

Turning Rage Into Action: Abortion Care and Residency Training in the United States

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When the *Dobbs v Jackson Women's Health* decision was handed down by the US Supreme Court in June 2022, its full impact was unknown. Currently, 58% of US women (40 million) of reproductive age live in states hostile to reproductive rights.¹ Twenty-four states have now banned abortion, despite it being a required Accreditation for Graduate Medical Education (ACGME) competency for all US obstetrics and gynecology (OB/GYN) residencies as well as a key component for family medicine and emergency medicine training.²

The *Dobbs* decision foreshadowed additional efforts to prioritize certain personal, political, or religious beliefs above an individual's health care decisions. The onslaught of legislation limiting health care is also occurring beyond women's health. By early 2023, 99 bills were introduced across the United States that limit LGBTQIA+ individuals' health care options.³ The effects of these restrictive health care laws are devastating to patients as well as physicians, both residents and teaching faculty.

Medical Ethics Guides Us: Bodily Autonomy Is Essential

In 2020 over 64 million US women were between the ages of 15 and 44,⁴ and over 45% of pregnancies were unintended (data from prior to the *Dobbs* decision).⁵ While there is not a US national bill of patient rights to guide decision-making in difficult patient situations, there are nationally accepted ethical principles. These include *autonomy*, *beneficence*, *nonmaleficence*, *patient-clinician relationship*, and *inviolability of human life* (BOX).^{6,7} The inability to follow ethical principles upon which physicians build their medical careers can lead to clinician moral distress.

With state legislative bodies determining the medical care that individuals can receive, significant ethical dilemmas are emerging. *Patient autonomy* no longer exists for pregnant persons living in certain states. *Beneficence* (do what is best for the patient) in some states is now based on one set of political or religious beliefs, rather than on families being guided by medical evidence and their own beliefs. *Nonmaleficence* (do no harm) can be overrun by state restrictions that have and will cause harm: maternal lives lost, mental distress, and avoidable maternal and neonatal suffering.⁸ Strong *trusted patient-clinician relationships* are essential for successful clinical interactions and clinicians' work satisfaction; this trust is eroded when patients are not confident that their clinician will provide the highest quality of person-centered care.

Adverse Outcomes in States With Extreme Abortion Restrictions

The Commonwealth Fund outlined impacts on women in abortion-restricted states using data collected prior to the current complete abortion bans in some states.⁹ These include fewer obstetric care clinicians, fewer obstetricians and certified nurse midwives, a higher rate of births with no or late prenatal care, and dramatically higher maternal death rates—across all races—in abortion-restricted states. Collateral findings include increased death rates for reproductive-age women and infants in these states (TABLE 1).

These restrictions affect specialty training beyond OB/GYN: physicians caring for women with severe cardiac disease, pulmonary disease, or cancer, as well as others caring for infants with severe anomalies. Patients, trainees, and faculty are confused by the competing risks of committing a crime vs committing malpractice or negligence. In either direction, moral injury is possible.

Violation of criminal laws is not covered by malpractice insurance. The use of nonmedical language and undefined terminology in many restrictive laws further obfuscates the issue¹⁰ and results in delays in

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the management of ectopic pregnancy and miscarriage.¹¹ To attempt to mitigate these delays, on July 22, 2022, the US Department of Health and Human Services mandated that hospitals and physicians in all states must provide necessary emergency abortion services to comply with separate federal legislation enacted in 1986, the Emergency Medical Treatment and Labor Act (EMTALA).¹² When a state law prohibits abortion, that law would be preempted in the case of a medical emergency. However, there are currently 2 opposing rulings: a court in Texas stated that state law supersedes EMTALA, and a court in Idaho stated that federal EMTALA supersedes state law. Additionally, the definition of “medical emergency” can vary given the vague and nonmedical language of these laws. In states where providing an abortion can result in legal action, including jail time and up to \$100,000 in fines, decisions regarding what is sufficiently life-threatening can pose a moral conflict for faculty and their trainees.

Effects of Restrictive State Laws on OB/GYN Residency Programs

Effects are being felt by all OB/GYN residency programs. There are 4409 OB/GYN resident physicians, with 59% (2600 of 4409) currently training in states that have already banned or will soon ban abortion procedures.¹³ The ACGME requires that programs “must provide clinical experience or access to clinical experience in the provision of abortions as part of the planned curriculum. If a program is within a jurisdiction that legally restricts this clinical experience, the program must provide access to this clinical experience in a jurisdiction where no such legal restriction is present.”² Those residents and programs in states where abortion is illegal must now find training in alternative states, without clarity regarding how to overcome the financial and logistic barriers.

Residents who have had training in abortion are more likely to both offer and feel confident in their abortion and miscarriage management skills. This includes all aspects of early pregnancy loss care including counseling, facilitating patient-centered care for medication and procedural options, and managing complications.¹⁴

A Tale of OB/GYN Residency Programs in 2 Restrictive States

Wisconsin: Bans All Abortion With Exception for Life of the Mother: The current Wisconsin ban is based on a trigger law written in 1849.¹⁵ For perspective,

BOX Nationally Accepted Medical Ethical Principles

Patient autonomy is the right of patients to make decisions about their health care without their physician's personal feelings influencing the care. Pregnancy and complications of pregnancy offer many patient-physician encounters in which informing the patient of their options, without any opinion or bias, is particularly challenging. For example, physicians offering routine genetic screening need to discuss what options are available if abnormal results are noted. Patients often ask, “What would you do if it was you?” but this question cannot be answered. These decisions need to be individualized for each patient and family.

Beneficence/Nonmaleficence is the act of doing good and not doing harm. Limiting the options available to provide pregnant people with care increase their morbidity and mortality, and potentially their livelihood.^{8,9} Patients must have safe, evidence-based care available, and those decisions must be made by the patient with their physician/clinician.

Patient-Clinician Relationship has trust as a cornerstone of the relationship, as it is essential for optimal health. Interference in this relationship from outside sources that have no knowledge of the patient's life, health, fetal status, or social situation jeopardizes trust. Legislation ungrounded in scientific evidence further erodes trust in clinicians and the health care system.

Inviolability of human life permits the withholding and withdrawal of life-prolonging treatment that is not worthwhile because it is futile or too burdensome for the patient. There are several fatal fetal diagnoses, along with diagnoses that will entail lifelong suffering for a child. The pregnant person's decision to sustain a fetus with anomalies should be considered a life-prolonging treatment. Therefore, if the pregnancy outcome will result in significant burden or death of the fetus, abortion should be an option.

surgeons routinely started washing their hands in the 1870s, and the first account of an ectopic pregnancy being treated without maternal death occurred in 1884.

There are 3 OB/GYN programs in Wisconsin with 73 residents. Prior to the *Dobbs* decision, residency abortion training at one Milwaukee-based residency program (connected to the Kenneth J. Ryan Residency Program, Bixby Center for Global Reproductive Health, University of California, San Francisco, a national initiative) included medication and procedural options at a Planned Parenthood site, in each year of residency. Residents on average completed 50 surgical termination procedures prior to regulation. In the residency hospital site, residents learned pregnancy termination up to the prior legal limit of 22 weeks. These experiences ensured that residents were competent to provide dilation and evacuation of the uterus in multiple situations. Now the Milwaukee-based program can no longer provide this training in Wisconsin.

TABLE 1Abortion-Restricted Compared to Non-Restricted US States, Pre-*Dobbs* Decision⁹

Direct Effects	32% lower ratio of obstetricians to births
	59% lower ratio of certified nurse midwives to births
	62% higher proportion of individuals giving birth with no or late prenatal care
	62% higher maternal death rates (28.8 vs 17.8 per 100 000 births in 2020) ▪ 33% higher: Non-Hispanic White (2018-2020) ▪ 31% higher: Hispanic (2018-2020) ▪ 20% higher: Black (2018-2020)
Collateral Effects	34% higher death rates for reproductive age women (ages 15-44)
	Higher infant mortality ▪ 34% higher: non-Hispanic White infants ▪ 12% higher: non-Hispanic Black infants ▪ 4% higher: non-Hispanic Asian infants

Currently, the program has an agreement with an outside state university for training, an “opt-out” rotation with Planned Parenthood for third-year resident physicians only. Creating this opportunity was extremely challenging despite having a Ryan Program connection (online supplementary data).

Tennessee: Prohibits Abortion at All Stages of Pregnancy: The Tennessee Human Life Protection Act prohibits abortions, with the “affirmative defense” to be used for medical emergencies after being charged with a felony.¹⁶ Affirmative defense applies when the pregnant person is at immediate risk of death or serious, substantial, irreversible major bodily function impairment. This defense, which is written by the physician, requires that the procedure is performed in a hospital with neonatal services, unless none are available within 30 miles. Under this bill, it is a Class C felony to perform any abortion (ie, up to 15 years in prison and a \$10,000 fine).

There are 8 OB/GYN residency programs in Tennessee with 135 residents. Prior residency education varied by program, with one Ryan Residency Training Program at Vanderbilt Medical Center. At the University of Tennessee program in Knoxville, residents rotated through an “opt-out” family planning rotation at the Knoxville Center for Reproductive Health. Post *Dobbs*, this center closed after more than 45 years of operation. For the Vanderbilt Medical Center program, current solutions include sending residents from Vanderbilt to New York City, at high cost (online supplementary data). Other programs are still trying to arrange alternative training solutions, without clear solutions, due to unstable access to abortion in neighboring states, such as Virginia and North Carolina. The need for first obtaining training medical licenses is a significant barrier to arranging rotations with hands-on experiences.

Collateral Damage to our Faculty

While restrictive abortion laws are dangerous to patients and disrupt resident learning, faculty are also affected in critical ways. OB/GYN faculty who work in states hostile to abortion take on the additional work of coordinating and helping patients to obtain needed care elsewhere; this administrative work is not reimbursed and is a sizeable emotional and time drain. Also, OB/GYN physicians working in states where abortion is not severely restricted receive a barrage of emails and text messages from all over the United States, while also trying to ensure that patients receive high quality of care.

Faculty are responsible for patient outcomes as well as acting as appropriate role models for residents. Faculty provide emotional and practical support for their residents. Being unable to provide care that is recommended by decades of evidence and by major medical societies causes moral distress. Repeated experiences of moral distress can lead to professional burnout, intention to leave medicine, and suicide (online supplementary data).

Where Do We Go From Here?

Start with advocacy by individuals and institutions (TABLE 2) and required curricula in medical school: all medical schools must educate students on abortion care and counseling for pregnancy options.¹⁷ Advocating for creation of standard procedures for access to training in states where women have choices, including medical license and malpractice waivers, will assist all programs experiencing challenges. For our patients, residents, and teaching physicians, we need leadership by all physicians and every program’s sponsoring institution in order to follow ethical principles and ensure safe, high-quality pregnancy and miscarriage care. We must ensure that evidence-based

TABLE 2
Advocacy Strategies and Resources

Approach	Strategy	Resources
Voting	Encourage, in a nonpartisan way, patients, residents, colleagues, family members to vote	▪ http://vot-er.org
State and federal level advocacy	Each major medical society has an advocacy plan: ensure abortion access is on the plan	▪ American College of Obstetricians and Gynecologists resources: https://www.acog.org/advocacy/abortion-is-essential ▪ Society of Maternal Fetal Medicine resources: https://smfmadvocates.org/ ▪ Go to <i>Doctors' Day on the Hill</i> in your state to interact with your representatives; there is usually training prior and an agenda to guide you for the day
Patient-centered pregnancy options counseling	Ensure patients get unbiased pregnancy options counseling Teach medical students and residents to provide this care This may be limited by "gag-laws" and rules on "aiding and abetting" If unable to provide full counseling, ensure information is available to patients	▪ RHEDI Options Counseling Unit: https://rhedi.org/options-counseling-unit/ ▪ Resources for abortion pill access, legal questions, where to get an abortion: ○ https://www.mayday.health/ ○ https://aidaccess.org/en/i-need-an-abortion ○ https://www.ineedana.com/ ○ https://www.plannedparenthood.org/ ▪ Help with funding for an abortion: ○ https://abortionfunds.org/need-abortion/ ○ https://prochoice.org/patients/naf-hotline/ ○ https://wrrap.org/assistance-services/ ▪ Medication termination available universally, at time of publication: https://www.aidaccess.org
Medical school curriculum	All students learn pregnancy options counseling	▪ Association of Professors of Gynecology and Obstetrics Medical Student Educational Objectives for Students: https://apgo.org/page/msostudent ▪ Medical Students for Choice externship: https://msfc.org/resident-opportunities/rhe-abortion-training/how-to-apply/
Institutional support	Schedule meetings to develop standard documentation, definitions, legal team access, and protocols for recurring questions and situations Enable malpractice coverage for residents on out-of-state rotations Institutional statement supporting patient autonomy and abortion care	▪ Educational videos and sessions, including urgent care and emergency: https://www.innovating-education.org/

care is how we practice medicine, and that our practice is not dictated by groups who do not understand basic biology or medical ethics.

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