Stigma Presents Barriers to Abortion Care

Lori Freedman, PhD
University of California, San Francisco

INTRODUCTION:

Today I want to talk to you about abortion stigma, what it is and how it affects women's health. For a brief overview: I will discuss the sociological definition of stigma – in general. Then I will explain what abortion stigma is, in particular. Third, we'll look at how abortion stigma affects women who need abortions and the clinicians who provide them. Fourth, we will look at how stigma affects abortion care services. Fifth, we will consider how abortion stigma can be decreased. I am a sociologist, and I do research about the ways in which the politics surrounding abortion affect medical practice in the United States. Because of that, this talk focuses a bit on the U.S. but, I will also bring in examples of how abortion stigma plays out other countries.

DEFINING STIGMA:

Turning to the sociological study of stigma. Erving Goffman wrote a book called "Stigma: Notes on the Management of a Spoiled Identity" in 1963.[1] He was an important thinker who shaped how sociologists study social interaction. His book about stigma used examples of people who are not viewed as "normal" in society; people such as those who have struggled with mental illness, physical deformities, or certain diseases. Some stigmas can be hidden–at least temporarily–such as alcoholism or having a prison record. Nonetheless, all are stigmatizing attributes that-- if known-- are considered "deeply discrediting". He explained that once a person's stigmatizing attribute is known, the person is "reduced in our minds from a whole and usual person to a tainted, discounted one."

What becomes stigmatized? Certainly there are <u>things</u> that have a stigma. Or <u>jobs</u> that people find to be very stigmatizing. But what matters is that the stigma attaches to a person, who is then devalued or tainted in some way. People manage stigma by hiding it, if possible. If it is not concealable, people do a number of things to manage stigma such as diverting attention from

it, explaining reasons for it, essentially trying to manage how it's understood. Another strategy for managing the unpleasant social approval that accompanies is to become aligned with people who are similar, this is called in-group identity, where people are able to create a "new normal" within the group, and reframe the stigma more positively.

ABORTION STIGMA and WOMEN'S HEALTH

Researchers from the organization IPAS offer the following definition of abortion stigma. It is, "A negative attribute ascribed to women who seek to terminate a pregnancy that 'marks' them as inferior to ideals of womanhood."[2] Around the world, women who have abortions are often regarded as selfish, promiscuous, irresponsible, heartless, and abnormal. Because of this women tend to do what they can to conceal their abortion experiences. Studies show that the majority of women who have had abortions anticipate judgment and stigma and therefore kept it a secret from their friends or family.[2-5]

Such concealment leads to something that Kumar, Hessini, and Mitchel called the prevalence paradox.[2] That is, because of the desire to avoid stigmatization, women who may have very good reasons to have abortion and feel very certain of their decisions may still hide, misclassify, or underreport their abortions… this leads people to believing abortion is not as common as it is. That perpetuates the idea that abortion is abnormal and deviant. When women's abortions are revealed, they are treated as deviant and face discrimination. After seeing this phenomenon, women fear stigma if they have had abortions; thus cycling back, it leads women to hide, under report their abortions, and so on. The prevalence paradox is all the more paradoxical in that abortion is one of the very most common health care experiences of women of reproductive age.

All this secret keeping and shame can lead to a loss of self-worth, women can become isolated, and fear asking their loved ones for help causing delays or, in highly restrictive settings, avoidance of professional help. For example, Ethiopia liberalized its abortion law in 2005, however unsafe abortion has persisted, women are reluctant to go to health care providers for help and often attempt to end pregnancies themselves enduring high rates of complications.

Women in Zambia similarly avoid the health system in part because of stigma and have had high complication rates due to unsafe abortion.

So therefore stigma or shame may translate to secrecy. Secrecy translates to a lack of social support, which can in turn make it harder to get safe and timely care when a woman lacks the money or knowledge to find it. In abortion restrictive countries this can translate to unsafe abortion and bad outcomes for women.

The prevalence paradox is a vicious cycle for women. Women are afraid to disclose their abortions because they anticipated judgment or rejection. So, people have little concept of how common abortion is due to this lack of disclosure. Which further gives the impression of abortion as rare, uncommon, abnormal. I think many of us fantasize that somehow this cycle would be broken with widespread disclosure and women would know they were not alone. But in some countries that can be a life threatening disclosure. And even the U.S. it can feel that way.

THE LEGITIMACY PARADOX for PROVIDERS:

Different vicious cycles occur for abortion providers. The legacy of the "back alley butcher" or "the abortionist" of the pre-legalization days in the U.S. have left a stigma on the work of abortion care. The abortionist image was that of a dirty, profit-motivated, incompetent criminal who harmed women. Abortion providers must combat that image and still at times find their work devalued, even in places where abortion is less contested. There is a problem of supply and demand. In large liberal urban areas in the United States, abortion provision is comfortable, doable, attractive for physicians, and there can even be an oversupply of abortion providers. But in the areas of undersupply, it's too scary, physicians feel too visible and there is a scarcity of doctors. While violence isn't actually more common in rural or remote areas, it feels as though it is more risky to provide abortions there because of increased visibility and doctors passed along cautionary tales about abortion providers being "run out of town".

The stigma of being an abortion provider causes what Lisa Harris has termed the "legitimacy paradox" -- a parallel to the prevalence paradox.[6] Because of stigma, many providers do not speak openly about their work and when abortion providers keep their abortion work secret in

everyday encounters, their silence perpetuates the idea that abortion provision is not normal or legitimate medical work. As a result, doctors perform less abortions or stay away from the practice altogether. This further marginalizes of abortion within medicine and makes abortion care more vulnerable to problems from opposition. And this in turn further encourages health care workers to keep their abortion work secret.

EFFECTS OF ABORTION STIGMA ON HEALTH CARE SERVICES:

Abortion stigma affects not only women, but also individual providers, and the abortion services themselves. In the U.S. abortion is safe, legal, and common but still highly controversial. Abortion has not been normalized as an integrated part of women's health care. Over 90% of abortions in the U.S. happen in abortion clinics that are specialized and segregated from most other medical care. In some ways this has been advantageous as people who work together providing abortion can create a safe-supportive environment for women that is private. And this supportive environment can help make the work more meaningful and sustainable. But on the other hand, this segregation has made abortion clinics vulnerable to legal and violent attacks.

By legal attacks, I refer to the phenomenon in the U.S. of state regulation of abortion practice. Hundreds of laws at the state level that target abortion providers specifically, creating expensive, unnecessary, and sometimes egregious restrictions. In terms of violent attacks, the high visibility of outpatient abortion clinics which are often located far away from other medical complexes make them more vulnerable to bombings, shootings, and protests. Countries known to be more supportive of abortion access– evidenced by government provision of abortion and/or funding for it--such as the U.K. and Scandinavian countries---appear to experience relatively less stigma and vilification of providers.

By trying to understand how stigma affects abortion services, we can identify areas for intervention in order to improve the experiences of patients and health professionals. Abortion stigma can have significant effects on how abortion care is organized. It shapes how health care is delivered at the level of the individual health care provider, the organization or medical practice, and the institutional or hospital environment.

[SLIDE IMAGE] Here are a couple of examples of how to distinguish between the effects of stigma at different levels. I define the institutionalization of stigma as the way stigma can shape the workings of a structure or a system - OR in other words [SLIDE IMAGE] Stigma routinely and systematically shapes the way abortion care is delivered.

From here I will talk briefly about how changes in the larger context of medicine have affected physician autonomy in the United States and similar health care systems in other countries. And, using interview data, I will explain a concept I call the "institutionalized buck-passing of abortion care". This theme emerged in my book. [CLICK] This is the research I am going to share with you now.[7]

So, starting with my research question and background: in 2006, I began working with Phil Darney, Uta Landy, and Jody Steinauer at UCSF on a study to try to understand why the number of U.S. abortion providers has been in steady decline---despite significant increases in abortion training since the 90s.[8] Abortion rights advocates in the U.S. had long argued that if more physicians got abortion training, more would provide abortion in their general practices, and therefore, patients would have better abortion access and continuity of care. By multiplying the sites of abortion care, primary care providers could also help normalize and destigmatize abortion, while unburdening abortion clinics who were beleaguered by protestors, violence, and regulatory battles.

[CLICK] Instead, however, Steinauer et al's national survey found that even among those physicians who had intended to keep providing abortions after completing their residency training, only half had done so. So, I set out to conduct in-depth interviews with abortion-trained ob-gyns around the country to find out why so many had stopped providing after residency. [SLIDE] We recruited ob-gyns who had graduated 5-10 years prior from residencies where all trainees were expected to learn abortion techniques unless they opted out. We wanted to know, given the least stigmatizing and most supportive abortion training conditions, what other factors beyond training made physicians stop providing?

I have to say, I found their stories surprising. Before starting the research I viewed abortion provision largely as an issue of individual choice. I expected to hear a lot from physicians about

the calculations that went into their decisions about whether to provide or not: such as risks of violence and harassment or personal moral discomfort with abortion.

Certainly these concerns surfaced in the interviews on occasion, but these were mostly doctors who had done many abortions during training and would be willing to continue providing abortions, given the right conditions.

When discussing what stopped them, the majority of physicians I spoke with-- who I called the "willing and unable"---cited the constraints imposed on them where they work.

This brings me to the macro context of medicine affecting abortion care. In the last 3 decades, physicians have lost considerable autonomy and control over their daily practice. In the so called "golden age" of medicine in the U.S., which was about the 1950s, and 60s, physicians generally had the power to practice how they wanted. Solo practice was the norm; physicians had much greater control over which tests they ordered and procedures they performed and fewer people looking over their shoulder. And this image of physician practice persists in our culture even if the reality does not. The call for physicians to integrate abortion into practice often rests on the idea that this is a choice that physicians have all the power in the world to make. But in the course of this research I met many physicians who felt relatively powerless over their practice for a variety of reasons. And some of those reasons derive from the major shifts in the organization and financing of medicine that took that control out of the hands of individual physicians and put it into the hands of larger care managing entities like group practices, hospital employers, HMOs and insurers. I explore this topic in more depth in the book.

Don't get me wrong, I'm not lamenting the lost golden age of medicine, there were serious financial problems –and abuses of power- that motivated this shift. But the shift in power is important to the broader context shaping what physicians can and cannot do.

[CLICK 4 TITLE, PIC, 93% IMAGE] So, why are specialized abortion clinics still responsible for 93% of the abortions that happen in the U.S.? Why are we still here despite significant increases in abortion training?

This orange building, by the way, is here to represent abortion facilities in the U.S., it is not actually any particular clinic, for the record.

[CLICK 4 SIGNS]. I'd like to show you examples of the different kinds of constraints on abortion care that physicians articulated in my interviews, starting with group practices and moving clockwise through the rest. I will also discuss the role that stigma plays in these examples, and finally the cumulative effect of these different barriers--- what I call the institutionalized buck-passing of abortion care.

While most doctors I interviewed had learned during residency from their trainers about the ideal of integrating abortion into their practice, and some even embraced it, few ultimately did so. Some were warned while interviewing for jobs that abortion practice was not permissible, and others learned about formal and informal no-abortion policies after taking the job.

To share an excerpt with you, one doctor recounted an experience of active policy making around abortion in her Midwestern practice. She said, and I quote,

"There came an instant where somebody asked, when [medication abortion] first became available, if we were going to provide that in the clinic or if we would write prescriptions... And it just generated this unbelievable panic in the clinic. And people were very strongly, "No, we are not an abortion clinic. We don't do those kinds of services"… I was just an employee at the time… I just kept my mouth shut and didn't say anything." Unquote

This interaction taught this physician that being associated with abortion was deeply tainting, even threatening, for her colleagues—to a degree which kept her silent, despite her opposing views. Examples of formal and informal no-abortion-policies arose in both liberal and conservative areas, though more often in conservative ones. Nonetheless, even in liberal cities, doctors found it hard to integrate abortion into their practices.

Sometimes surgery centers would also prohibit abortions further challenging physicians who were trying to provide abortions for their patients. For example, a physician told me that she had been taking patients to a surgery center in her western city until little by little, all the staffers refused to assist her.

Not only does stigma constrain abortion provision in group practices and surgery centers, but barriers in hospitals further allow stigma to shape how and where abortion care is delivered. Some physicians attributed hospital barriers to cultures of nursing resistance, others had surgery

schedulers intercept and discourage them –even for fetal anomalies. Many hospitals simply didn't allow abortion provision.

For example, a physician in the South said of her private hospital with no religious affiliation, and I quote: "Let's say we have a sixteen-week anomaly…we have to have a signature from the Chief of Staff, the Maternal Fetal Medicine doctor, the OB Chief-you have **all** these signatures that you have to get. and that actually made me realize [our hospital] doesn't allow straightforward terminations." UNQUOTE

Beyond such gatekeeping and barriers in hospitals, another issue arising in urban areas is the policy of large HMO employers to contract out to abortion clinics, ostensibly for financial reasons, even when abortion did not appear to be highly contested.

One physician employee of such an HMO explained how abortion stigma and conflict avoidance may underlie their policy to contract out, I quote, "They're sent out - for all [our patients]… the chief of my department told me that very early on…And she's somebody who's actually a supporter, but she was relieved as the chief not to have to deal with…who was going to do them, who wasn't going to do them, and whether the department had to be all in agreement about providing the service …I don't know if they're thinking that they don't want to be a target that way or have people protesting …It might just be a relief for them to just say we have these other [folks] do them and Planned Parenthood takes it all, *takes all the flack."* Unquote

This last physician really captured the buck-passing sentiment. But there is an inadvertent buck-passer that I wanted to include in the diagram. Though this buck-passer doesn't make direct referrals. [SLIDE] Since we know that Catholic hospital patients have abortions like everyone else and that Catholic hospitals prohibit provision of contraception and sterilization, they are at least as responsible as all the other parties in the diagram for funneling patients to abortion clinics. And finally,

I want to include the self-referring patients, which must make up a very large proportion of patients. Many women who do not want to be pregnant seek care in an abortion clinic before ever visiting their primary care provider. There are several reasons for this, some having to do with anticipating stigma and judgment from their provider, but also because they know that is where services are reliably offered for all of the reasons I've presented.

Of course, it is hard to fully present all the factors that contribute to the institutionalized buck passing of abortion care in such a short presentation. There are several underlying contributors that are hard to disentangle from stigma and serve to complicate abortion provision, such as Low reimbursements, provider glut (certain areas), provider pigeonholing, loss of referrals, and conflict avoidance. In the interest of time I won't discuss them all now, but feel free to ask me questions about any of these during the discussion.

But I would be remiss to only focus on the barriers that stopped physicians from providing abortions. I think it's also important to mention that the physicians I met who did perform abortions post-residency had some important things in common. Some things that many of you might relate to.

First, they thought it was important. Really important. Worth being inconvenienced and uncomfortable. In fact, this one point is where most of the otherwise willing providers dropped off. They may have been concretely pro-choice, they may have valued abortion training very much, but when it came to professional decision making, they tended not to want to go against the grain for many reasons including stigma and their relative lack of power and resources compared to their more established superiors.

But a few in my study became fellows in contraception and abortion care or moonlighted in abortion services post-residency --for a period. One physician declined a job that prohibited abortion and painstakingly managed to integrate it into her private practice despite resistance. I think they all felt very good about these contributions. But certainly there is no denying that abortion stigma, and the way it penetrates and shapes the structures of medical institutions, serves to remind health care providers over and over again that abortion care is not sanctioned, it is not quote unquote "normal". For now, it remains both marginal and exceptional.

IN CONCLUSION:

There are a few ways to decrease abortion stigma. To start, telling abortion stories fosters normalization and empathy. Abortion stories can be shared person to person, or through writing, movies and TV shows with empathetic accounts. People are working on finding new ways to

help women confidentially share their abortion stories for this reason through a variety of studies and projects, some of them accessible on line such as these listed here.

On the second point, offering compassionate care teaches women that they are accepted. That health care providers are not seeing them as tainted or devalued. Treating abortion patients with respect reduces shame, at least within clinic walls.

And finally, creating professional alliances builds what Goffman referred to as "in-group" identity... Providers find community support by making professional connections with others who also find the work to be meaningful. Those who provide abortion care are drawn together at the workplace or through professional associations like the National Abortion Federation in the U.S. because they feel their work is important. Together, they can share in the value of helping women who desperately need it, knowing that they are making an enormous difference in women's lives.

12. So, to conclude, abortion stigma may pose a challenge to both women and providers. Stigma can lead women to hide their abortions creating the prevalence paradox– that hiding abortions makes them appear uncommon and deviant and therefore more stigmatizable. And stigma can also deter providers from wanting to offer abortion care.

Compassion and community are essential ingredients to helping transform stigma and create a supportive and positive work environment. A shared sense of common purpose with colleagues and the gratitude of patients make abortion stigma bearable for many providers around the world. They are willing to combat abortion stigma precisely because the work is so tremendously meaningful.

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