THE EXPERIENCES OF ABORTION PROVIDERS IN POST-DOBBS AMERICA

AN HONORS THESIS

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Abstract

In *Dobbs v. Jackson Women's Health Organization* (2022), the United States Supreme Court issued the landmark decision that overturned *Roe v. Wade* (1973). In June 2022, the court’s decision returned the authority to regulate abortion to the states. In many states, codified abortion bans and trigger laws have resulted in abortion being outlawed. Although the proliferation of targeted regulation of abortion providers (TRAP laws) has steadily reduced the availability and accessibility of abortion services across the country for decades, the *Dobbs* decision has guaranteed the closure of clinics in restricted states. While much of the existing scholarship is dedicated to the effects of abortion restrictions on patients, abortion providers are often absent from the discussion. Moreover, abortion provision during the post-*Dobbs* landscape requires new research.

The purpose of this research project is to answer the following question: how are abortion providers responding to the overturn of *Roe v. Wade* in their respective states? Additionally, how have providers’ unique professional identities at the intersection of care work, dirty work, and invisible work been forced to change amongst industry disruption? These questions are important because the stigma associated with abortion work renders its practitioners invisible in society. Moreover, the lived experiences of abortion workers before and after the *Dobbs* decision have not been considered in existing academic literature.
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Introduction

In 1973, the United States Supreme Court issued the historic decision in *Roe v. Wade*. In a 7-2 majority, the Court argued that the Due Process Clause of the Fourteenth Amendment established a fundamental right to privacy, which protects a pregnant person's choice whether to have an abortion (*Roe v. Wade*, 1973). In 1992, the Supreme Court reaffirmed *Roe v. Wade* in *Planned Parenthood of Southeastern Pennsylvania v. Casey* but redefined several provisions. In *Casey*, the Court considered the constitutionality of several Pennsylvania abortion statutes, including a parental consent provision, a spousal notification provision, and a 24-hour waiting period. Ultimately, the Court upheld all the restrictions in *Casey*, except the spousal notification provision. *Casey* rejected *Roe*'s trimester framework for scrutinizing state abortion restrictions and established the “undue burden” standard. The undue burden standard asks whether the “purpose or effect [of the law] is to place substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability” (*Planned Parenthood of Southeastern Pennsylvania v. Casey*, 1992) (Smentkowski, 2023).

The decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) weakened the legal protections previously afforded to pregnant people in *Roe v. Wade* (1973). Three decades later, the implications of *Casey* are glaring. Since 1973, states have enacted 1,338 abortion restrictions, with 46% of those restrictions enacted in the past decade (Guttmacher Institute, 2023). Abortion restrictions disproportionately harm marginalized communities, particularly people of color and people living in poverty. Due to interlocking systems of oppression, marginalized people are less likely to overcome the web of barriers to care that abortion restrictions compound (Fuentes, 2023).
On June 24, 2022, the Supreme Court issued its official ruling in *Dobbs v. Jackson Women’s Health Organization*. Jackson Women’s Health Organization, the last abortion clinic in Mississippi, challenged a Mississippi law that banned abortion after 15 weeks. The Supreme Court upheld the ban on appeal, overturning both *Roe* and *Casey* and reversing nearly 50 years of precedent. Consequently, the ability to restrict or protect abortion was returned to the states (Center for Reproductive Rights, 2022). Within six months of the *Dobbs* decision, 24 states had banned abortion or were likely to do so. As of April 2023, 12 states have near-total bans in effect (Nash et al., 2023).

![Abortion restrictions by state as of April 24, 2023.](image)

In my research, I ask: how are abortion providers responding to the overturn of *Roe v. Wade* in their respective states? Additionally, how have providers’ unique professional identities at the intersection of care work, dirty work, and invisible work been forced to change amongst industry disruption? To answer these research questions, I conducted interviews with abortion providers...
providers. The term “abortion providers” refers to anyone directly or indirectly involved in abortion provision, including but not limited to physicians, counselors, and clinic administrators. In this thesis, I will review the existing literature on the topic, discuss the research methods, conduct an analysis of my findings, and discuss its future implications.
Literature Review

In this section, I will review the existing literature on the subject. First, I will introduce the three theoretical frameworks that guided my research. Next, I will apply these theoretical frameworks to abortion work. Then, I will review the literature on the experiences of abortion providers in the United States.

Care Work

Cancian (2000) described care work as “both feelings and effortful, goal-directed activity, and it centers on responding to an individual’s needs” (p. 137). Care work is an activity that is dominated by women. Predominantly female occupations are socially and economically valued less than predominantly male occupations. The link between feminization and devaluation is causal due to cultural norms that attribute more economic and social value to work performed by men (Busch, 2018).

Historical perspectives on care work suggest that the connection between care and women is socially constructed (Abel, 1990). Meyer (2000) writes, “The myth that women have a natural capacity and desire to care has proved to further reinforce gender inequalities by disproportionately burdening women with unpaid or low-paid care work” (p. 6). This naturalization of skill phenomenon contributes to the economic devaluation of feminized skills because some workers are believed to just be doing what comes ‘naturally’, such as performing care work (Hatton, 2017).

Invisible Work

In 1987, Daniels coined the term “invisible work” to describe the unpaid labor that women performed in the domestic sphere, including housework and childrearing. Its contemporary definition has expanded to include unpaid work that does happen in formal places
of work but often goes unrecognized and uncompensated, mostly by women. Invisible work is not conceptualized in the public imagination as work, so it remains hidden, rendering the workers themselves invisible in society. Moreover, “work that is not seen is not valued, either symbolically or materially” (Crain et al., 2016, p. 5).

**Dirty Work**

Hughes (1962) developed the concept of “dirty work” to describe work that society deems socially necessary but physically, socially, or morally tainted. Ashforth and Kreiner (1999) expanded on Hughes’s original concept of dirty work by defining the three kinds of taints. Harris and colleagues asserted that abortion work is associated with all three taints: physical (blood, fetal parts); social (contact with stigmatized patients); and moral (ambiguous fetal moral status) (Harris et al., 2011). Furthermore, the practitioners of dirty work, or “dirty workers” are stigmatized; “The perceived taint of the dirty work is apt to be projected onto the workers so that they are seen to personify dirt” (Ashforth and Kreiner, 1999, p. 416).

**Application of Theoretical Frameworks**

Abortion work exists at the intersection of care work, invisible work, and dirty work. These three theoretical frameworks are interlocking with respect to abortion work, creating a uniquely marginalized professional identity for abortion providers.

Abortion work requires providers to respond to patients’ needs, whether those needs are physical (performing the procedure, administering medication) or emotional (counseling the patient). Moreover, the types of care workers that make up abortion providers are predominantly women. As of 2022, women made up 87.9% of nurses (United States Bureau of Labor Statistics, 2022); 86.4% of active residents and fellows specializing in obstetrics and gynecology (Association of American Medical Colleges, 2022); 69.9% of counselors (United States Bureau
of Labor Statistics, 2022); and 60.5% of active obstetrician-gynecologists (Association of American Medical Colleges, 2022). Data that aggregates abortion workers as a group does not exist in the literature.

Like many forms of care work, abortion work is also a form of invisible work because it is not recognized or valued in society. Moreover, abortion providers perform various invisible tasks to ensure quality care for their patients (shouldering some of the burden placed on patients by abortion restrictions, contacting patients to cancel their appointments due to the *Dobbs* decision). Abortion work is also a form of dirty work because it is physically, socially, and morally tainted due to the stigma associated with abortion.

Many professions fit into one or two of these theoretical frameworks, but not all three. For example, garbage collectors perform work that is dirty, but it is not care nor invisible work. Teaching is care work, but it is not dirty nor invisible. Restaurant dishwashers are invisible, but their work is not care nor dirty with respect to all three taints (physical, social, and moral).

Evidently, these theoretical frameworks come together to create an experience for abortion providers that is unique from other professions. Abortion providers are devalued in status and pay for practicing a feminized skill and working in a feminized industry. Furthermore, the work that abortion providers perform is unrecognized due to its invisibility in society. However, when abortion work is visible, the narrative is negatively constructed through the stigmatized lens of dirty work. Furthermore, disruption to the industry caused by the *Dobbs* decision will create an experience for abortion providers that is categorically different from other professions (for example, the automotive industry).
The Impact of Abortion Restrictions on Providers

Although individual states could not legally ban abortion until *Dobbs v. Jackson Women’s Health Organization* (2022), state abortion restrictions have been negatively affecting the accessibility of abortion for decades. Since *Roe v. Wade* (1973), a total of 1,338 abortion restrictions have been enacted in the United States. In 2021, more state abortion restrictions were enacted than in any year since the *Roe* decision (Nash, 2021). Medoff (2009) identified the most common abortion restrictions as Medicaid funding restrictions, parental involvement laws, mandatory delay laws, and mandatory counseling laws. These kinds of abortion restrictions are intended to delay and discourage patients from seeking care.

After the *Planned Parenthood of Southeastern Pennsylvania vs. Casey* (1992) decision, many states started enacting targeted regulation of abortion providers (TRAP laws). TRAP laws subject abortion providers to licensing fees, regulations, and requirements that are not imposed on comparable medical practitioners and facilities (Medoff, 2009). TRAP laws impose
requirements that are difficult or impossible for providers to meet that serve little to no benefit to patients. The purpose of TRAP laws is to reduce the availability of abortion services. Examples of TRAP laws include applying state standards for ambulatory surgical centers (ASC) to abortion clinics, minimum measurements for physicians’ offices where abortions are performed, and requirements that abortion providers have admitting privileges at a hospital (Guttmacher Institute, 2020). Mercier and colleagues researched the experiences of abortion providers operating under North Carolina’s 2011 Woman’s Right to Know (WRTK) Act. The WRTK Act mandated a 24-hour waiting period before an abortion can be performed, as well as biased scripted counseling. Employing a snowball sampling method, Mercier and colleagues conducted qualitative semi-structured interviews with people involved in abortion provision in North Carolina. All providers involved in the study objected to the WRTK Act, and most participants cited negative impacts on the providers themselves, the patients, and the patient-provider relationship. Additionally, all providers demonstrated adaptations to the restrictions imposed by the WRTK Act at the institutional level and within interactions with patients. Mercier and colleagues’ research contributed to the emerging scholarship on the effects of state abortion restrictions on providers (Mercier et al., 2015).

Mercier and colleagues conducted further research on the challenges imposed on abortion providers working under TRAP laws by employing the sociological framework of invisible labor. The invisible labor framework posits that work dominated by women often goes unrecognized and uncompensated. Moreover, work that is rendered invisible in society leads to the workers themselves being erased as well. Mercier and colleagues’ research demonstrated that abortion providers shouldered some of the undue burden placed on patients by TRAP laws in order to preserve abortion access and maintain quality of care. Compliance with abortion
regulations resulted in increased emotional and financial burdens on providers, leading to significant strains on the abortion provider workforce (Mercier et al., 2016).

**Occupational Identity of Abortion Workers**

Like any other profession, the practitioners of dirty work have an occupational identity that contributes to their self-definition. Occupational identity is defined by Ashforth and Kreiner (1999) as a set of primary characteristics that typify the line of work. The stigma of dirty work makes it challenging for dirty workers to construct positive occupational identities, especially in the United States where professional work plays a central role in overall identity (Ashforth and Kreiner, 1999) (Harris et al., 2011). Furthermore, dirty workers risk adverse consequences, including status loss, discrimination, and difficulties associated with disclosing their profession to others. Consequently, occupational stigma can result in social isolation and low self-esteem (Harris et al., 2011).

After the initial Supreme Court decision in *Roe v. Wade* (1973), scholars started to consider the value of researching abortion provision as an occupation. In 1995, Joffe published *Doctors of Conscience*, a study that analyzed the struggles of abortion providers before and after *Roe v. Wade*. Physicians were recruited using snowball sampling for in-depth qualitative interviews. Joffe emphasized the importance of focusing on abortion providers as research subjects because “the actual delivery of abortions cannot take place unless some persons are willing to view this phenomenon as their ‘work’” (p. 6). Moreover, interviews with physicians who provided illegal abortions before the codification of *Roe v. Wade* reveal the potential similarities between the experiences of pre-*Roe* and post-*Dobbs* abortion providers.

The most pervasive theme in Joffe’s *Doctors of Conscience* was the professional stigma associated with abortion work, especially among providers’ colleagues in the medical
community that did not provide abortions. One participant described his colleagues’ characterizations of physicians who provided abortions: “You weren’t a good person and probably weren’t a good doctor either. At the very least, you were an embarrassment to the medical community” (p. 153). Moreover, abortion providers described their work as being devalued by their colleagues for lacking intellectual rigor. Additionally, working in a freestanding abortion clinic further tainted a provider’s professional reputation in the medical community (Joffe, 1995).

Despite the stigma associated with abortion provision, physicians had specific motivations for providing abortions. The most common motivations for participation in abortion work included: a loved one dying of an unsafe illegal abortion, a personal traumatic experience with an illegal abortion, longstanding participation in progressive social movements, and witnessing the dire medical complications associated with unsafe illegal abortions. It is worth noting that many physicians included in this study provided illegal abortions before Roe v. Wade. However, Joffe’s research makes a distinction between these “doctors of conscience” (physicians who provided abortions for moral reasons) and the stereotypical “abortionist” or “back-alley butcher” that participated in abortion work out of greed, frequently risking the lives of their clients (Joffe, 1995).

In response to the lack of scholarship analyzing how providers experience and manage the stigma associated with dirty work, O’Donnell and colleagues conducted semi-structured interviews with healthcare professionals involved in abortion provision. This research found that abortion providers experience a strong sense of occupational culture, which is consistent with the existing research on stigmatized professions. Occupational culture is a distinctive pattern of thoughts and actions shared by members of the same profession. However, study participants
also described frequently feeling devalued and disrespected by other healthcare professionals that were not engaged in abortion work, which can lead to concealment of occupational identity outside of the workplace (O’Donnell et al., 2011).

Harris and colleagues researched how abortion stigma affects providers’ regular provision of abortion care by conducting focus groups with employees at a Midwestern reproductive health clinic. All the workers involved in abortion provision (including physicians, surgical assistants, nurses, phone staff, managers, and counselors) experienced the effects of abortion work stigma such as interpersonal conflicts, isolation, threats to safety, and violence. Additionally, the physicians who performed the abortions were regarded as less legitimate compared to other doctors who were not involved in abortion provision (Harris et al., 2012). Furthermore, this research revealed that abortion providers rarely discuss their work with acquaintances and strangers, despite a strong sense of professional pride and identity. Consistent with the existing scholarship on stigmatized work identity, the central concern in managing the stigma of abortion work is disclosure management (Harris et al., 2011, Kumar et al., 2009). The combination of stigmatization and physicians’ reluctance to discuss their work creates what Harris and colleagues refer to as the legitimacy paradox, where abortion providers remain in the public imagination as incompetent and immoral butchers. The legitimacy paradox threatens the abortion provider workforce, encourages restrictive abortion policies, and reduces the availability of abortion services for patients (Harris et al., 2012).
Methods

The research protocol was approved by the Tulane University Institutional Review Board. Ten (10) semi-structured qualitative interviews were conducted with abortion providers in the United States. An interview guide with open-ended questions about abortion providers’ experiences was used. The interview guide covered a range of topics, including the positive and negative aspects of their work, the reasons they performed abortion work, and their feelings about the Dobbs v. Jackson Women’s Health Organization decision.

Inclusion criteria was that the person must have been involved in abortion provision directly or indirectly before the Dobbs decision on June 24, 2022. This criterion was used to account for abortion providers who may have lost their jobs following the Dobbs decision. The term “abortion providers” includes obstetrician-gynecologists, nurse-practitioners, counselors, patient advocates, and clinic administrators.

A snowball sampling method was used to recruit participants for the study (existing study subjects recruit future subjects). The initial snowball originated from the researcher’s experience working at a local affiliate of a reproductive health and rights organization. Potential participants were contacted by email. The email included the details of the study and invited recipients to schedule an interview using Calendly, a website for scheduling meetings. On the Calendly website, the researcher offered multiple dates and times over a month period. A consent form was attached in the email outlining the recipient's rights as a research participant. If the recipient decided to participate in the study, they gave written consent over email. After obtaining consent, the researcher gave the participant a pseudonym.

Interviews were conducted and recorded on Zoom with audio and video. The interviews lasted 45 minutes to 75 minutes. The researcher conducted the interviews in a private and locked
room and participants were encouraged to do the same for privacy. Interviews were automatically transcribed with Otter.ai, an online artificial intelligence application that transcribes meeting notes. The interview transcripts were verified manually for accuracy. If the participant disclosed any identifying information, it was manually redacted from the transcript. For transcription and analysis, participants were only referred to by their pseudonyms.

Participants were incentivized to participate in the research study. They were compensated in the form of a $50 Amazon gift card granted by the Newcomb Institute Grant Program at Tulane University. After transcription, interviews were analyzed manually by the researcher for thematic codes. Sections of the transcripts that corresponded to a thematic code were inputted into a separate document and color-coded.

The sample size was 10 participants. All participants in the study identified as women. 9 of the participants were white; 1 participant was Hispanic. 4 participants were clinic directors; 3 participants were OB-GYNs; 2 participants were patient advocates, and 1 participant was a nurse-practitioner. Participants were from a range of locations. 5 participants were from California (most protective toward abortion); 2 participants were from Louisiana (most restrictive toward abortion); 1 participant was from Alabama (most restrictive toward abortion); 1 participant was from North Carolina (restrictive toward abortion) and Georgia (very restrictive toward abortion); and 1 participant was from North Dakota (most restrictive toward abortion) and Minnesota (protective toward abortion).
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Race/Ethnicity</th>
<th>State(s)</th>
<th>State Restriction Level</th>
<th>Position</th>
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<tr>
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<td>Very protective</td>
<td>Nurse practitioner</td>
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<tr>
<td>Avery</td>
<td>Woman</td>
<td>White</td>
<td>Louisiana</td>
<td>Most restrictive</td>
<td>Patient advocate</td>
</tr>
<tr>
<td>Beth</td>
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<td>White</td>
<td>North Dakota, Minnesota*</td>
<td>Most restrictive/Protective</td>
<td>Clinic director</td>
</tr>
<tr>
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<td>Very protective</td>
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<tr>
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<td>Restrictive/Very restrictive</td>
<td>Clinic director</td>
</tr>
</tbody>
</table>

Table 1. Table of research participants.

*One abortion provider (Rose) oversees clinics in North Carolina and Georgia. Another abortion provider (Beth) served patients in North Dakota before relocating her clinic to Minnesota post-Dobbs.
Analysis

In this section, I will analyze the findings of the interviews in the context of five themes. The themes include providers’ motivations to perform abortion work, the challenges associated with abortion work, the abortion provider community, the trauma of the Dobbs decision, and the aftermath of the Dobbs decision.

Motivations to Perform Abortion Work

Abortion providers described their work as “gratifying,” “rewarding,” and “fulfilling.” Providers are motivated to perform abortion work for various reasons, but most providers (8) reported that the best part of their job was interacting with patients. One abortion provider described how the best part of her job was providing supporting patients during emotional conversations.

One of my favorite parts of being a patient advocate was talking to people and giving … [them] an opportunity to have an open and honest conversation about what's going on in their life. The good, the bad, the ugly, the tears, the laughs, whatever it is … So really, my favorite part of being a patient advocate and in the director role was being … a rock for people and letting them know that they have the strength [and] they have the power to overcome whatever obstacles may be in front of them.

- Julia, Louisiana

Julia and other providers prided themselves on their ability to offer patients practical and emotional support, which is a keystone of care work. Providers feel like they make a difference in patients’ lives and that what they do is meaningful and impactful. In a way, supporting patients was mutually beneficial because providers are inspired by their patients.
All providers that participated in the study described an ethical and moral responsibility to do abortion work. Providers also feel a keen sense of duty to their job, demonstrated by one provider describing how she stumbled into abortion work as her “superhero origin story.” Several (3) seasoned providers were also motivated by the opportunity to mentor the next generation of abortion providers. One abortion provider said that the opportunity to mentor providers is what motivates her to keep going. Another provider from California, Audrey, said that she is motivated to mentor future generations of providers so that they can continue the fight for abortion rights.

It's like training the next generation of clinicians you know, to take over … and continue the fight … I had the opportunity to work with a lot of doctors and providers that trained me that had been in a pre-Roe world … They had seen … all of the horrible things that happened pre-Roe, and that was why they became abortion providers … I've learned and heard many of their stories, so I think it's important for us to continue to mentor and pass that on because the clinicians that I'm training now have never worked with someone who was providing illegal abortions … Sadly, a lot of those providers have died … [I’m] just trying to carry on that legacy by mentoring the next generation of providers.

- Audrey, California

Evidently, Audrey’s desire to carry on the legacy of mentoring the next generation of abortion providers demonstrates a strong commitment to abortion work and a respect for providers of previous generations.

While abortion providers of previous generations struggled to construct positive professional identities due to the stigma of dirty work, all the abortion providers in this study were proud of their “life’s work.” Ultimately, providers are motivated to perform abortion work
because they consider it a calling. Providers have become mobilized to discuss their work because it is a form of resistance against stigma.

**Challenges of Abortion Work**

Abortion providers described several challenges associated with their work pre- and post- *Dobbs*, including threats to safety, managing patient demand, and complying with changing abortion restrictions. Managing these challenges constitute invisible work because abortion providers are uncompensated and unrecognized for performing them. Furthermore, providers in exclusively emotional care roles experienced these challenges in addition to feeling devalued at the bottom of the abortion provider totem pole.

All the abortion providers in the study described experiencing regular threats to their safety. Although there is anti-abortion protest activity across the country, the harassment appears more targeted and personal in the restricted states, likely because there are fewer providers and greater hostility. The most common threat was verbal and emotional harassment from anti-abortion protestors. Two providers said that the protestors were the worst part of their job. Another provider pointed out that there is no other profession where its workers are told they are going to hell for killing babies, which makes her job “bizarre” and “unique.”

One provider, Rose, explained how the anti-abortion protestors in North Carolina strategically planned a protest outside of the clinic she owned and operated on her wedding day. In many states, anti-abortion protestors organize a 40 Days of Life event. However, in North Carolina, the group of anti-abortion protestors take it a step further by organizing a 40 Weeks of Life event that culminates in a parade of 2,000 to 3,000 people. The anti-abortion protestors found out when Rose’s wedding was and planned their parade on the same day, on the same block of her clinic. On the morning of her wedding, Rose was dealing with the massive protest
activity outside of her clinic. Rose also described how she has experienced verbal harassment, depositions, and stalking at the hands of anti-abortion protestors.

You know, when I had my first kid, my daughter, I had a lot of antis tell me that the reason she was born with a congenital heart defect … was like God punishing me. And that she was going to die because of God punishing me for killing all these babies. If there's a way they could be insidious in my day-to-day life, they found it … I've been deposed several times over the past couple of years, including having people like … show up at the clinic pretending to be like fire marshals to get to me in the back. I've had them show up at my house. It's a lot.

- Rose, North Carolina/Georgia

Rose said that she has experienced several forms of targeted harassment from anti-abortion protestors, which takes an emotional toll. Negative experiences with anti-abortion protestors were not limited to providers working in restricted states. Lauren, a provider in California, said that protestors broke into the hospital she worked at and harassed providers and patients. Lauren was fearful that the protestors would become violent. Ultimately, law enforcement removed the protestors without incident, but a sheriff now guards the facility.

To mitigate the negative impact of anti-abortion protestors on patients, providers described organizing clinic escort programs, providing patients with information before their visit about protestors (what to expect, where to park to avoid them), and comforting patients after a traumatizing interaction. These activities fall outside of the official job description of abortion providers and often occur before they have even started delivering care.

Another challenge that providers experienced was managing patient demand, especially since the Dobbs decision. Providers are experiencing higher patient volumes due to clinic
closures in states where the procedure is banned. The director of an independent abortion clinic in North Carolina explained how the demand for abortions has surged at her clinic in the past year. Pre-Dobbs, her clinic saw between 7,000 and 8,000 abortion cases. In 2022, the clinic saw 11,500. In 2023, the clinic is on track for 15,000 abortion cases, all with the same number of staff.

Since Dobbs, clinics’ operations have been forced to change to accommodate the surge in patient volume with the same amount of resources (if not fewer). For example, Rose’s clinics in North Carolina and Georgia can now only provide first trimester abortions because they can’t see everyone.

We aren't able to see everybody, which has never happened before. We've never had to wait longer than the allotted three days in North Carolina. I've never had that problem before … We actually had to reevaluate how we like, schedule patients and what [trimester] we go up to … So right now, we're actually only going to first [trimester] in both locations in North Carolina and Georgia … We're doing that because of sheer volume and trying not to overload staff and physicians right now … That was a hard decision for me because it's harder to get care, and we have doctors who can do it.

- Rose, North Carolina/Georgia

Evidently, Rose struggled with the decision to only offer first trimester abortions because abortion providers feel a moral and ethical responsibility to provide services. Consequently, providers are constantly overburdened by patient volume due to the limited availability of providers. The consequence is independent providers feeling like they are responsible for keeping an entire geographic area covered in terms of abortion services. A clinic director and
abortion counselor from California explained how providers are caught in a lose-lose situation when it comes to responding to patient demand.

Clinics are beleaguered and besieged and overwhelmed … Everyone's sort of motivated to help and the thought of not helping someone is very disturbing. And so, it catches us in this lose-lose right? … I guess you're caught between like, well, we can either see fewer people and spend more time with them, or we can see more people and spend less time with them … There's no choice there.

- Natalie, California

Natalie explained how abortion providers are caught in a lose-lose situation where they are forced to either see fewer people and spend more time with them or see more people and spend less time with them.

Even before *Dobbs*, complying with burdensome abortion restrictions was a significant challenge for providers. One abortion provider, Julia, said that many people think the most stressful part of her job is having difficult conversations, but it is actually complying with the “red tape” of abortion care. Julia expressed frustration with abortion restrictions because they add additional barriers to patients seeking care.

While all abortion work involves care, three providers almost exclusively performed emotional care work as patient advocates or abortion counselors. These abortion providers experienced an additional layer of devaluation because they were not physically providing the abortions or running the clinic. A provider who served as the Director of Patient Advocacy at a Louisiana abortion clinic prior to the *Dobbs* decision described the treatment of patient advocates by the office and medical staff.
I think within the clinic itself, people didn't quite understand how hard the work of a patient advocate was, so they were kind of at the bottom of the totem pole … The patient advocates were definitely the least appreciated of anybody in the clinic, even though they did a significant amount of the work.

- Julia, Louisiana

Julia explained that even among abortion providers, there was a hierarchy in the value of certain jobs. Similarly, Natalie, a clinic director that specializes in abortion counseling described wondering whether anyone cares about what she does because it does not have monetary value.

[Counseling] is not reimbursable labor … So, it has not been designated or seen … It does not have monetary value … So, it's an easy thing to remove from the workflow … It's an obvious thing that you would take out from your practice. And so, I think for me, the hardest thing about what I do is … I have to wonder every day, whether anyone but me actually cares about what it is I do, because it's not valued. And if given the chance, like you know, that's obviously what you would … cut out. Like, you know, you can see more patients if you don't ask them about how they're doing. You know, you can reduce your cycle time … It makes me like regularly wonder whether there's actually any point to what I'm doing.

- Natalie, California

Natalie said that the hardest part about her job was its devaluation in society. This sentiment suggests that there is a hierarchy of value within the field of abortion work that privileges administrative and physical care work and places emotional care work at the bottom.
Community

Providers use their “tight knit” and “supportive” abortion provider communities as a coping mechanism for the challenges associated with their work. Dirty work stigma facilitates the development of abortion providers’ strong occupational culture. All providers that participated in the study described feeling connected to the people they worked with. Many providers described their colleagues as a “clinic family.” Further mechanisms of connection with fellow providers included social gatherings, group messages, and membership in local and national abortion organizations. One abortion provider described how she immediately “fell in love” with the people she worked with.

I was in love with the people who worked there and their compassion for the people who are seeking services, as well as their knowledge and just being … badass, like knowing what they needed to do for their patients to make sure that they were receiving the care that they need. [I] fell in love.

- Julia, Louisiana

Julia and other providers demonstrated a great deal of respect and admiration for their colleagues. One provider went as far as to say that she would lay herself off before laying off any member of her staff because they are each so imperative to getting the work done. Furthermore, several providers expressed that their community is what keeps them going.

I feel extremely supported by my supervisors and the leadership of the department …

We just have a great team because everyone's here because they specifically want to be here... That’s where the survival comes from.

- Natalie, California
Natalie, like many other providers, expressed that having a community of people that shared a commitment to abortion work was a source of resilience in an occupation with many challenges.

**Trauma of the Dobbs Decision**

All abortion providers that participated in the study described the *Dobbs v. Jackson Women’s Health Organization* decision as traumatic. Three abortion providers (from California, Louisiana, and North Carolina, respectively) were returning home from the National Abortion Federation (NAF) Conference when the leaked draft opinion was released by *Politico* on May 2, 2022. Several (2) providers compared the *Politico* leak to a loved one dying. The leak did not alleviate the devastation that providers experienced when the official decision was released.

On June 24, 2022, the United States Supreme Court released the official decision in *Dobbs v. Jackson Women’s Health Organization*. Common reactions from abortion providers were sadness, disbelief, anger, and fear. Providers described the devastation as twofold: personal and professional. Providers explained how they put their personal emotions aside to respond to patients’ needs. Julia, an abortion provider from Louisiana, described being at work when the decision was released.

I will never forget this day. And unfortunately, I was wearing one of my favorite work outfits, so that outfit is tainted forever. I can't wear that outfit ever again … I spilled coffee all over my floor and my desk because I was shaking so much. I was just angry. I was so mad. But we had patients in the clinic … So, I had to deal with having that decision come down on a personal level briefly. So right now, we're in a world where if I have an unwanted pregnancy, I personally can't have an abortion and how that makes me feel that people's rights are being taken away. But now, on the other side of my office door are 30-40 people who are currently pregnant and don't want their pregnancy … So I
had to put my own feelings away to be that rock that I'm meant to be, to be the person who had to break it down for these people who maybe weren’t even aware that abortion rights were on the verge of collapse anyway, because it was amazing how many people didn't even realize that this case was pending just because people have different access to information.

- Julia, Louisiana

Although Julia felt angry, she also knew that she had to put aside her personal emotions to care for her patients. This phenomenon is indicative of the expectation of care workers to respond to others’ needs before their own.

Several abortion providers described a “back-and-forth” experience during the period between the Dobbs decision and the official “end” of legal abortion in their state. During this period, clinics in hostile states relied on rulings and temporary restraining orders to continue providing abortions. Moreover, abortion providers in restricted states performed novel kinds of invisible work so that they could continue providing abortions whenever possible. One abortion provider described how she called patients to cancel their appointments when the bans were in effect.

And it was near the end, it was just kind of like everyone [the staff] pitching in … especially with all of the back-and-forth with the laws … I would be sitting on the phone for six hours a day, calling patients that were on their way, telling them to turn around. You're not having this procedure today, you know … To be the person that's telling someone basically like, you're going to have a child even though you don't want to … there's really no training for that.

- Avery, Louisiana
When the bans were active, providers like Avery experienced an internal struggle because turning patients away was not only painful, but at odds with their personal and professional codes of ethics. During this period, several (3) abortion providers had traumatic experiences with patients that will “haunt” them. Avery described the trauma of turning minor patients away who likely now have children.

It's like you're literally watching something unfold that I was told my whole life would never happen … So, after all this happened and I stopped working there and I felt like … My whole world is shattered. I had ten patients who were raped in that last week who probably now have children, and half of them by their fathers. Like there's no justifying that and then at the same time, I have even more patients who weren't raped, who still shouldn't have had children if they didn't want to.

- Avery, Louisiana

Julia, an abortion provider from Louisiana, said that one of the hardest days of her life was during the “back-and-forth” period.

So, one of the hardest days of my life … was a day during that back and forth …[I was] having to carry that … unpredictability into every conversation that I was having with a patient. So, they come in for their consultation … [And I had] to kind of like asterisk every single statement with “If we can,” “If we're allowed to” [provide abortions]. Yeah, that big ‘if’ was super difficult, because people are like, “What do you mean, ‘if’? Like, I'm here today, I'm signing all this paperwork, today. Can I have my abortion?”

I walk in, and there's already two cars sitting out in the parking lot … The first two patients of the day were coming from San Antonio and Houston … They got up at what, three o'clock in the morning, two o'clock in the morning to drive to the clinic and be there
on time for the procedure that we told them we would be able to do … So [we had to] call those people and explain to them that we cannot do your procedure today. [They said], “Well, I'm already sitting in the parking lot." And just that, like, gut wrenching phone conversation of being confused, being angry, being absolutely, like, stressed out of their mind, and sad, like, just sadness of having to carry an unwanted pregnancy no matter what their reasons that they cannot carry that pregnancy, and tears, so many tears. And to make it even like, more of a rough day for me, was the person who had traveled from San Antonio, there was a language barrier. So, I'm trying to explain to someone who only understands every other word coming out of my mouth … that you're here, but we can't help you … And that language barrier just absolutely was one of like the most difficult experiences of my life, because that just adds to her trauma of the situation and the burden for her. Her language barrier only made her … feel more devastated because she … didn't quite understand. Like you're in America, you're in the land of the free … Why am I not allowed to make a decision about my body?

- Julia, Louisiana

Like several other providers, Julia was traumatized after having to turn away multiple patients. The idea of turning patients away after they had surmounted tremendous barriers will continue to haunt providers, especially since they often feel responsible for mitigating these obstacles.

**The Aftermath of Dobbs**

In the aftermath of *Dobbs*, four abortion providers in the more restrictive states (Alabama, North Dakota, and Louisiana) immediately experienced significant disruptions to their day-to-day operations. These four providers continued to work during the “back and forth” period, but ultimately lost their jobs, moved locations, or changed the services they offered. One
Alabama provider, Emily, was able to keep the doors of her clinic open by switching to providing full-spectrum reproductive healthcare services (excluding elective abortions). Although she can no longer provide abortions, she still identifies as an abortion provider.

One provider, Beth, moved her clinic – the sole clinic in North Dakota – to Minnesota in response to the *Dobbs* decision. This brought a unique set of challenges. Beth described the additional labor she has performed to comply with the *Dobbs* decision and how it has “consumed” her life.

We've had to update the website constantly. We have different scripts that we read to patients based on [their state of origin] … We serve three different states with different levels of hostility … So, we have to really be on top of it and … be nimble and give different information to different patients depending on … where they come from … It’s been challenging … So, we're asking a lot of our staff, but you know, you don't work at the only clinic in the region, if you're not committed and, you know, willing to do that … I'd say the last year … I have never worked so long and so hard, like so many hours … I literally had to leave the state … I can really compartmentalize my emotions, but it's probably been the most emotional year of my work life. It's just completely consumed me.

- *Beth, North Dakota/Minnesota*

Following the *Dobbs* decision, Beth performed various forms of invisible work in order to continue serving patients. The most poignant form of invisible work was moving her clinic across state lines. Other forms of invisible work were constantly updating the website to reflect changing restrictions and keeping multiple state-mandated scripts on hand for out-of-state patients.
Two Louisiana providers lost their jobs following the state’s near-total abortion ban. Both providers described losing their jobs as a tremendous loss to their personal and professional identities. One provider described the experience as isolating, because people outside of the abortion provider community did not understand how she was feeling. Outsiders expected her “just to move on.” Consequently, she clung to fellow abortion providers. This sentiment further demonstrates the interdependence of the abortion provider community as a result of their stigmatized identity. Julia, an abortion provider from Louisiana, described how it feels like she has lost a part of herself after being displaced by the Dobbs decision.

I've lost a career path that I know that I'm making that difference in. And I know that I've lost an outlet of compassion that I didn't realize was there. I am an advocate … I am there to show people support and help them get the resources and services that they need … I've lost a … part of myself that hopefully I'll get back.

- Julia, Louisiana

Abortion providers’ tendencies to remain hidden also carried over to their conceptualizations of loss. Providers felt uncomfortable focusing on their feelings regarding the aftermath of Dobbs for several reasons. First, providers felt like they were less deserving of attention and compassion because the patients were the ones who were “actually” suffering. This feeling was compounded by the fact that the experiences of abortion providers are invisible in society, so they felt “selfish” for accepting recognition, even if it was for the pain they were experiencing. One abortion provider described how it felt “wrong” to talk about herself, despite feeling devastated at the loss of her calling.

It feels wrong to talk about yourself and … how you feel about it whenever you have … patients coming in that are having these moments, because it's not about you and it's
about them. So, when it was over, it was very confusing because you have all these feelings that you feel like you're not supposed to be having because it's not about you. And … I felt like I had finally found … my place in the world and … I found my career and … what I was good at, and it was taken away because of bullshit. And at the same time, it's like boo fucking hoo. Like that's been happening to people since the dawn of time … You know, how lucky am I that I'm 28, and that's the first time that happened? … It gets very confusing, because you don't want to talk about your own feelings about it. Because it doesn't feel like it does any good … if you're the ones that are supposed to be talked about. And so afterwards … there was an organization that helps … abortion care workers with funds because they had lost their jobs. And I just remember all … [of us] sobbing because it was like, “Oh my god,” somebody noticed us. Like we weren't asking to be noticed, but somebody did, and it was overwhelming.

- Avery, Louisiana

Although Avery felt like it was wrong to be recognized, she experienced a catharsis when an organization offered funds to abortion providers that had lost their jobs. Several abortion providers expressed that they did not feel the need to be recognized because recognition is not the reason they do this work. However, Avery’s catharsis demonstrates that the value of recognition should not be disparaged because it can have a significant impact on providers.
Conclusion

In this section, I will identify the key takeaways of the research and discuss its future implications for academia and broader society.

The abortion landscape in post-Dobbs America is rife with chaos and confusion for abortion patients and providers. Consequently, abortion providers have been performing novel forms of invisible work in order to preserve abortion access and maintain quality of care. These forms of invisible work included contacting patients to modify their appointments due to the Dobbs decision, updating their policies to account for the current abortion restrictions, managing an influx of out of state patients, being deposed in lawsuits, and regulating their emotions in front of patients. These activities constitute invisible work because although they are integral to the availability and quality of abortion care, they are also unrecognized and uncompensated activities that occur outside of traditional job descriptions. Invisible work has negative impacts on providers, including stress and burnout. Moreover, the nature of invisible work is that it is uncompensated, which exacerbates already existing gender inequalities in the labor market.

Despite feelings of tremendous devastation and loss in the aftermath of Dobbs, abortion providers struggle to draw attention to their experiences because they feel like it is their responsibility to care for others as care workers. This research suggests that the invisibility of abortion work is a self-fulfilling prophecy. Because abortion work is invisible in society, providers are hesitant to defy invisibility because it is inconsistent with their occupational identity.

Furthermore, the negative consequences of invisible work on abortion providers are likely compounded by the fact that they struggle to draw attention to their personal experiences. To remedy the invisibility of abortion work, abortion providers must be centered in the
conversation surrounding abortion work. Moreover, abortion work as an industry requires greater investment to fairly compensate providers and allow for growth in the provider workforce. This is necessary because abortion providers (particularly independent providers in restricted states) are burdened with the responsibility of preserving abortion access for their entire geographic area while having limited resources and being constantly under attack. It is also important that abortion providers are recognized as whole people, and not just politicized objects to be exploited by the far-right.

Another significant implication of this research is that it builds upon the limited literature dedicated to studying abortion providers. This is important because the stigmatized nature of dirty work leads to its workers rarely being studied in academia. In the existing literature, abortion providers of previous generations struggled to construct a positive occupational identity and disclose their job to others due to stigma. However, this research suggests that the current generation of abortion providers views their work as their calling. While the status of abortion work as dirty work has not changed, what has changed is how abortion providers respond to being dirty workers. Future research is recommended to assess what factors have driven this transformation. I speculate that the polarization of American political parties and the right’s adoption of the “abortion issue” has resulted in providers being more open about their work. Future research may also consider if the politicization of a stigmatized profession incites mobilization among its workers. In other words, does the garbage collector or restaurant dishwasher mobilize without a political inciting incident like the Dobbs decision for abortion providers?

This research also expands our understanding of invisible work by considering it in the context of industry disruption. When abortion providers experienced industry disruption, they
performed additional forms of invisible work to preserve their occupational integrity and continue to get the job done. However, providers are also experiencing the emotional consequences of decisions they were forced to make because of *Dobbs* that harmed patients. Consequently, abortion providers impacted by industry disruption need support services to cope with the trauma of *Dobbs*. This lends insight to new research questions, particularly about how industry disruption impacts politicized professions within the broader context of right-wing extremist attacks on democracy. For example, how do the findings of this research apply to physicians that provide gender-affirming care to transgender youth?

There were several limitations associated with this research. First, the sample size of the study was limited to ten abortion providers. Although I recruited abortion providers of various racial and ethnic identities, nine out of the ten that participated in the study identified as white. This is likely due to several factors. First, most abortion providers are white. Second, the burdens of care work, invisible work, and dirty work disproportionately harm women of color, meaning that participating in research is likely more burdensome than for white providers. Moreover, the current abortion landscape has led to increased risks of criminalization, which is more likely to impact Black providers. Thus, further research is required to account for the experiences of abortion providers of color.
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