

“I Went Into This Field to Empower Other People, and I Feel Like I Failed”: Residents Experience Moral Distress Post-*Dobbs*

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ABSTRACT

Background The 2022 Supreme Court ruling in *Dobbs v Jackson Women’s Health Organization* nullified the constitutional right to abortion, which led to effective bans in at least 14 US states and placed obstetrics and gynecology (OB/GYN) residents in dilemmas where they may have to withhold care, potentially causing moral distress—a health care workforce phenomenon less understood among resident physicians.

Objective To identify and explore moral distress experienced by OB/GYN residents due to care restrictions post-*Dobbs*.

Methods In 2023, we invited OB/GYN residents, identified by their program directors, training in states with restricted abortion access, to participate in one-on-one, semi-structured interviews via Zoom about their experiences caring for patients post-*Dobbs*. We used thematic analysis to analyze interview data.

Results Twenty-one residents described their experiences of moral distress due to restrictions. We report on 3 themes in their accounts related to moral distress (and 4 subthemes): (1) challenges to their physician identity (inability to do the job, internalized distress, and reconsidering career choices); (2) participating in care that exacerbates inequities (and erodes patient trust); and (3) determination to advocate for and provide abortion care in the future.

Conclusions OB/GYN residents grappled with moral distress and identified challenges from abortion restrictions.

Introduction

All obstetrics and gynecology (OB/GYN) graduate medical education programs must fulfill the Accreditation Council for Graduate Medical Education (ACGME) mandate for integrated, opt-out abortion training.¹ Since the 2022 Supreme Court decision in *Dobbs v Jackson Women’s Health Organization* overturned the constitutional right to abortion, 14 US states have banned abortion at all gestations with very limited exceptions. In addition, 6 states have enacted laws more restrictive than prior to *Dobbs*, and many more are expected to pass additional restrictions.² Thus, it is very challenging to ensure that the more than 1300 OB/GYN residents training in the 14 states with the most extreme bans, not to mention those in other restrictive states, are prepared to fulfill their professional obligations to perform an abortion to save a pregnant person’s life^{3,4} and to learn core reproductive health, abortion, and miscarriage care skills that are more likely learned with

integrated abortion training than in programs without.^{5,6} These restrictive laws also jeopardize training of residents in family medicine (more than 3000 currently train in states with abortion bans),⁷ which has a scope of practice that includes abortion care and sometimes includes abortion training during residency.⁷ They also affect the education of medical students, who are expected to learn how to provide pregnancy options counseling and understand the basics of abortion care so they can counsel and refer their future patients no matter their specialty,¹ trainees outside of OB/GYN and family medicine who will care for people seeking abortion care and who may choose to provide the care, and health professions students in other disciplines.

In addition to challenges in gaining competence, in states with abortion bans or restrictions, health care professionals and learners encounter situations where they are compelled to deliver care that is not evidence-based or patient-centered and that leads to patient harm.^{8,9} Moral distress, as defined by Andrew Jameton in 1984, and cited by Mark Repenshek, “arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.”¹⁰ While

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Editor’s Note: The online supplementary data contains the interview guide used in the study.

research on moral distress has primarily focused on nurses, all health care professionals face moral questions surrounding patient care and can feel powerless when unable to intervene in situations they deem inappropriate.¹⁰⁻¹⁶

Numerous studies explore moral distress within the health care workforce, but the phenomenon is less understood among resident physicians.^{17,18} What literature exists confirms that moral distress is not only evident in residency,¹⁹ but that residents are also especially susceptible to its effects,²⁰ due in part to their relative low-level positions within hierarchical institutions.²¹ Despite this, few residency programs take proactive measures to tackle moral distress,²⁰ and approaches to identifying and mitigating its effects are largely unknown.²²⁻²⁴

While studies have documented the adverse and wide-ranging consequences of abortion restrictions and bans on patients,²⁵⁻²⁹ little attention has been given to the effects on physicians and learners. This study explores the experience and implications of moral distress for OB/GYN residents who are unable to practice evidence-based, patient-centered abortion and other reproductive health care due to these restrictions. Our data will provide valuable insights about the experiences of moral distress among trainees in OB/GYN and other specialties that include reproductive health care.

Methods

Participants and Setting

Between February and April 2023, we invited current residents at OB/GYN programs affiliated with the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning (Ryan Program) that were located in states the Guttmacher Institute, a research and policy organization dedicated to advancing sexual and reproductive health and rights worldwide, considered to have “restricted,” “very restricted,” or “most restricted” abortion policies to participate in an interview about their abortion training experience post-*Dobbs*.² This included 36 Ryan Programs in 16 states and the District of Columbia. The Ryan Program provides technical support to OB/GYN residency programs to initiate or expand dedicated family planning training, which is a requirement of all OB/GYN residency programs.⁷ There are currently 116 Ryan Programs in total, representing 39% of all accredited OB/GYN residency programs in the United States.³⁰

Program directors at these 36 Ryan Program sites were asked to forward our study announcement to their residents via email. The announcement asked for resident volunteers to interview about their

KEY POINTS

What Is Known

The recent *Dobbs v Jackson Women's Health Organization* decision holds educational implications for obstetrics and gynecology (OB/GYN) education, although understanding of its effects on resident moral distress is only emerging.

What Is New

This qualitative study of 21 OB/GYN residents shows how they grapple with moral distress and identity challenges in the face of abortion bans and restrictions.

Bottom Line

Knowledge of these phenomena allow educators to proactively mitigate these potential negative effects on residents in abortion-restrictive states.

experiences training in a state that restricts abortion care and did not mention moral distress. Interested residents completed an online poll about their availability to interview and were offered monetary remuneration for their time, if interviewed. The research team invited residents to participate in one-on-one semistructured interviews via Zoom at their convenience between February and April 2023. Immediately after the Zoom interview, we de-identified persons and institutions and assigned each participant a number. Participants were offered a \$40 Amazon gift card as compensation for their time.

Interview Guide

Informed by a literature review of moral distress and resident education, we developed a semistructured interview guide (provided as online supplementary data).^{22,31-36} Interview questions focused on resident experience with abortion training and care at their institution after the *Dobbs* decision. Most questions were open-ended to generate narrative responses to the questions. After initial development by the research team, the guide was pilot tested by 2 OB/GYN residents and then revised based on feedback to optimize resident comfort and to encourage rich responses. Interviews were professionally transcribed.

Data Analysis

We utilized Dedoose 7.1 (SocioCultural Research Consultants) to code the interviews using thematic analysis. We chose thematic analysis to explore and understand the patterns and themes present in the responses without developing a comprehensive new theory. Thematic analysis provided a structured and systematic approach that aligned well with our desire to identify and present the themes in a clear and accessible manner.³⁷ Three members of the research team (J.K.T., E.C., N.D.) created a preliminary

codebook after fine-coding 4 transcripts. Subsequently, we revised the codebook through applications of the preliminary codes to those 3 transcripts as well as 3 additional transcripts to better represent the data's range and breadth. We resolved any discrepancies or questions about the codes through discussion and consensus. The entire research team, first independently and then together, analyzed the codes to identify patterns and themes.³⁸

During the interviews we created memos which allowed us to preliminarily identify when interviews ceased to produce new themes or concepts. When we confirmed during coding that the last interviews did not include new concepts, we concluded that we had reached theoretical sufficiency, defined as having collected enough data to "reach a sufficient depth of understanding that can allow the researcher to theorise."³⁹

Researcher Reflexivity

The research team consisted of a social science researcher (J.K.T.), 2 research associates trained in public health and administration (E.C., N.D.), and a physician with qualitative methods expertise (J.E.S.). Researchers J.K.T., E.C., and N.D. conducted the interviews (J.K.T. interviewed 7 residents, E.C. interviewed 6 residents, and N.D. interviewed 8 residents), and these 3 coded the data with oversight by J.E.S. The entire team synthesized the data to identify themes. Researchers J.K.T. and J.E.S. trained in qualitative methods in their graduate programs, and researchers E.C. and N.D. were trained on this study by a leading qualitative researcher at their institution. J.E.S. is an obstetrician gynecologist who conducts discussions with learners and faculty about moral distress and abortion training; her perspectives were balanced by other team members conducting interviews and doing initial coding, and she participated in coding review, synthesis, and manuscript preparation. All are familiar with residents' experiences in training and concepts related to moral distress, as together they lead an education program focused on resident training. Researchers employed rigorous self-reflection and routine meetings during the study design, interview, and analyses periods to reflect on ways their identities and experiences in resident training may have affected the study and interpretations of the data.⁴⁰ None of the researchers had ever been in contact with these residents before this study, nor were they in any position of authority to the residents.

The University of California, San Francisco Institutional Review Board approved the study. We utilized Open AI ChatGPT 3.5 to help edit the abstract

into a format concurrent with *Journal of Graduate Medical Education* guidelines.

Results

Thirty-seven residents agreed to be interviewed. After we conducted 21 interviews, researchers agreed theoretical sufficiency had been reached. We interviewed the 21 participants over Zoom, and interviews ranged in length from 35 to 62 minutes. Nineteen residents self-identified their gender as female, 2 as male; 18 self-identified their race/ethnicity as White, 2 as South Asian, and 1 as Asian. Residents described a variety of patient scenarios during which they experienced moral distress. These included obstetric complications, fetal anomalies, pregnancies of unknown location, and undesired pregnancies. The TABLE provides information on each participant, including postgraduate year, program state, and a summary of the patient scenario(s) in which moral distress was described.

We identified 3 salient themes in the resident experience of providing care in a setting with abortion restrictions, related to why and how they feel moral distress, as well as the consequences. Description of these themes, subthemes (FIGURE), and representative quotes are included below.

Challenges to Their Identity as a Physician

Residents described challenges to their physician identity caused by *inability to do the job* (subtheme 1), which led to *internalized distress* (subtheme 2) and *reconsidering career choices* (subtheme 3).

Residents described ways that the restrictions threatened their ability to provide patient-centered and evidence-based care, which they consider a duty and core to the physician identity. They expressed feelings of worthlessness and failure, and often felt used as "pawns" for reasons irrelevant to medicine. Participant 7 said, "*This is within the purview of what I'm supposed to be able to provide. It is my duty to be able to do these things. And, when I can't do those things, I have a sense of loss of purpose or identity.*" Participant 2 said, "*I feel a complete sense of inability to care for people. We...do the bare minimum of what we're allowed to do. But we can't actually care for patients when they need it because we're not allowed to. And it's just this complete sense of like a worthlessness...it's so hard.*" Participant 5 said, "*It makes you question like...am I even helping patients? Am I even really making a difference? Am I...doing this patient a disservice? And so then it gets into your morals. Right?... You start to question your decisions...and then, it's scary because...these moments are forming your future*

TABLE

Characteristics of US Obstetrics and Gynecology Residents and Patient Scenarios They Described While Articulating Their Moral Distress Related to Abortion Restrictions

Resident Interview No.	Postgraduate Year	Program State	Patient Scenario No. 1	Patient Scenario No. 2 (If They Described a Second Patient)
1	3	Alabama	Undesired pregnancy in setting of pregnancy of unknown location	Undesired pregnancy in setting of pregnancy of unknown location
2	4	Texas	Pregnancy in a patient with a medical complication: diabetes	Pregnancy with an obstetric complication: previable PPROM
3	2	Indiana	Undesired pregnancy	Pregnancy with a fetal anomaly
4	3	Louisiana	Undesired pregnancy	Post-abortion care
5	2	Louisiana	Undesired pregnancy	NA
6	4	Utah	Pregnancy in a patient with a medical complication: alcohol use disorder	NA
7	3	Louisiana	Pregnancy in a patient with a medical complication: not specified	NA
8	2	South Carolina	Undesired pregnancy	Pregnancy with an obstetric complication: previable PPROM
9	2	Ohio	NA	NA
10	3	Pennsylvania	Undesired pregnancy	NA
11	2	Arizona	Pregnancy with a fetal anomaly	NA
12	1	Arizona	Pregnancy with an obstetric complication: previable PPROM	NA
13	4	Utah	Pregnancy with an obstetric complication: previable cervical insufficiency	NA
14	3	Utah	Undesired pregnancy	Undesired pregnancy
15	2	Florida	Pregnancy with an obstetric complication: previable intrauterine growth restriction	Pregnancy with an obstetric complication: hyperemesis
16	4	Ohio	Pregnancy with an obstetric complication: previable preeclampsia	Pregnancy with an obstetric complication: previable preeclampsia
17	2	Utah	NA	NA
18	1	Utah	Undesired pregnancy	NA
19	3	Utah	Pregnancy with an obstetric complication: hyperemesis	NA
20	1	Missouri	Pregnancy in a patient with a medical complication: mental health disease	NA
21	4	Pennsylvania	Undesired pregnancy	NA

Abbreviations: PPROM, preterm premature rupture of membranes; NA, not available.

decisions—right—and the way you process things in the future.”

Inability to Do the Job: Residents described frustrating scenarios in which they were unable to care for patients and effectually unable to do their jobs. Some residents were instructed that patients had to be in “extreme harm” before they could administer

care due to language in new restrictive laws. In many cases residents felt they were being forced to endanger the patient to comply with the law. Participant 13 said, *“I have patients that are potentially getting sicker waiting for me to make sure that we all agree that this is safe for all of us, from a legal standpoint, to move forward. There’s a big conflict of interest [between] the patient’s well-being and*

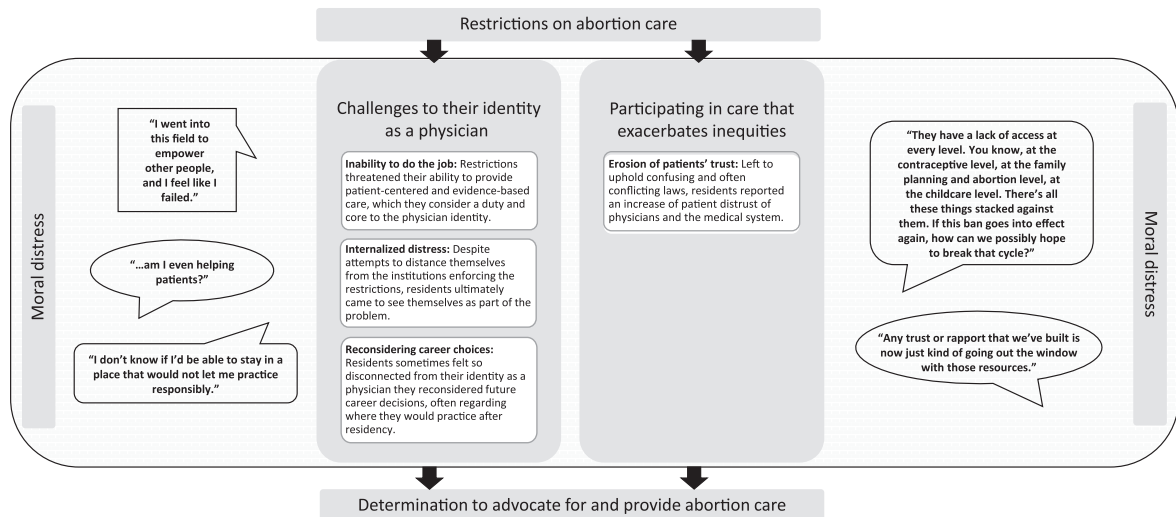


FIGURE
Obstetrics and Gynecology Residents' Moral Distress Due to Restrictions on Abortion Care After the US Supreme Court's *Dobbs* Decision

what we feel is right for the patient, and then, trying to cover ourselves from a legal standpoint." Participant 18 said, *"Medicine is betraying the patient because there's no medical reason why we can't provide [abortion] services."*

Internalized Distress: Despite attempts to distance themselves from the institutions enforcing the restrictions, residents ultimately came to see themselves as part of the problem. Residents described themselves as "participating in the enactment of injustice," feeling like a "robot of the State" and being "puppets," a "pawn," or a "hypocrite." These feelings of moral distress were particularly salient given the rationale residents initially used to choose OB/GYN as a specialty. Participant 20 described a scenario in which a patient presented with an undesired pregnancy and complex mental health issues. The patient was just past the maximum gestational limit, and the resident was distressed at the lack of options they were able to offer their patient, saying *"The reason that I went into this field was to empower other people, and I feel like I failed."* Participant 6 said, *"It is very threatening to your...sense of self as an agent of good in the world."*

Every resident described having witnessed the deleterious effects of withholding high-quality care, which caused moral distress marked by feelings of frustration, helplessness, and anger. Participant 15 said, *"I was mostly just really angry. Because...I felt the risk to her life was huge. I mean she at any point could have had a severe hemorrhage...And I was frustrated and angry that other people didn't seem to be recognizing that."* Residents further

internalized the systems that tied their hands and restricted their medical practice as personal failures. Participant 6 said, *"I think our system was responsible for her having a miscarriage that she didn't want... And myself, as an agent within that system, also feels like I failed her."*

Reconsidering Career Choices: Residents sometimes felt so disconnected from their identity as a physician they reconsidered future career decisions, often regarding where they would practice after residency. Some residents expressed interest in staying in abortion-restricted states, and others wanted to move out of states where abortion is severely restricted so they might provide the full spectrum of OB/GYN care. Some felt fearful of potential punitive consequences for providing the care they wanted to and concern that their training wouldn't be utilized to the full extent. Participant 9 said, *"I don't want to stay here for the rest of my training. I don't know if I'd be able to stay in a place that would not let me practice responsibly."* Participant 8 described being torn by 2 "powerhouse" fellowship programs in restrictive states *"that offer everything that I'm looking for, but both are places where abortion is not legal right now, and that I think would really, really affect my ability to get appropriate training in that specialty."*

Participating in Care That Exacerbates Inequities

Residents described discomforting experiences with patients in which abortion care was needed, but they were simply not allowed to provide it. Some explicitly described how social determinants of health,

exasperated by the *Dobbs* decision, negatively affected their patients' access to abortion care, leading to poor outcomes and *erosion of patients' trust* (subtheme).

Residents expressed great frustration in how the *Dobbs* decision exacerbated existing inequities. Nearly every resident recounted a scenario in which their patient was unable to access abortion care due to cost, distance, lack of transport, lack of childcare, or inability to take time off work. Participant 8 said, "*They have a lack of access at every level. You know, at the contraceptive level, at the family planning and abortion level, at the childcare level. There's all these things stacked against them. If this ban goes into effect again, how can we possibly hope to break that cycle?*"

Residents noted that barriers to care grew insurmountably as patients who initially had reproductive options watched them slip away due to delays in required testing or evolving state policies that put the patient over allowable gestation limits in surrounding states. Such barriers to care inevitably led to poor outcomes for patients. Residents recounted feelings of moral distress when patients with pregnancy or fetal health complications were forced to languish until their physical symptoms aligned with the arbitrary and uninformed state laws^{41,42} that govern abortion care. Participant 16 said, "*She eventually delivered at 22 and 1 after becoming eclamptic and abrupting because she was managed for 4 days with a weird protocol and not what SMFM and the Society of Family Planning would have recommended for her termination.*" Residents felt responsibility for these outcomes that came at the expense of their patients' mental, financial, and physical health or the inability to care for existing children.

Erosion of Patients' Trust: Left to uphold confusing and often conflicting laws, residents reported an increase in patient distrust of physicians and the medical system. Participant 15 said, "*It was kind of like a smack in the face that we told her, initially, yeah, we think that is the right thing to do. And then, we went back and said, 'Oh, but we can't do it.'*" Participant 4 described a patient as hesitant and withholding of information around their pregnancy, unsure who they could trust amid an evolving and confusing legal landscape. They said, "*I had a patient that came in after having an elective termination in another state...and then, having complications afterwards...she was seen in the ED and did not disclose to anyone that it was an elective termination...I think it's really affecting care. And so it's made me take more time with these patients. And it takes time to understand their circumstances and, hopefully, develop enough trust with patients that they disclose to me.*"

When laws prohibited abortion care in the training hospital, residents were left to refer their patients to list of out-of-state clinicians—oftentimes to navigate on their own. Participant 10 said, "*Any trust or rapport that we've built is now just kind of going out the window with those resources.*" Some communicated to their patients that their inability to care was not a reflection of their medical judgment or personal feelings about the patient's choices, for example by telling patients they were sorry and that "*they were well within their rights to ask for that care*" or that "*it being illegal doesn't mean that it's wrong.*"

Determination to Advocate for and Provide Abortion Care

As a result of their moral distress, residents described profound *determination to advocate for and provide abortion care* in the future. Despite grappling with varying abortion restrictions and oftentimes confusion regarding those limitations, many residents remained resolute in their commitment to provide abortion care and advocate for access, and sometimes felt even more motivated by the *Dobbs* decision. The moral distress of not being able to provide care to their patients resulted in an emotional resolve to champion abortion access going forward. Participant 20 said, "*This just reinforced everything. Like to want to be able to offer my patients the care that they desire and deserve to have but knowing that I couldn't in that moment for me was like a catalyst, I guess.*" Participant 19 said, "*I'm not going to stop what I'm doing because I care about this. I'll go to jail for it, I guess.*"

Residents emphasized that abortion is essential health care, and many felt implored to advocate and push the boundaries wherever possible, even if that meant the resident had to go above and beyond normal expectations. Participant 17 said, "*I feel pretty driven and determined. I don't know what resolution looks like. I don't know if it will ever occur...I deeply hope so, but I feel really driven to do what I can to make that happen, and to preserve and expand access in places where it still is in existence.*" Participant 8 said, "*I feel like I am willing to jump through hoops to help patients get the care that they deserve because I believe so deeply in their right to have that care.*"

As residents who often felt powerless against state and institutional restrictions, the very situations that caused moral distress led to a sense of empowerment against the various limiting systems. Participant 21 said, "*I [want] to be able to use the skills I have to provide abortion care even if it's not as typical. I feel*

more empowered to do that now post-Dobbs.” Participant 16 described feelings of motivation in the face of restrictions because of the camaraderie with the dedicated team around them: “Being able to be around people that also care about this is really uplifting and gives me hope that we can still provide these patients with the care that they need safely.”

Discussion

To our knowledge, this is the first qualitative study to explore the experiences and implications of moral distress experienced by resident physicians in the context of post-Dobbs abortion restrictions. The results shed light on the multifaceted effects of these restrictions on residents’ professional identities, working within dynamic legal and medical systems and consequent patient care, and determination to provide care despite limitations.

We found that the inability to provide evidence-based abortion care led to a wavering sense of professional identity among residents. This disruption of identity aligns with existing research on moral distress in health care professionals, demonstrating its prevalence among residents in this context.^{17,19} Residents also described the discomfort and frustration stemming from their inability to provide essential care due to legal constraints. This conflict between ethical responsibilities and legal restrictions created distress for residents, leaving them feeling complicit in perpetuating inequalities and injustices. This is particularly concerning given that these restrictions disproportionately affect economically disadvantaged and other oppressed populations and undermine patient trust in the medical system.^{43,44} Yet, despite facing moral distress, residents demonstrated remarkable determination to continue advocating for evidence-based abortion care, which speaks to the resilience and willingness of these residents to navigate challenges to ensure access to essential health care services.

The implications of these findings are far-reaching, as residents raised concerns about the potential impact of abortion restrictions not only on their own careers, but also on the future OB/GYN workforce, concerns that have been raised in the medical literature.⁴⁵⁻⁴⁷ Residents voiced fears that these restrictions could deter future applicants from considering programs in states with severe abortion limitations, leading to a shortage of OB/GYN physicians in practice and a lack of physicians offering the full spectrum of reproductive health care.^{48,49} This sentiment underscores the broader implications of legal restrictions on medical education and workforce development in the field of OB/GYN.

While this study provides valuable insights into the experiences of OB/GYN residents facing post-Dobbs

abortion restrictions, several limitations should be acknowledged. First, the study was of OB/GYN residents, which may limit the generalizability to other specialties that include reproductive health care, but practicing clinicians of many specialties are currently struggling with the effects of abortion restrictions suggesting relevance outside of OB/GYN.^{7,45} While the study’s sample is geographically diverse, it is relatively small, and the participants were selected from programs affiliated with the Ryan Program, which all have a commitment to integrated abortion training. Our sample also included mostly female-identifying residents and those who identify as White or Asian, which may limit generalizability but does reflect the demographics of most US OB/GYNs currently in clinical practice.⁵⁰ Additionally, the study relied on self-reported experiences and patient scenarios, which might be influenced by recall bias or social desirability. Future research could explore the experiences of residents with more diverse identities and from a wider range of programs, including non-Ryan residency programs, providing a more comprehensive understanding of the effects of abortion restrictions on medical training.

Conclusions

We found that residents experienced moral distress due to challenges to their identities as residents and because of the ways that abortion restrictions exacerbate inequities. They also expressed determination to advocate for and provide care despite these restrictions.

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