic. She was the most skilled and knowledgeable MA and rarely made mistakes. During an interview, one of the doctors marveled at Chloe's focus and joked that Chloe could probably do an abortion by herself. Chloe was well liked and respected by all the staff and had the best rapport with patients. Chloe's trajectory to working at the clinic was typical of most of the MAs; it was a job that was available when she was looking for work. Similar to the other MAs Chloe liked the technical and more scientific aspect of her work and found it more interesting and preferable to the work offered in other medial assisting positions. Chloe was happy that it was not the MAs' responsibility to hear all the details of patients' lives, which made it easier to not get as emotionally involved. Chloe admitted to feeling upset or confused about patients who had had multiple abortions or who, in her opinion, waited too long to have an abortion. However, when these topics came up, she suppressed her own feelings and focused on being nonjudgmental and accepting patients' choices as valid regardless of the circumstances. Aside from Chloe's hedging comments, medical assistants did not outwardly criticize patients in interviews. But I did observe indirect judgement in the clinic. MAs' criticisms were couched in off-handed comments or jokes such as saying, "we'll see you later," when an abortion patient refused birth control or "why did she wait so long?" when someone had a later stage abortion. It is important to note that I never witnessed an MA treating a patient differently. They were always professional and friendly.

*Alex (2 years at the clinic)*

Alex had a different path than most of the other MAs and was one of the two MAs who weren't Latina. She had a bachelor's degree in biology from a 4-year university. She had originally been pre-med but was unsure what to do when she finished college, so she tried some different things.

> I became a physical therapy aid first because it didn't require any certifications or anything. Got some years there, but I was thinking about [Physician's Assistant] school at the time and they wanted more clinical hours. So, I applied to a fertility clinic and they hired me on as a medical assistant there and so I have that background in women's reproductive services. You know, I started out with women and men who wanted to have children [but] weren't able to have children on their own. And then after that I wanted to go a little more broad, because you know fertility is so specific. So uhm then I started looking at applying for other jobs and I applied to [the clinic] because I saw that they had an opening and I got it. So that's how I ended up there.

I probed about whether her applying to work at the clinic had anything to do with the mission of the clinic. She said, "It was more at the right place at the right time, although I do believe in the mission too. I saw the opening and thought WOW that could be really fun to work there." Alex had taken a "non-traditional" route to get her MA certification. Instead of going through a program, she worked for a doctor who approved her skills and knowledge and signed off on her getting her certificate. While working at the clinic, Alex had taking the necessary courses to be an Emergency Medical Technician (EMT). She split her time between working at the clinic and as an EMT. She was planning to quit the clinic in a few months when she started nursing school. I asked Alex to reflect on the what she did and did not like about her job at the clinic.

> I guess you can start with the frustrating part, the positive part is that being the surgical medical assistant you are kind of the glue. You are the go between for all the other providers. So you know you got to make sure that the RNs are happy,

> that the doctors are happy and the recovery nurse is happy and the manager is happy and the patient flow is going just right because you are the one kind of transporting everyone everywhere they need to go. All the paperwork all the supplies, if it weren't for this position it would be really hard. Operations would be more difficult.

Alex framed MAs' position in the clinic as both positive and negative. In her opinion the clinic could not operate smoothly without the MAs: "if one piece is not working then everything kind of falls apart." She liked being an integral part in the clinic even if it meant that part of her job meant keeping everyone happy.

In addition to keeping her coworkers happy, Alex acknowledged the emotional labor required to work with patients. We talked about how she managed that part of her work.

> Alex: What makes it hard for me to do my job? I don't know, I don't think there's anything really hard about my job. I mean there's the emotional aspect of like seeing scared people all day long and being there for them and being kind of an emotional sponge, but you know you got people coming in with all sorts of stories and they're telling you there life story left and right so there's definitely an aspect there that kind of makes it a challenge to you know not let your own feelings get involved.
>
> Me: How do you manage that balance?
>
> Alex: Um…let's see. (long pause) Practice. You do what you need to do at work and make them feel safe and do what you need to do to unwind via yoga, have some tea, take a nice bath, whatever.
>
> Me: So like self-care practices help you?
>
> Alex: Yeah
>
> Me: Is there times when it was like particularly emotionally challenging? Like instances when you thought, "this is not what I thought it was going to be"?
>
> Alex: Yeah probably with the patients who have been sexually abused and have been pregnant because of result of it and like I'm setting them up for procedure

> and they're like balling their eyes out and telling me what's been going on with them and just trying to hold their hand everything's, well you don't know everything's going to be okay with them after they leave but at least for this little part everything will be fine
>
> Me: Yeah, yeah
>
> Alex: Yeah, yeah, it's kind of hard to not let your own emotions get involved there, but yeah. Those things do happen and it's sad.

Alex described herself as an introvert and wanted her career to move in a direction where she did not have to do as much emotional labor. She was thinking about becoming a certified nurse anesthetist because it required less interaction with the patient, "just meet them talk for a bit and then I provide my services …"

Alex's family knew she worked at the clinic, are supportive of abortion, and even donate money to the clinic. As for her friends, "Most of my friends are supportive and some of them are not. They just don't like that one aspect of our organization. It just kind of turns them off, what can you do?" In general she does not tell new people she meets where she works, "I don't because there's just a lot of political backlash happening and you just can't be sure where everyone stands. Until I know I won't really disclose [where she works]." She provides a generic response when people are curious about she works, "The general answer is I work at a women's health clinic and if they keep asking it's like well it's a surgical site and we do very specific specialized cases and yeah usually stop there."

Finally, I asked specifically whether she was uncomfortable working with products of conception, "No! It's incredibly interesting, because I really like doing um, the dissections and the class and the anatomy and physio. I wanted to do medicine forever, so you know being in that like you know?" Working in surgical abortion offered Alex the opportunity to be exposed to anatomy and physiology, things she enjoyed learning in about in college. She was unbothered by

the fact that she was handling aborted fetuses. She had seen preserved fetuses at a "Bodies" exhibit at a museum before working at the clinic and found it interesting. During her interview for the job at the clinic she talked to the manager about the exhibit to demonstrate that she was comfortable with the work.

Alex's educational trajectory and previous support for abortion made her somewhat unlike the other MAs. Her parents were openly supportive of abortion and she did not have any hesitation about working at the clinic. Additionally, the position at the clinic was one stop on her way to more advanced degrees. Alex did, however, have some of the same challenges as the other MAs. Even though her parents were supportive, she had to gauge who she could tell about her work and how much she could tell them. She struggled with managing the emotional part of her job, especially hearing patients' circumstances and reasons for their abortions. Finally, Alex's comments about MAs position in the clinic are typical of other MAs' feelings regarding their responsibility for keeping their coworkers happy and maintaining the flow of clinic operations.

*Juliana, Nicole, and Sam (3 years at the clinic)*

Juliana, Sam, and Nicole became friends while attending the same MA training program at a nearby for-profit vocational school. Juliana was the first to get a job at the clinic. She had already attended community college for a couple years but stopped when she was unsure what she wanted to do for a career. Her mom encouraged her to go into the "medical field" so she enrolled at a local for-profit school and after finishing her certification the school set her up with an interview at the clinic. Juliana had originally wanted to work in a pediatric setting and did not want to work at the clinic.

> I was like no. So then when [the school] got me the interview, they were like "we think you'll fit great, you're a fast learner so you'll do great there, and it's the

> surgical side", and I was like no, they were like "well at least go and give it a try, we'll see what happens." So then I went to the interview [and] I wasn't too thrilled about it, but the interview went great and then that same day they called me … I was like, well I need to take a day to think about it, because my parents, they're very religious, so I was like how am I going to break it down to them. So then, well I had a part time job and it was minimum wage … I kind of just have to look at the big picture and I just put what I thought aside, and then I'm like I'm there for work and that's it.

Knowing her parents would disapprove, she waited until she had worked in the clinic for over a month before she told her parents. When she did tell them she emphasized that abortion was only a small portion of the services offered and told them she was mostly assisting in appointments related to well women's exams, like pap smears and breast exams. Her dad rationalized her decision to work at the clinic, "well they are paying you money, it's fine." She recalled her mom telling her, "well as long as you keep it to yourself and you know what you stand for, then it's fine." One of Juliana's more religious friends could not accept her working there.

> … it was four friends and we were very close, one of them was very religious and she told me "well if you keep working there I'm not going to talk to you," … I'm like, are you going to pay me what they're paying me? I'm like, if you don't want to do it I get it … People are going do it no matter what. She said I was being part of [abortion] and then she brought religion into it and then over time she's like 'you're gonna stay there?' I'm like yeah, and…I lost a friend.

Through working at the clinic Juliana became more accepting of abortion but was still uncomfortable assisting in terminations of more advanced pregnancies. She talked about the emotional toll of the "hard cases" and how she doesn't feel she was adequately trained to handle them. "I don't think we're trained emotionally, they kind of just throw us [in]." Her training consisted of the specific tasks required to assist the doctor. When Juliana first worked at the clinic, more experienced staff would talk her through difficulties. If they saw she was having a hard time they tell her to take moment to breathe and they shared their experiences with being emotionally overwhelmed.

Nicole and Sam, both hired after Juliana, came to work at the clinic along a similar trajectory but were more comfortable with abortion. Nicole, who had known she wanted to work in healthcare since high school, recalled finishing her certification and getting hired the clinic the next month, "I was pregnant so I was like I just gotta get something I don't care what I get." Being pregnant presented a sense of urgency to her job search. She was not concerned by the abortion aspect of the work; when she read the job description it seemed like, "just any other job." Sam had finished school after Nicole and Juliana and asked them to put in a good word for her at the clinic so she could get hired too. I asked Sam if she had any reservations about working in an abortion clinic and she said, "Nuh-uh. I came in open-minded to do everything because I was in desperate need of a job." Working at the clinic was attractive because she wanted to work with her friends.

Both Sam and Nicole had experience working in other clinics and preferred abortion work because they got to do more advanced clinical work. At one point, Nicole had quit the clinic to work at a children's hospital but came back to the clinic after a few months. She had quit the abortion clinic because of scheduling issues but quickly became dissatisfied with her job

at the children's hospital. "I didn't go to school to do front office stuff and that was mainly what it was. And I missed the surgical like I missed all that." During my fieldwork, Nicole was taking classes at a local community college with the goal of getting into nursing school. I asked her whether she would want to stay in women's reproductive health as a nurse she said, "I mean, I really like the surgical aspect of it so I feel like as a nurse I would want to do a surgical setting, that's what I think now. But who knows later." Nicole knew that she enjoyed the surgical aspect of her job at the clinic but did not have a clear understanding of what kinds of surgical work is available outside of reproductive healthcare and thus could not envision what other jobs were possible.

During her internship at school Sam had worked at a community clinic that mostly served patients with diabetes or high blood pressure. She preferred the abortion clinic because of the surgical work and acknowledged that it may seem weird to find the gory parts interesting, "I don't know it may be weird, because it looks really gory and everything but it still amazes me that if I want to look at like a little lung or a little thing like I can, and not a lot of people get to say that." She identified a part of her job that was exclusive to abortion work; she got to see things that other MAs. Sam mentioned this at the end of the interview when I asked if there was anything else she wanted to share indicating this was important for me to know. I probed with "So you like the science part of it," she replied, "like the biology part of it, yeah" Her comments also communicated a dissonance between how she felt and how she thinks other people feel. She acknowledged that maybe it was "weird" to enjoy looking at POCs. Not only was it gory but perhaps immoral to find aborted fetuses interesting.

Like Juliana, both Nicole and Sam's parents were against abortion but accepted their daughters working at the clinic because it was a good job. After initial pushback the parents did

not pressure them to quit the clinic nor did they shame them for working there. Some of Nicole's and Sam's younger family members were supportive and interested in their work. Nicole's sister in law thinks it's "really cool" that Nicole works at the clinic. Sam talks about the clinic to her cousins and encourages them to go to there for birth control. Sam said that some people in her social circle have gone to the clinic for services but were largely unaware the clinic provided abortions. Like all the MAs I interviewed both Sam and Nicole are cautious about telling people where they work then they first meet them. Nicole recalled a story where she met a woman at a laundry mat and the woman asked Nicole where she worked, "I got that like vibe from her like I probably shouldn't tell her where I work so I was like oh it's just a clinic."

Sam admitted that she sometimes did wonder about why people get multiple abortions, "yeah, I mean sometimes I wonder but like I don't know, maybe their life is super complicated, I don't know. I don't think I'll even know." In training she was taught to put herself in patients' shoes and to "not judge, just keep a smile on so they feel like they could come back, and like not – because I want them to come back, I really want our patients to come back and have somewhere to go instead of like getting referred out or something." For Sam it was more important that patients have somewhere to go for their abortion than it was for her understand why people have multiple abortions. Sam said that staff meetings usually included a short customer service training which communicated messages regarding being non-judgmental and putting oneself in "patients' shoes."

## DISCUSSION

The MAs I talked to did not get their MA certification with the goal of providing abortion care or even reproductive healthcare. Their trajectory to working at the clinic was that they were interested in working in the medical field, got their certification and found their way to clinic either through networks or just saw the clinic was hiring and applied. Working at the clinic was a

step forward in putting their education and credential to use. Some of the MAs did want to continue their education and get a nursing degree, while others were satisfied with their current jobs and had no plans for advancing. While some MAs did think of themselves as "pro-choice" prior to working at the clinic, none of them sought out work at the clinic *because* of the clinic's mission or their own beliefs about reproductive rights. Abortion work was aligned with their career goals not because they wanted to work ensure access to abortion but because they wanted to work in healthcare.

Contrast this with doctors who told me they knew they wanted to work in women's reproductive health and family planning as they planned their careers in medicine. They specifically sought out volunteer opportunities as undergraduates and medical students and applied to residency programs that would give them experience with birth control and abortion. Two of the three doctors I interviewed specifically talked about taking women's studies courses during their undergraduate education. The doctors were clearly motivated to pursue abortion work as a career choice which may have been reinforced by learning about feminist ideologies and the reproductive rights movement.

MAs enjoyed their jobs at the clinic; they liked assisting doctors with surgeries, they liked that they did not have to do front desk duties, and they liked the feeling of helping people. Comparing their experiences working in other clinics, the MAs found working in the abortion clinic to be more satisfying. They had more diverse clinical duties and gained advanced skills such as ultrasound guidance. Chloe, Alex, and Sam all talked about being fascinated by the biological aspects of their work and that surgical abortion allowed them to see things they otherwise would not have. They enjoyed what would be considered to be more gruesome things like being able to see different stages of fetal development. Not all of the MAs were equally

comfortable with seeing fetuses; Juliana struggled with assisting the 2nd trimester procedures. She liked that she was helping people and despite her own complicated feelings about abortion defended her work to friends and family. All MAs I spoke with took pride in their work, but this pride was not necessarily because they were ensuring access to abortion. Medical assistants in the clinic could be "refocusing" to highlight the parts of their job they thought of as positive. Focusing on their jobs as skilled laborers was a way to manage stigma associated with abortion. It may also have served to elevate their status within healthcare more generally and differentiate themselves from MAs who did mostly administrative work.

Additionally, MAs found satisfaction in "helping people" but at the same time were happy that they didn't have to do the heavy emotional work nurses did. They wanted to be in a position to help people, but they did not want to bear the burden of hearing all the details of every patient's story. They did not link their helping patients to abortion specifically, but rather were vague and talked about "helping women" or helping those with "nowhere else to go. "Their hesitation to talk about helping people access abortions could be due to the medical emphasis of their work. Medical assistants did share a feeling of camaraderie but this was more about working together, not working together to provide abortion.

Most MAs' families tolerated abortion work because it provided steady employment. While most MAs' parents preferred they *not* work at the clinic, the stability of the work, the pay, and benefits compensated for their parents' distaste for the work. Alex was the exception as her family was pro-choice and even donated money to the clinic. Even though Alex's family was more supportive, she felt similar constraints as other MAs when talking about her work. All were cautious about disclosing where they worked when they first met someone and avoided specifics when people asked them about it. Even among more supportive peers and partners MAs felt they

could not share too many details because as Chloe said about her husband "he doesn't want to hear it." Having to hide their work from family and friends likely took an emotional toll. Positive professional identities are constructed in part by the status and characteristics others ascribe to our jobs. MAs shared that they worked in healthcare but they could freely share more specifics about their jobs, leaving an empty space where people could assign value. Instead they were generic health workers without the privilege of working in specific field of medicine. Finally, not being able to talk about their jobs reinforced the stigma associated with abortion.

All workers in the clinic, regardless of position, talked about being careful about with whom they share where they work. Doctors were especially cautious and rarely shared outside of their families and most immediate social circles. One doctor practiced under her maiden name so that her kids, who had their father's last name, could be linked to her work. For doctors this was an issue of personal safety, as doctors have been targeted with violence and murdered for providing abortion. Doctors and nurses, however, had established and respected professional identities regardless of their field of medicine and so could lean on their social status and title when people inquired about their jobs. Medical assistants did not have the privilege.

Finally, MAs talked about not judging patients. They wanted to provide quality and compassionate care regardless of the patient's circumstances and choices. Chloe's comments revealed a schism between the clinic's ethos to not judge abortion and her own observations about patients. Chloe expressed concern that some people were cavalier in their approach to abortion by either waiting too long or having repeated abortions. The MAs mostly refrained from criticizing patients during interviews yet did occasionally express some judgement when working. Medical assistants were aware that they were supposed to express unequivocal support for abortion and so adopted the language provided by the clinic--"put yourself in her shoes" and

"we are not here to judge"-- when talking about their work with an outsider. In reality they did judge patients for their choices. Instead of addressing what was motivating judgment, a reproductive rights logic encouraged them to suppress their complicated feelings about abortion.

# CHAPTER 6: CONCLUSION

In this dissertation I have described the current state of abortion provision. Starting with the premise that abortion has changed in the decades since Roe v Wade, I argued that the push to make abortion care like mainstream healthcare has had important consequences. In this chapter, I will discuss what my findings might mean for abortion care, abortion workers, and abortion advocates.

## ROUTINES DECISION MAKING AND INSTITUTIONAL LOGICS

In chapter 3, I explored how institutional logics structured abortion care in a standalone clinic. Like other accounts of competing logics, I found that some logics gained primacy in structuring clinic operations. Notably, a modern medical logic that prioritizes doctors' authority, efficiency, and maximizing labor was very influential in shaping clinical care. Once you got past the bullet proof glass, abortion care largely resembled care at other outpatient surgical centers rather than that in the feminist clinics that emerged immediately after Roe vs Wade. Processes were streamlined and duties were compartmentalized to make the best use of clinic space and to use the cheapest workers for as many tasks as possible. The turn toward a patient centered flow suggests a logic that prioritized the patient experience, a customer service logic of sorts. However, the patient centered flow also supported a modern medical logic as it cycled patients more quickly through abortion appointments, allowing the clinic to see more patients and generate more revenue.

Rather than being at odds, I argue that a modern medical logic largely structured how care was organized in the clinic (e.g. patient centered flow, appointment structures, etc.) while a reproductive rights logic informed how workers related to their work, to patients, and to abortion more broadly. The modern medical logic routinized care according to evidence based practices and managed care processes. The reproductive rights logic was less influential in the clinical

practice of abortion. I have defined a reproductive rights logic as one that prioritizes women's autonomy, normalizes abortion, and emphasizes the political nature of abortion work. It is a logic rooted in the feminist principles of the women's and reproductive rights movement. In previous ethnographic accounts of abortion clinics, the reproductive rights logic was evident in clinics encouraging patients to process their feelings about abortion with counselors and in small groups. Workers with no medical background but who were pro-choice activists were incorporated into clinical care. A feminist logic, broader than a commitment to reproductive rights, structured clinics as workers tried to create more egalitarian organizations by reducing physicians' authority and share job duties. A modern medical logic does the opposite, as duties are compartmentalized within a strict staff hierarchy.

A reproductive rights logic was not wholly absent from clinical care and surfaced when routine care was not possible and non-routine decisions about care had to be made. The vignettes in Chapter 3 described instances when staff were unsure which direction to take. Doctors, whose entire professional trajectories were motivated by a reproductive rights logic, made decisions when routinized care was not possible. In addition to their authority as physicians, doctors had multiple logics at their disposal to justify their decisions. In the fourth chapter, I described how doctors were the moral and morale leaders in the clinic. In essence, they embodied the reproductive rights logic in the clinical space. Their decisions, while routed in sound medicine, also reflected their pro-choice beliefs and desire to secure widespread and unfettered access to abortion.

At first glance, normalizing abortion is good because it destigmatizes abortion. Framing abortion as a safe, normal, and frequent procedure has been a strategy of reproductive rights advocates. Activist campaigns such as "Shout your abortion," the "1 in 3 Project", and The

National Network of Abortion Fund's claim that "Everyone loves someone who had an abortion," promote that view. However, I argue that the reproductive rights logic presents a paradox. Clinics' efforts to treat abortion as similar to other healthcare procedures ends up downplaying the politicized aspect of abortion and makes a modern medical logic dominant. If we claim that abortion is like any other healthcare service without considering how abortion work is quite different from other forms of healthcare, then abortion work loses an important connection to the politics of abortion. This connection may be particularly important for lower status workers as they make sense of their roles in abortion care.

## THE REWARDS AND LIMITS OF INTIMACY

In chapter 4, I found that duties were allocated to meet the needs of a modern medical logic and that MAs fared worse than other staffers in this arrangement as they were responsible for the most stigmatized work. I used dirty work and intimate work to identify different types of abortion work. I showed that the type, frequency, and purpose of dirty work and intimate work wee key sources of variation in the jobs people did in the clinic and argued that this variation created different opportunities to reap potential rewards of intimate work. MAs engaged in the dirtiest work in the clinic and their intimate work was directed toward doctors rather than patients. Nurses' intimate work was necessary to mitigate risk, but their dirty work was tempered as it was the least associated with the distasteful aspects of abortion. Finally, doctors were freed up to be the bearers of emotional labor and held a special place on the dirty work spectrum due to their occupational prestige and support for abortion in the clinic.

Intimate work in abortion care can be rewarding when it bolsters one's emotional connection to abortion or when it can be reframed as critical to the health and safety of the patient. This type of intimate work was largely unavailable to MAs in the clinic. Instead, MAs engaged in relatively superficial intimate work with patients, more akin to good customer service

than deep emotional work. Furthermore, a modern medical logic rewarded their intimate work with doctors, further distancing MAs from intimate work specific to abortion.

Not all abortion workers engage in the same types of work; their experiences are not uniform. Education and training socializes healthcare workers differently (Becker et. al. 1961; Simpson 1979), yet research treats abortion providers as uniformly stigmatized, or discusses them in isolation from each other. This chapter provided an organizational level analysis to compare different occupations within one setting, and to better understand the roles of different workers in relation to each other. My findings suggest that it may not be useful to think of abortion workers as a monolithic group that share the same concerns or need the same professional supports. Doctors, nurses, and MAs may need different organizational and professional supports to mitigate the negative effects of intimate and dirty work. For example, the route to developing positive self-identities for MAs may be through their intimate work with doctors. Alternatively, clinics could find ways to more equally balance dirty work with less stigmatized work in MAs' regular duties.

## LOCATING MEDICAL ASSISTANTS IN ABORTION WORK

In chapter 5, I explored medical assistants' experiences in abortion work and found potential challenges to their developing positive professional identities centered around abortion provision. None of the MAs I spoke to were motivated by a strong commitment to reproductive rights when they decided to work in the clinic. They were motivated by the need to get a job in healthcare that provided stable income. Even Alex, who had the strongest pro-choice stance prior to working at the clinic, did not decide to work at the clinic because it was an abortion clinic. Alex wanted to get more hands-on experience with surgical work as she pursued nursing school and it just so happened that the clinic provided this experience. Juliana was the MA who was most worried about working at the clinic but her need for a job outweighed her discomfort with

abortion. The MAs came to the clinic with varying degrees of support for abortion but even those who were unsure had to be somewhat open to the idea or they would not have taken the job. We often think about people either being staunchly for or against abortion, but in reality, there are people who have contradictory feelings about abortion. MAs in this study expressed some of those contradictions: abortion is acceptable as long as a person doesn't have too many, or doesn't wait too long to have the abortion, or doesn't try to prevent future pregnancies with birth control.

Another interesting contradiction is MAs' interest in the surgical part of their job while seeking to distance themselves from some of the emotional labor it entailed. They like working at the clinic because of the surgical aspect of their work. They felt they were getting to participate in advanced medical care. It is interesting that one of the things they valued was the part of their job that was also the dirtiest. They talked about appreciating seeing POCs because of the anatomy and biology. At the same time, they did not want to know the details of every patient's story. They wanted to ensure patients felt safe and comfortable but did not want the burden of doing deep emotional labor. This may appear to be at odds with how scholars think about the benefits of intimate work. It makes sense when considering MAs' position in the clinic hierarchy and in healthcare more broadly. By emphasizing their skilled labor, they elevated their status as healthcare workers. Yes, emotional bonds provide a source of satisfaction for those engaged in intimate work, but MAs were not motivated by building intimacy with patients. When comparing their work at the clinic to other jobs they had had, they mentioned that the clinic work was more "hands-on," indicating greater proximity to what we think of as healthcare. Billing insurance, entering information into a computer, and listening to patients' stories is not what MAs envisioned when deciding on a career in healthcare.

Additionally, MAs may have been less interested in hearing patients' stories because it was not valued by the organization. In many of the clinics that opened after Roe v Wade, a non-medical staff member would sit with a patient, talk to them about their choices, and provide time for the patient to process their feelings about abortion. Such work is not prioritized within a modern medical logic and in the clinic studied has been absorbed into the nurses' duties. If the clinic prioritized the medical aspects of the abortion care, then it makes sense that MAs would do so as well. Another reason MAs may have not been interested in hearing stories is that they were not equipped to deal with the emotional burden. Their training as medical assistants or after being hired at the clinic did not include instruction on how to recognize and make sense of unpleasant or overwhelming feelings.

Race and ethnicity, class, and gender are certainly important to consider with regard to MAs' education and professional trajectories and their experiences with abortion work. It is not surprising that occupational hierarchies in the clinic mirrored the race/ethnicity and class-based social hierarchies and the demographics of the geographical area. The majority of the MAs in the clinic were Latina. There was some educational variation with a few MAs having an associate's degree, a few taking community college courses at the time of the study, but many only had a high school diploma and the MA certification. Alex, who was Asian American, was the only MA with a bachelor's degree. The nurses were racially diverse (white, Asian, and Persian) and the doctors were all white. There were disparities in the education to career pipelines based on race/ethnicity, class, and gender. Medical assisting was characterized as a "good job" by the Latinas in my study, implying that other, more advanced medical-based degrees were seemingly out of reach.

Finally, many MAs did not talk about their work in their personal lives. Family members actively discouraged them from being open about where they worked. This was not due to concerns about safety but because families disapproved of abortion. For many abortion workers, hiding their job was a part of their job. There was fear about offending friends and family and being ostracized in their networks. Doctors, nurses, and MAs all shared the same concerns and talked about being worried about their kids. Chloe's husband told her not wear to a t-shirt with the clinic's logo to drop the kids at school. While all abortion workers struggle with disclosing their work, MAs face unique challenges. MAs, more so than other staff, received more pushback from immediate family members. Doctors were more concerned that they would be outed as abortion providers in their neighborhoods but they could talk about their job to their partners, parents, and siblings. MAs could not talk openly about their work even in their most immediate circles. They had to navigate two contradictory environments; at work abortion was affirmed and supported and at home abortion was shameful and should be hidden. It is not surprising that they did not become particularly politicized as a result of working at the clinic.

One of the things my dissertation addresses is what it means to have a new category of abortion worker. All MAs felt they were providing an important service for women and took pride in their work but the source of their pride was largely unrelated to abortion. De-emphasizing abortion in their work may have been a strategy to distance themselves from abortion stigma and elevate their status as skilled medical workers. But it also reveals the effects of a waning reproductive rights logic in abortion care. Does it matter, then, that MAs do not express a strong commitment to reproductive rights as long as they provide safe and compassionate care? According to a modern medical logic the answer would be "no" but if we think about unpaid labor and workplace inequalities, then we may come to a different

conclusion. There is a group of workers, primarily women of color, who must exert significant emotional labor to navigate pro-choice and anti-abortion environments in their daily lives and who are not provided opportunities to express their own complicated feelings about abortion. These workers are also the lowest paid workers and hold the lowest social status in the clinic. While feminist ideals historically were not entirely successful in addressing racial inequalities in abortion clinics, having a more influential politicized logic might be necessary in addressing workers' diverse needs.

## FURTHER RESEARCH

Very little is known about medical assistants in healthcare. As this group continues to grow, more empirical work is needed to map their position within healthcare. The current organization of healthcare has created an underclass of health workers who may have steady employment but who can be easily replaced and have little opportunity for upward professional mobility. People of color, and people from lower income or largely immigrant communities are over-represented in these positions. Medical assisting certification programs are often housed in predatory for-profit schools. Together, this leads to questions regarding workplace and social inequities and skilled vs. unskilled labor in healthcare.

My study calls for further work on conceptualizing politicized institutional logics. Aside from knowing how logics operate in an organization, the circumstances under which logics conflict, and how actors employ logics, we know little about differences in the relative weight or importance of logics. I found that a politicized logic was more influential in structuring how people relate to their jobs rather than the particulars of the job itself. Further research should examine which aspects of organizational life politicized logics influence, especially in healthcare. Finally, I found that there are limits to the rewards for intimate work. More research is needed to fully understand the relationship between stigmatized work (both intimate and dirty)

and organizational structures. Scholars have primarily been concerned with how workers find satisfaction in their work but less attention has been paid to how organizations play a role in creating the conditions for workers to be satisfied.

Ethnographic research provides an in-depth look at a single context and is not meant to be generalized across settings. Observations and accompanying analysis shed light on abortion care in one organization. While an accounting of small, tedious, day-to-day activities provides a useful description of abortion work, the specificity of my conclusions may not apply to other healthcare centers or even other abortion clinics. However, the analysis derived from my observations might be applied to other settings to further our understanding of institutional logics, work, and professional identities. The clinic under study was a relatively well-resourced member of a group of clinics in an urban area in a progressive state. Conclusions would likely be different in a small independent clinic in a conservative state. Analysis was limited to those staff in the clinic most closely associated with the medical aspect of the abortion. Further research should include all staff in the clinic (e.g. front desk workers and call center staff) to expand the discussion of abortion workers.

This study gives us new insight into the current state of abortion work. Though the accuracy of this snapshot may be short-lived due to the precarious policy environment for abortion and the ever-shifting landscape of healthcare provision, documenting the features of abortion care is nonetheless important. It is important to recognize abortion work as a useful site for broad sociological exploration rather than a politicized and unique case. It is also important to see how healthcare structures organizes work and the diversity of experiences among abortion workers.

## IMPLICATIONS FOR ABORTION CARE

At first glance it appears that I am advocating for a reproductive rights logic to be reinfused back into abortion care. But that is not my intention. On one hand, I have sought to show what abortion clinics and workers may lose when a reproductive rights logic takes a back seat to a modern medical logic .But I have also shown that a reproductive rights logic may be problematic for some workers as it discourages workers from acknowledging complicated feelings about abortion. Today, advocates are moving away from a reproductive rights approach to a reproductive justice approach and this shift may be helpful for clinics as well. The reproductive rights movement has always struggled with incorporating women of color and particularly Black women and Latinas. A reproductive justice logic does not center abortion as the most important concern and acknowledges the full spectrum of concerns people have as they do (or do not) become parents. Instead of simply telling MAs not to judge patients the conversation would center on the structural inequalities in the context of which people make their reproductive decisions.

An overall better understanding of why MAs choose to work at abortion clinics is also required. I have made some initial steps in this area but we need to know more, especially as it pertains to race, class, and gender. That we have abortion workers coming from anti-abortion families should be not overlooked by clinic administrators and pro-choice advocates. While it may be unlikely that workers will change their families' minds about abortion, workers do have some influence in their circles, especially with similarly aged friends and family. Additionally, many of the MAs in the study had small children. The topic of how they would talk to their kids about abortion never came up, but one can imagine that the children of MAs would be more informed about reproductive healthcare, perpetuating a more progressive shift in their

communities. Aside from influencing friends and family, MAs can participate in democratic processes to influence policy on abortion.

Finally, medical assistants' roles as abortion providers should be more clearly acknowledged and steps should be taken to integrate them into professional spaces where people discuss family planning and abortion. There is a gap in MAs' professional identities; they are health workers but their occupations are unintelligible in society. My study has shown that they are seeking out opportunities to define their work as skilled. If clinics and doctors found professional development opportunities, this could provide the necessary catalyst for them to meaningfully link abortion to their work. Perhaps abortion work could become more than just a job.

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## APPENDIX A. Dirty work and intimate work duties for clinic staff

**Medical Assistant**

Dirty Work

- ▷ Collects, tests, and disposes of urine
- ▷ Cleans blood and other bodily products from exam room furniture, instruments, and floor
- ▷ Cleans and sterilizes surgical tools and equipment
- ▷ Transports, examines, and disposes of POCs and tissue
- ▷ Cleans blood, ultrasound gel and other bodily fluids from the patient

Intimate work

- ▷ Comes into contact with patient's semi-nude body
- ▷ Covers surgical tools and equipment before the procedure
- ▷ Tends to groggy patients (cleaning, dressing)
- ▷ Chatting with patients immediately before and after the procedure
- ▷ Learning doctor's preferences
- ▷ Anticipating doctors needs

**Nurse**

Dirty Work

- ▷ Blood samples for hemoglobin, RH, Betas
- ▷ Comes into contact with genitals during vaginal ultrasound
- ▷ Places IV needle
- ▷ May come into contact with post-procedure blood in recovery

Intimate work

- ▷ Takes medical history
- ▷ Screens for rape, sexual assault and coercion
- ▷ Reproductive planning and birth control
- ▷ Abortion counseling
- ▷ Comes into contact with semi-nude bodies during ultrasound
- ▷ Spends the most time with the patient (20-40 minutes)
- ▷ Answers patients' questions and concerns

**Doctor**

Dirty Work

- ▷ Comes into contact with blood, tissue and other bodily products
- ▷ Comes into contact with genitals
- ▷ Terminates the pregnancy
- ▷ Removes pregnancy tissue from the body
- ▷ Examines POC and tissue

Intimate work

- ▷ Obtains informed consent from patients for the procedure
- ▷ Answers patient questions and concerns
- ▷ Knows intimate details about the patient's medical history and personal life

- ▷ Counsels patients who are unsure or have to be turned away
- ▷ Comforts upset patients