

Post-Dobbs: The Consequences of Abortion Bans on Complex Family Planning Training

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Since the 2022 Supreme Court decision in *Dobbs v Jackson Women's Health Organization*, many states have proposed legislation to completely ban or heavily regulate abortion, including nationwide restrictions on mifepristone.^{1,2} While abortion restrictions more directly impact the training of certain medical specialties, the idea that clinicians can be prohibited from learning how to provide a safe, common medical procedure should disturb everyone in the field of medicine. Abortion bans affect all clinicians who may encounter pregnant people. Anesthesiologists and neonatologists will be called upon to participate in emergency cesarean sections for patients with previable preterm premature rupture of membranes. Interventional radiologists will perform emergency uterine artery embolization for patients hemorrhaging due to a cesarean scar ectopic pregnancy that was unable to be treated earlier. Oncologists, cardiologists, and neurosurgeons will be unable to perform lifesaving interventions for pregnant patients with a positive urine pregnancy test. Thus, everyone in the medical field should pay attention to the changing national and state abortion laws and recognize how these laws may impact their future practices.

As resident obstetrician-gynecologists (OB/GYNs) in the state of New Jersey, we are among the lucky few to train in a state that has codified abortion as a fundamental right.³ Additionally, our program is one of 108 Ryan Residency Training Programs in the United States, meaning that our residency program has financial support for integrating family planning into our training.⁴ According to the Accreditation Council for Graduate Medical Education (ACGME) requirements, graduating OB/GYN residents must have “access to clinical experience in the provision of abortions,” “participate in the management of complications of abortions,” and perform at least 20 abortion procedures.^{5,6} In reality, this training has not been guaranteed at every residency program even prior to *Dobbs*. Now that *Roe v Wade* is overturned, nearly half of all US OB/GYN residency programs are in states certain or likely to ban abortion,⁷ and bans issued thus far

affect at least 20% of all Ryan programs.⁴ The ACGME currently states that OB/GYN programs in restricted states must “provide access to this clinical experience in a different jurisdiction where it is lawful.”⁵ While it is true that there are some opportunities for “away rotations” for visiting residents to train at outside institutions for several weeks, these spots are limited, require significant coordination, and do not have capacity to train all residents in restricted states. Residents have to scramble to access limited training options.

Another group greatly affected by the constantly changing landscape of abortion restrictions are complex family planning (CFP) physicians. CFP is a 2-year fellowship program that can be pursued after OB/GYN residency.⁸ First founded in 1991, this fellowship provides opportunities to expand knowledge and skills in clinical care, teaching, advocacy, and research in CFP. Graduating fellows may go on to establish new Ryan programs, become leaders of national family planning organizations, perform research, and testify before Congress. Since the subspecialty obtained ACGME accreditation in 2020,⁸ CFP graduates complete written and oral examinations for the American Board of Obstetrics and Gynecology CFP certification. Despite academic legitimization, these expert subspecialists now find their field becoming progressively more stigmatized, siloed, restricted, and even outlawed. Out of 30 CFP fellowship programs in the United States, currently 5 programs are in states where an abortion ban has been introduced, and several other programs are in states at risk of losing abortion rights.⁹ As prospective fellowship applicants, we are acutely aware that abortion clinicians have been murdered for this work.¹⁰ We are forced to consider the implications of pursuing advanced training and practice in the face of bans that prevent us from providing the best evidence-based care for our patients. Similar advanced training programs in abortion and contraception care for family medicine, internal medicine, and emergency medicine trainees are also affected, including 31 Reproductive Health Education in Family Medicine residency programs, 5 Reproductive Healthcare and Advocacy Fellowship sites, and 15 Women's Health Fellowship sites.¹¹⁻¹³ Given that generalist OB/GYNs in the post-*Dobbs* era may have

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increasingly limited exposure to performing abortion care in the second trimester, the need for CFP physicians and other clinicians with advanced abortion training is clear.

With abortion care training under threat, we encourage academic leaders in medicine to use their collective professional power to advocate against restrictions and encourage their institutions and states to create or expand abortion access, training, and clinician protections. We advocate that all OB/GYN residency programs located in states with abortion restrictions, and, ideally, residency programs in any specialty involved in reproductive health, should be required to have routine, meaningful, “opt-out” clinical experiences in abortion care, either through structured out-of-state rotations or through advanced simulation training. Though residents in these states will likely still gain some experience in miscarriage management, if some receive their abortion training primarily via simulation, it is essential to evaluate best methods for this training to ensure competence. Manual uterine aspiration workshops that use fruit to model first trimester procedures are common, and additional efforts should be made toward creating and evaluating models to teach residents skills for second trimester dilation and evacuation procedures. While ACGME requirements should be enforced and programs that do not comply should be at risk of citation or losing accreditation, these consequences will only further limit the number of skilled reproductive health care clinicians in states with abortion restrictions—states that already have higher rates of pregnancy-related and neonatal morbidity and mortality as well as higher proportion of pregnancy-related care deserts.¹⁴ There must be close observation of residents in restricted states to ensure access to family planning training.

Individual organizations have been tirelessly working to create additional training opportunities for clinicians.^{15,16} Program leaders in states with abortion protections should also be actively working to find ways to incorporate visiting residents for abortion training, although funding mechanisms will need to be developed. Health care systems may be able to redirect clinical revenue toward supporting abortion training and care. Some programs within protected states are already doing so, but often with reliance on philanthropic and community support.¹⁷ This funding may not be sustainable and therefore may require large-scale structural support. Individual state governments, non-profit organizations, and professional medical organizations such as the American Medical Association or American College of Obstetricians and Gynecologists (ACOG) could provide financial support to programs participating in residency exchanges, to create a smoother process for residents

for out-of-state rotations. The CFP fellowship was initially funded by an anonymous benefactor,¹⁸ and now the Society of Family Planning has financial support from various sectors.¹⁹ While perhaps unlikely, the federal government could recognize the importance of resident and fellow abortion training and provide support—financial, legal, and otherwise—for institutions in restricted and non-restricted states, to include additional CFP fellowship programs.

Organizations like the ACGME or ACOG should create additional methods to track how the *Dobbs* decision has affected residency training and competencies. Apart from access to clinical training, it is important to consider trainee moral distress. How are residents’ mental health and well-being affected by experiencing avoidable morbidity and mortality in their patients? How do state restrictions affect how and where they choose to practice after graduation? Typically, about 57% of residents stay to practice in the state in which they trained.²⁰ Data from the 2022-2023 application cycle shows a decrease in medical student applications to OB/GYN residencies that was highest in states with complete abortion bans.²¹ How will these trends continue over time? If restrictive laws create gaps in skilled clinicians, who will fill them?

Nearly a million abortions are performed per year in the United States.²² If systemic change does not occur there may be an entire generation of clinicians who cannot provide comprehensive abortion care in the state in which they live.²⁰ State laws may be temporary, but new waves of graduating reproductive health care clinicians will be practicing for the next half-century.

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