

Roe v Wade, Dobbs, and the Future of Graduate Medical Education

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On June 24, 2022, in the *Dobbs v Jackson Women's Health Organization* decision, the Supreme Court of the United States overturned *Roe v Wade*, the landmark 1973 Supreme Court decision that affirmed the federally protected, constitutional right to abortion.^{1,2} *Dobbs* placed legal decisions on abortion rights in the jurisdiction of individual states, and as a result, about half of all states have limited access to abortion services beyond restrictions that *Roe* would have permitted, ranging from comprehensive bans to additional timing limits.¹ This decision by the Supreme Court signifies an important shift in graduate medical education (GME), as the training of obstetrics and gynecology (OB/GYN) residents and fellows is now legally restricted in some states.

In light of this frameshift in GME, a session was held at the 2023 Annual Educational Conference of the Accreditation Council for Graduate Medical Education (ACGME) to discuss the issues around this court decision and its impact. A Featured Plenary session entitled "*Roe v Wade* and the Future of Graduate Medical Education" was held on February 24 and was attended by more than 700 conference participants. The goals of the session were to illustrate the issues raised by the Supreme Court decision from the perspectives of 3 knowledgeable panelists: the chair of the ACGME OB/GYN Review Committee (RC), a chair of an OB/GYN academic department in a state which restricts abortion access, and an attorney who advises clients on reproductive health care issues and federal regulatory and state statutory developments following the *Dobbs* ruling. Herein is a summary of the session.

Impact of the Dobbs Decision on OB/GYN Program Requirements

Longstanding OB/GYN Program Requirements (PRs) require programs to provide clinical experience and

didactic education in comprehensive family planning, including abortion.³ This education must be built into the structured curriculum, though an individual resident may opt out of participating in induced abortion for religious or moral reasons. The OB/GYN RC at the ACGME anticipated the Supreme Court decision. Because of the passage of S.B. 8 in Texas in September 2021, the committee had previously dealt with the situation of having PRs that had become unlawful (S.B. 8 is a state law that specifically prohibits abortion when fetal cardiac activity is detected).⁴ With the passage of S.B. 8, the RC communicated with the OB/GYN programs in Texas to reaffirm the requirements for abortion. In anticipation of the Supreme Court decision, the RC drafted revised PRs and posted these for public comment in June 2022 just after the Supreme Court decision was released. These PRs reinforced the need for comprehensive family planning experiences for residents, to include clinical experience in provision of abortion, and generally required programs to provide these experiences in another location for those programs in states where such experiences were unlawful. The RC added more granular requirements for miscarriage management as an important clinical experience that helps to build skills in uterine evacuation. The draft PRs included a provision for trainees who desired experience in induced abortion but would be unable to do a travel rotation (for family or other reasons). For these individuals, the draft PRs required a didactic and simulation curriculum in induced abortion with assessment. The public comment period resulted in many comments supporting the requirement for clinical experience in induced abortion, while also noting that didactics and simulation were not an adequate proxy for clinical experience. In early September 2022, after incorporating public comments, the RC issued finalized PRs which require all programs to provide clinical experience in family planning, including induced abortion (with continued individual resident opt-out available). Programs located in jurisdictions where components of the requirements are unlawful must generally make

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arrangements for training in jurisdictions where this care is lawful.

The RC communicated the draft PRs and final PR changes at the twice-yearly program director association meetings and via ACGME e-Communications. Ongoing work in the specialty continues to assist in development of an infrastructure that helps programs to comply with the PRs. This work is being done among multiple specialty and subspecialty societies in OB/GYN, the program director association, and the RC.

Impact of the Dobbs Decision on Clinical Practice and Education of OB/GYN Residents

In some states clinical practice in abortion services had already been restricted even prior to the *Dobbs* decision. In states that had trigger laws that went into effect automatically after *Dobbs* overruled *Roe*, OB/GYN training programs had to quickly develop new protocols for patient care. In certain states, abortion care now is allowed only to save the life of the pregnant patient, and protocols have been developed in close consultation with legal representatives and administrative leaders. Training programs in states where abortion is strictly limited by state law are encouraged to become familiar with local laws and to work closely with legal advisors in creating protocols for safe and legal care of patients. Programs in these states can provide clinical experience in family planning, including contraception, medical and surgical management of miscarriages (spontaneous abortions), and management of ectopic pregnancies. Depending on the exceptions provided in state laws, programs may be able to provide clinical experience in induced abortions for maternal and/or fetal medical indications. Furthermore, clinical experience in induced abortion can be obtained through collaboration with clinical sites in states in which abortion is lawful as it was before *Dobbs* (ie, subject to state laws that could not unduly burden the right). It is important to note that the resources to establish this collaboration are significant, and visiting residents can put a strain on the receiving training programs. From the patient perspective, many people do not have the social or monetary support to travel to receive care, and this leads to worsening disparities in access to care, especially for Black women and other marginalized groups.^{5,6}

Importantly, care team and institutional uncertainty and fear of legal or licensure action has exerted a chilling effect on other aspects of clinical care for people who are or can become pregnant, in fear that such care could harm the fetus. Hesitancy to operate

on a pregnant patient with appendicitis, delay in treating a pregnant patient with breast cancer, and reluctance to use evidence-based medication therapy for a rheumatologic disorder in a person with a uterus are all examples of clinical care impact post-*Dobbs*. The post-*Dobbs* era has uncovered stark gaps in knowledge about women's health and reproductive medicine across many specialties. OB/GYNs must serve as resources for peers in other specialties, and institutions must timely involve legal teams with expertise in this domain in order for the entire house of medicine to continue to provide high-quality, evidence-based health care.

Legal Issues

Legal Context for How the Supreme Court Ruled on the Dobbs Case

It was 1973 when the Supreme Court ruled in *Roe v Wade* that the US Constitution protected a woman's fundamental right to have an abortion in various circumstances.² The court held that a woman's right to abortion needed to be balanced against the government's interest in fetus and maternal health, and so the Court adopted a framework based on the trimesters of pregnancy. A woman's right was at its strongest during the first trimester when a state could restrict it in only limited circumstances, whereas a state could impose much greater restrictions in the third trimester. At its core, *Roe* limited the degree to which states could regulate abortions by providing federal constitutional protections.

The next major ruling in this area occurred in 1992, in *Planned Parenthood v Casey*.⁷ *Casey* reaffirmed the central holding of *Roe*, but no longer followed the trimester approach. It created a pre- and post-viability test to balance competing interests, which eased the showing that states had to make to defend their laws restricting abortion. After *Casey*, state laws passed federal constitutional muster so long as they did not impose an undue burden on the right to an abortion.

Before and after *Casey*, there were a handful of other Supreme Court cases reviewing state-imposed restrictions on abortion involving timing, methods, and location.^{8,9} There also were cases safeguarding the access of health care providers and patients to clinics against violent protestors.¹⁰⁻¹²

In June 2022, the Supreme Court overruled *Roe* and *Casey* in *Dobbs v Jackson Women's Health Organization*. The Supreme Court rejected the view that there is an implied right to privacy—and, by extension, bodily autonomy—in the US Constitution. As a result, whether (and to what extent) abortion will be permitted is mostly a question for each state.

Ongoing Role for Federal Law

Despite these rulings, however, federal law continues to play a role. For example, in light of the closing of abortion clinics in many states, travel to other states to obtain this care has become significant, and provision of abortion-inducing drugs, including mifepristone, has taken on a more central role. The travel of patients and health care providers to other states rests in part on the Supreme Court's continued recognition of the *federal* constitutional right to travel. Additionally, mifepristone access will be affected in part by *federal law*. FDA regulation of mifepristone (FDA approved Mifeprex in 2000, generic mifepristone in 2019) changed in January 2023 to allow dispensing not only in-person in health care settings but also by certified pharmacies.¹³ As of this writing, however, there are pending lawsuits seeking to invalidate FDA's approval of mifepristone on the one hand,¹⁴ and seeking to ease access to mifepristone, on the other hand.¹⁵ This issue is likely to end up before the Supreme Court.¹⁶

Future of Legal Intrusion of Courts in GME

A significant question after *Dobbs* is how it will affect federal constitutional law generally. The majority opinion of the Supreme Court was explicit that the ruling is limited to abortion rights and does not affect other rights. However, the legal debate continues because the rationale of the majority opinion could be read to implicate other rights, and the concurring and dissenting opinions suggest as much. These include some other areas involving privacy and liberty rights recognized in the past, such as marriage equality. The decision's rationale could also implicate gender-affirming care. Some states have already passed laws limiting the medical care of transgender people (particularly minors),¹⁷⁻²¹ and litigation challenges are likely to be brought.

Impact of Dobbs Decision on Recruitment and Retention of Trainees and Faculty in Legally Restrictive States

Analysis of the 2023 and future match outcomes will reveal the impact of the post-*Dobbs* environment on residency recruiting and medical student decision-making for OB/GYN and other specialties. OB/GYN applicants may have concerns about skill acquisition. Furthermore, residency and fellowship training occurs at the height of a person's reproductive years. Access to comprehensive reproductive health care may play a role in applicants' prioritization of programs. The impact of these legal restrictions on the match experience of GME learners will be examined in the coming years.

The Future of GME

With the *Dobbs* decision, the ACGME faced a novel situation, wherein aspects of required training in a clinical discipline were rendered unlawful. Given that graduates of ACGME-accredited training programs need to be equipped to practice in a variety of settings, locations, and environments, this created new challenges for which the OB/GYN experience serves as a potential model. It remains to be seen whether this represents the first of many instances in which state laws impact the clinical care (and thus the training) that can be delivered within the patient-physician relationship.

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