"It will only get worse"

How the Supreme Court’s Dobbs Decision Will Decimate Reproductive Health Care for Generations

What the doctors training the next generation of reproductive health care providers warned us about their profession and their patients.
# TABLE OF CONTENTS

Introduction by Ranking Member Frank Pallone, Jr. 1

Executive Summary 3

I. Access to Reproductive Health Care Has Degraded Rapidly as a Result of Dobbs 7

A. The Supreme Court’s Decision has Destroyed Fifty Years of Precedent and is Having Drastic Consequences 8

B. OBGYNs are the Providers on the Front Lines of Reproductive Health Care and Address the Harmful Consequences of Dobbs Every Day 10

II. Methodology 11

III. Dobbs and the State Abortion Restrictions it Permits are Causing Lasting Harm on the Next Generation of OBGYNs and Endangering Patient Health 12

Finding 1: After Dobbs, residency applicants are more concerned about and closely scrutinizing the quality of abortion training that programs can offer because it is essential to comprehensive reproductive health care, including maternity care. 13

Finding 2: OBGYN residents and program directors are seeing sicker patients suffering from greater complications due to delayed care caused by Dobbs. 15

Finding 3: Dobbs has harmed the training of OBGYN residents in restrictive states. 18

Finding 4: Counseling restrictions severely complicate the training and development of OBGYN residents in restrictive states and are having a negative impact on the patient-provider relationship. 21

Finding 5: Dobbs has also harmed the training of OBGYN residents in protective states. 23

Finding 6: Dobbs and restrictive state laws will lead to a workforce less prepared to provide comprehensive reproductive health care. 25

Finding 7: OBGYN residents and program directors are more frustrated, more discouraged, and experiencing more negative mental health effects because of Dobbs. 27

Finding 8: OBGYN residency program standards, which include abortion care training, are essential to comprehensive resident education across the country. 31

Finding 9: After Dobbs, OBGYN residency applicants more strongly prefer programs in states that permit abortion care. 33

Finding 10: A patchwork of restrictions is leading to disparate systems of reproductive health care, worsening reproductive and maternal health care shortages, and a fractured OBGYN workforce. 35

IV. Congressional Action is Necessary to Restore Access to Comprehensive Reproductive Health Care Nationwide 38
Introduction by Ranking Member Frank Pallone, Jr.

Two years ago, the Supreme Court issued an opinion in *Dobbs v. Jackson Women’s Health Organization* that shattered decades of precedent and cast into doubt the ability of women around the country to receive the reproductive health care that they need and deserve.\(^1\) When that opinion was issued and Republican politicians and judges in conservative states adopted draconian restrictions on women’s ability to make decisions about their own bodies, it was clear that reproductive health would suffer and there would be dire consequences for the quality of care in certain states. Now, two years later, we have seen those fears come true.

Study after study has shown that pregnant women in states with restrictions die at higher rates, and *Dobbs* will only make it worse.\(^2\) Infant mortality has increased in those states.\(^3\) Pregnant women are leaving restrictive home states to receive care out-of-state, away from their families and support networks.\(^4\) And conservative states are increasingly threatening doctors and patients alike with investigations and prosecutions based on unclear exceptions to their laws, further risking the lives of patients in need of care.\(^5\)

For these reasons, I announced an investigation last September to examine the impact that laws passed and permitted by the *Dobbs* decision are having on reproductive health care.\(^6\) This report is the result of that investigation, which has focused primarily on the effect that *Dobbs* has had on the future of our reproductive health workforce.

By speaking directly to the people responsible for training the next generation of obstetrician-gynecologists (OBGYNs)—most of whom themselves also provide care as OBGYN clinicians—we heard resounding confirmation of the deeply damaging impact of *Dobbs* on women’s health. OBGYN residents reported seeing sicker patients that suffered from greater complications due to delayed care. We also heard about concerning trends in limitations on training, strains on the resources of residency programs, and harm to the mental health and morale of OBGYN residents and providers. These restrictions will lead to a workforce less prepared to provide comprehensive reproductive health care in the future—both in states that have laws restricting access to comprehensive reproductive health care and states that are seeking to protect access.

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\(^3\) Alison Gemmill et al., *Infant Deaths After Texas’ 2021 Ban on Abortion in Early Pregnancy*, JAMA Pediatrics (June 24, 2024).

\(^4\) *171,000 Traveled for Abortions Last Year. See Where They Went*, The New York Times (June 13, 2024).


\(^6\) *House Committee on Energy and Commerce, Pallone Announces Committee Democrats Will Investigate the Consequences of Republican-Imposed Abortion Restrictions on Health Care Providers and Patients* (Sept. 18, 2023) (press release).
We heard about how the *Dobbs* decision has created chaos and confusion for OBGYNs. They are terrified about the risks of criminal prosecution, and it is impacting many aspects of a resident’s practice and training. In some restrictive states, training has been practically eliminated or limited to simulations and textbooks, forcing residents to travel out-of-state to receive essential training. Over time, stark differences in training between OBGYNs in protective and restrictive states will effectively create two different pools of OBGYNs with entirely different sets of training, knowledge, and ways of caring for their patients.

The findings in this report are staggering and raise the potential for alarming long-term consequences. The devastating impacts of *Dobbs* and new restrictive state laws do not stop at those states’ borders. Rather, the medical education of the next generation of OBGYNs and the quality of care they will be able to provide is being negatively impacted across the board. While the effects of *Dobbs* on OBGYN residency programs in states with restrictions were apparent before this investigation, this report also sheds light on how states without restrictions are spending their resources accommodating out-of-state residents, often to the detriment of their own programs.

Hope is not lost, however. We consistently heard that incoming residents are more motivated than ever to advocate for comprehensive reproductive health care and to do everything they can to provide the best care for their patients, even in the face of harmful legal and bureaucratic obstacles. OBGYN residents and their program directors are frustrated, but they recognize now more than ever how essential they are to ensuring women can access reproductive health care across the country.

This report reinforces that the restrictions preventing women from making their own reproductive health care decisions are tremendously harmful and must be eliminated. Congress has the power to fix these growing disparities before they become permanently entrenched and even more harmful. House Democrats have led the charge to pass the Women’s Health Protection Act, which would restore the protections of *Roe v. Wade* and create a federal right to access abortion free from harmful state laws.\(^7\)

While the individuals who spoke with Democratic Committee staff are not named in this report in order to protect them from professional retaliation, political harassment, or personal harm, their willingness to speak with and entrust us with their stories was essential. Without them, this investigation would not have resulted in this report and its findings. I hope that with this report, they feel their voices are heard. I also hope that others continue to come forward and share their experiences with us so that Committee Democrats can build on this report’s findings as we work to restore access to and protect comprehensive reproductive health care. We will continue to fight to ensure quality, accessible, affordable, and comprehensive reproductive health care is available to all.

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\(^7\)H.R. 12, 118th Congress.

Frank Pallone, Jr.
Ranking Member
August 1, 2024
Executive Summary

The Supreme Court’s 2022 decision in *Dobbs v. Jackson Women’s Health Organization* eliminated the constitutional right to abortion, sending a shock throughout the nation and unleashing chaos and suffering for patients in need of abortion care and physicians who provide it. Abortion care is integral to comprehensive reproductive health care. Dramatically and abruptly eliminating access to abortion has fundamentally changed the way OBGYNs and other providers can serve patients and how well the next generation of OBGYNs is being trained.

This investigation was launched by Ranking Member Frank Pallone, Jr. in September 2023 to examine how providers, and by extension their patients, are being impacted by *Dobbs*. In conducting this investigation, Democratic Committee staff interviewed OBGYN educators and residents to learn how *Dobbs* has impacted the study and practice of obstetrics and gynecology.

The investigation found:

After *Dobbs*, residency applicants are more concerned about and closely scrutinizing the quality of abortion training that programs can offer because it is essential to comprehensive reproductive health care, including maternity care.

Residency directors note an increased interest from applicants in the quality of abortion care training available at a program. Many program leaders said that the topic dominates a large portion of residency interviews. Aspiring OBGYNs know that abortion skills are integral to their training and worry that legal restrictions will impede their ability to provide high quality care to patients. The skills necessary to provide abortion care are applicable to a broad range of reproductive health care, such as treating pregnancy complications including premature rupture of membranes, ectopic pregnancy, and miscarriage management.

**OBGYN residents and program directors are seeing sicker patients suffering from greater complications due to delayed care caused by *Dobbs*.**

*Dobbs* put in place incredible barriers for patients seeking access to abortion care, regardless of the circumstances of the patient. Due to these barriers, both logistical and financial, patients are often unable to receive care in a timely manner. Patients are increasingly delaying care and presenting in the hospital with more complications. Forced delays in care cause patients’ pregnancy complications to worsen, resulting in poorer health outcomes and more stressful and skewed training for OBGYN residents.

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9 Throughout this report, states are referred to as either “restrictive” or “protective” based on the status of their laws regarding abortion care. Because this report is focused on the impact of *Dobbs* specifically, “restrictive” states are those states that have in effect any law that would not have been considered constitutional under the framework of Roe (but that is now permissible after *Dobbs*) while “protective” states are those that have laws that would be permissible under Roe. However, it should be recognized that certain restrictions on abortion still exist within “protective” states.
Dobbs has harmed the training of OBGYN residents in restrictive states.

Particularly in restrictive states, OBGYN residency leaders had to adapt quickly to comply with state law while attempting to provide residents with comprehensive education. In some cases, training has been practically eliminated, and in other cases, it has been limited to simulations and textbooks. Many such programs send residents to programs in protective states for temporary family planning rotations that include abortion training. These arrangements are logistically and financially challenging for both the home residency program and the residents themselves.

Counseling restrictions severely complicate the training and development of OBGYN residents in restrictive states and are having a negative impact on the patient-provider relationship.

In some restrictive states, providers cannot provide abortions and extreme, ambiguous laws coupled with threats of prosecution have led to institutional or legal guidance that has limited or eliminated their ability to discuss abortion as a treatment option. These restrictions and threats also prevent providers from assisting patients in obtaining abortion care out of state. Residency directors said that restrictions on clinical communication degrades trust between the provider and patient and robs patients of autonomy to make informed decisions about their health. In states where doctors might be criminally charged for discussing abortion, residents are deprived of opportunities to observe or practice the vital skill of patient counseling.

Dobbs has also harmed the training of OBGYN residents in protective states.

Taking on out-of-state residents causes strain on the capacity and resources of programs in protective states. It puts additional demands on faculty to instruct more trainees and can result in their full-time residents seeing fewer patients when dividing the patient caseload between more physicians. Residency program leaders who are involved in these partnerships note that they require a heavy administrative burden and take several months to establish and do not include any additional resources or financial compensation.

10 As discussed further in note 45, laws that prosecutors have cited as potentially limiting providers’ ability to discuss or refer patients for treatment are being challenged as unconstitutional under the First Amendment and other grounds.
Dobbs and restrictive state laws will lead to a workforce less prepared to provide comprehensive reproductive health care.

Dobbs has dramatically limited training for residents in restrictive states. Educators are not always certain what training is permitted and access to clinical training has become much more difficult to provide. The current legal landscape is causing great concern among residency program leaders about the quality of physicians finishing their residencies and the future of OBGYN education and practice. There is serious concern that the quality and comprehensiveness of training in restrictive states is harming the ability of residents there to practice at the same level as OBGYNs trained in protective states.

OBGYN residents and program directors are more frustrated, more discouraged, and experiencing more negative mental health effects because of Dobbs.

Oppressive state laws, confusing legal exceptions to abortion restrictions, fear of legal jeopardy, and a general concern about the future of reproductive health care are weighing heavily on OBGYNs. Fears about personal safety and an inability to provide the necessary standard of care to patients are exacerbating stress and frustration for OBGYNs and residents nationwide. Notwithstanding these negative impacts, some residents and OBGYNs have been inspired to advocate for the right to comprehensive reproductive health care. The persistent moral injury that many providers report, however, intensifies a negative outlook for the future of their profession.

OBGYN residency program standards, which include abortion care training, are essential to comprehensive resident education across the country.

Residency program leaders universally agree that abortion care is integral to other components of reproductive health care and cannot be eliminated or isolated from residency training. OBGYN residency program accreditation requirements ensure minimum exposure to abortion care skills for all residents who want the training. While residency directors know that minimum requirements do not guarantee mastery, they maintain that abortion training should continue to be part of OBGYN residents’ education.
After *Dobbs*, OBGYN residency applicants more strongly prefer programs in states that permit abortion care.

Residency program directors stated that since *Dobbs*, application trends at their individual programs indicate restrictive states are less appealing to applicants and facing greater recruitment challenges. Residency directors in restrictive states note that residents are increasingly doubtful that they want to be OBGYNs in places where there is increased fear about legal liability and limited ability to care for patients.

A patchwork of restrictions is leading to disparate systems of reproductive health care, worsening reproductive and maternal health care shortages, and a fractured OBGYN workforce.

Extreme restrictions on abortion are currently in place in roughly half the nation and are leading to a deepening divide between physicians who are minimally trained in abortion care compared to those who can receive comprehensive abortion training in their residency programs. Limiting the skills of a large proportion of the workforce for the long-term will attract fewer doctors to a specialty that is already in shortage and poses great risk to patients. The longer these harmful abortion restrictions remain in place, the harder it will be to repair the damage.

Taken together, these findings demonstrate an urgent need for federal legislation to undo the harm that the Supreme Court and Republican legislatures have done to reproductive health care before damage to our health care system becomes irreversible, as it already has for some patients. Specifically, Congress must pass legislation providing a federal right to abortion, which would ensure that patients can receive comprehensive reproductive health care and that a sufficiently trained workforce of OBGYNs is able to provide that care wherever it is needed.
Background

I. Access to Reproductive Health Care Has Degraded Rapidly as a Result of Dobbs

Dobbs is having predictable and catastrophic impacts on reproductive health care. It was just over 50 years ago that abortion was enshrined as a fundamental right. In 1973, in the landmark case Roe v. Wade, the United States Supreme Court held that the Constitution confers a qualified right for a woman to terminate a pregnancy up to the point of viability.\(^\text{11}\) Specifically, it held that a right to privacy was implicit in the Fourteenth Amendment’s Due Process Clause and included the fundamental right to an abortion. The Court adopted a trimester-based approach resulting in dramatically increased access to safe and legal abortion.

Nearly 20 years later, in Planned Parenthood v. Casey, the Supreme Court reaffirmed Roe’s “essential holding” that women have a constitutional right to abortion.\(^\text{12}\) However, the Court rejected Roe’s trimester framework and held that a state restriction on abortion is constitutional as long as it does not place an “undue burden” on a woman seeking an abortion.\(^\text{13}\)

Roe and Casey together created a legal framework that ensured access to abortion nationwide. Following Roe, women could receive abortion care, and providers were free to provide such care without fear of criminal prosecution. In the wake of Casey, however, many states enacted medically unnecessary laws imposing various restrictions. This included waiting periods and mandatory counseling as these restrictions were determined not to constitute an “undue burden” on a woman seeking an abortion. Certain states’ laws further complicated access for many women by limiting who could provide abortions and imposing costly compliance burdens on the clinics that provided them. Targeted Regulation of Abortion Providers, or “TRAP,” laws became popular in conservative states by creating such complicated administrative and medical hurdles that many abortion providers could not realistically overcome.\(^\text{14}\) Over time, these restrictions created “abortion deserts” where, while remaining technically legal, abortion was inaccessible to many women, especially those in poor or rural parts of the country.\(^\text{15}\) Throughout the implementation of these restrictions, however, Roe remained in effect, providing a legal backstop against complete bans on care and a nationwide standard that permitted abortion in every state. Devastatingly, the Supreme Court’s decision in Dobbs undid these protections and eliminated the Constitutional right to abortion.


\(^{13}\) Id.


A. The Supreme Court’s Decision has Destroyed Fifty Years of Precedent and is Having Drastic Consequences

During his presidency, former President Donald Trump appointed three justices to the Supreme Court thereby creating a 6-3 conservative majority.\textsuperscript{16} Not long after his third Supreme Court appointment was confirmed, a state law restricting abortion, that intentionally defied settled precedent, was brought before the Court and in 2022, a five-justice majority overturned both \textit{Roe} and \textit{Casey}.\textsuperscript{17} The Supreme Court’s decision in \textit{Dobbs} unraveled 50 years of legal precedent. It held that the Constitution does \textit{not} provide a fundamental right to an abortion and that the issue of abortion access should be left up to the states. This was the first time in history that the Court took away a fundamental right.\textsuperscript{18}

\textit{Dobbs} had an immediate and widespread impact. Some states had previously enacted “trigger bans,” which outlawed abortion as soon as the Court issued its decision in \textit{Dobbs}.\textsuperscript{19} Others acted quickly to pass strict abortion bans that prohibited almost all abortions after the detection of a fetal heartbeat, some as early as six weeks gestation.\textsuperscript{20} Fourteen states now have total bans on abortion and eight more states enacted bans between 6 to 18 weeks gestation.\textsuperscript{21}

Varying state laws and confusing statutory language make it difficult for providers to know when a given medical situation qualifies as an exception to their state’s abortion ban. For example, nearly all state laws banning abortion contain some kind of exception allowing abortion to protect the life or health of the pregnant woman, but these laws are vague at best about how dire a threat to a woman’s health must be to allow an abortion.\textsuperscript{22} This leaves providers in a constant state of legal risk, fearing that providing medically appropriate care will result in criminal liability.

Other states, however, have protected abortion in the wake of \textit{Dobbs} and have created safe harbors for women from other states to receive care. California, Michigan, Ohio, and Vermont have enshrined the right to abortion into their state constitutions and fourteen other states permit abortion up to the point of viability.\textsuperscript{23} Seven states and the District of Columbia

\textsuperscript{16} \textit{How Trump Transformed the Supreme Court}, The New Yorker (Nov. 11, 2021).
\textsuperscript{17} See note 1.
\textsuperscript{18} \textit{Dobbs}, 597 U.S. at 359 (Breyer, Sotomayor, and Kagan, JJ., dissenting).
\textsuperscript{19} \textit{What are Abortion Trigger Laws and Which States Have Them?}, The New York Times (June 24, 2022).
\textsuperscript{20} \textit{Tracking Abortion Bans Across the Country}, The New York Times (July 1, 2024).
\textsuperscript{21} The fourteen states are Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West Virginia. The eight other states are Florida, Georgia, Iowa, South Carolina, Nebraska, North Carolina, Arizona and Utah.
do not restrict abortion based on gestational limitations.\textsuperscript{24}

This inequality of access in the wake of \textit{Dobbs} means that women who live in abortion-restrictive states must travel across state lines, sometimes hundreds of miles, to obtain access to abortion care.\textsuperscript{25} The average time to travel to an abortion facility has multiplied threefold following the \textit{Dobbs} decision.\textsuperscript{26} These inequalities are exacerbated for racial and ethnic minorities with data showing that women of color travel even longer distances on average to access abortion.\textsuperscript{27} States with abortion bans are seeing an increase in pregnancy-related deaths, as fewer women can obtain proper treatment for serious complications.\textsuperscript{28} In short, \textit{Dobbs} has reduced access to medically necessary care and worsened health outcomes.

\textit{Dobbs} has also negatively impacted the medical workforce, specifically in the field of obstetrics and gynecology. Patients and their doctors across the country are confused by an ever-evolving patchwork of laws, with no clear understanding of when, where, or under what circumstances they can legally access abortion. Further complicating this problem is the fact that some states have passed laws that prosecutors have cited in an effort to prohibit providers from counseling patients on where they can access abortion care out of state.\textsuperscript{29} Additionally, states like Oklahoma and Texas have passed laws prohibiting a provider from assisting a patient in obtaining an abortion, which many physicians have interpreted as restricting their ability to counsel patients on the full range of medical options appropriate for that patient.\textsuperscript{30} And overzealous prosecutors in states like Alabama have threatened to aggressively prosecute anyone helping someone access abortion out-of-state.\textsuperscript{31} These laws and threats negatively impact physicians’ ability to provide comprehensive and accurate information to patients by seeking to prohibit discussions about patients’ options in other states.

**RESTRICTIVE AND PROTECTIVE STATES**

Source: \textit{The New York Times} as of July 29, 2024.

\textsuperscript{24}The seven states are Alaska, Colorado, Minnesota, New Jersey, New Mexico, Oregon, and Vermont; Tracking Abortion Bans Across the Country, The New York Times (July 1, 2024).

\textsuperscript{25}See note 4.

\textsuperscript{26}Benjamin Rader et al., Estimated Travel Time and Spatial Access to Abortion Facilities in the US Before and After the \textit{Dobbs} v Jackson Women’s Health Decision, JAMA (Nov. 1, 2022).

\textsuperscript{27}Center for American Progress, Abortion Access Mapped by Congressional District (Apr. 2024) (https://www.americanprogress.org/article/abortion-access-mapped-by-congressional-district/).

\textsuperscript{28}See note 3.


\textsuperscript{31}Alabama AG: State May Prosecute Those Who Assist in Out-of-State Abortions, Alabama Political Reporter (Sept. 15, 2022); \textit{Federal Judge Criticizes Alabama AG for Abortion Threats, Allows Case to Continue}, Alabama Political Reporter (May 7, 2024).
B. OBGYNs are the Providers on the Front Lines of Reproductive Health Care and Address the Harmful Consequences of Dobbs Every Day

OBGYNs provide a range of reproductive health care, including preventive care, prenatal care, disease screening, oncology, reconstructive surgery, and family planning. The path to becoming an OBGYN begins in the third year of medical school, when students gain firsthand experience in obstetrics and gynecology through clinical rotations. Students may then choose to pursue a specialization through a four-year post-graduation residency program.

As part of the residency application and interview process, graduating medical school students create a ranked list of programs to which they are applying. Residency programs, likewise, create a ranked list of applicants who meet their eligibility requirements. The National Resident Matching Program (NRMP) administers the annual Match program, which places residency applicants into residency programs across the country through an independent algorithmic process that aligns the rankings of programs and candidates. After completing residency, OBGYNs may pursue fellowships in subspecialties including complex family planning and maternal-fetal medicine, among others.

Since Dobbs, OBGYNs are facing numerous challenges caring for pregnant patients, particularly those who develop complications. Abortion restrictive laws have unduly limited education and training of medical students, residents, and fellows. These dramatic changes affecting the OBGYN profession are having severe consequences for providers and patients and will only worsen over time.

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II. Methodology

OBGYN residency program leaders are practicing physicians and the educators of the next generation. As the professionals who are directly impacted by legislative changes to abortion access and are responsible for training future OBGYNs to provide care as allowed within new and evolving restrictive frameworks, residency program leaders are best situated to observe resident reactions, behaviors, and trends in their field.

Accordingly, we invited all OBGYN residency programs to participate in interviews with Democratic Committee staff. In total, we spoke to leaders and educators from 20 residency programs across 15 states between February and June of 2024, with at least one program representing each U.S. region.\(^\text{35}\) Ten programs are located in states that protect access to abortion and 10 programs are located in states that restrict access to abortion. Democratic Committee staff asked a series of questions during interview sessions covering a range of topics, including:

- Legislative changes in the program’s state since the *Dobbs* decision;
- Trends related to interest in or applications to residency programs as compared to years prior to *Dobbs*;
- Necessary adjustments to training protocols to ensure the ability of residents to receive abortion care training;
- Observations about how residents have reacted to new state laws;
- Observations about how *Dobbs* has affected patient care;
- Challenges that residency program leaders or residents have experienced when complying with new laws;
- How abortion restrictions are personally affecting interviewees or residents, including concerns about their careers and where they might practice;
- How *Dobbs* changed guidance from or collaboration within institutions; and
- How the decrease in abortion access will have long-term effects on OBGYN training and the profession.

In addition to these residency program leaders, we spoke with other stakeholders, including current OBGYN residents and fellowship directors.

In order to encourage candor and ensure the personal and professional safety of those who participated in interviews with Democratic Committee staff, interviewees are quoted anonymously in this report, identified only by the geographic region in which they are based and the current nature of abortion restrictions in their state.\(^\text{36}\)

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\(^{35}\) References to a state’s geographic region in this report apply the same definitions as the U.S. Census. See U.S. Census Bureau, *Census Regions and Divisions of the United States* (https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf) (accessed July 9, 2024).

\(^{36}\) See note 9 for further explanation of the descriptors assigned to states based on abortion restrictions.
III. *Dobbs* and the State Abortion Restrictions it Permits are Causing Lasting Harm on the Next Generation of OBGYNs and Endangering Patient Health

Our investigation found that the Supreme Court’s decision in *Dobbs* is profoundly affecting physicians and patients in all states, regardless of whether the state’s laws restrict or protect access to abortion. In addition to harming current providers and patients—who must now navigate a maze of statutes, competing and evolving judicial interpretations, and inconsistent institutional guidance—these restrictions are disrupting the education of OBGYN residents.

The status of abortion rights in a state is affecting whether medical students pursue their residency in that state and where they choose to practice. During the application process, prospective OBGYN residents are increasingly assessing the quality and comprehensiveness of the abortion training a residency program can offer. All the while, current residents and residency program leaders are reporting numerous negative effects on their well-being because of new legal and professional threats stemming from restrictive state laws.

OBGYN residency program leaders are working to adapt their programs to continue providing residents with the necessary abortion training that is critical to building skills that are applicable to the full spectrum of reproductive health care, but it is often shorter, less comprehensive, and less integrated into their overall training than before *Dobbs*. Over time, these limitations on training and access to care will increase risks to patients and will reduce the number of OBGYNs who are able to provide comprehensive reproductive health care, particularly in restrictive states.

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Finding 1

After Dobbs, residency applicants are more concerned about and closely scrutinizing the quality of abortion training that programs can offer because it is essential to comprehensive reproductive health care, including maternity care.

“They wanted to know about training and would they be trained to competence. This was the first year that I had to say no, we would not be able to train you to competence.”

OBGYN residency program leaders are seeing clear evidence that residency applicants are scrutinizing the quality of abortion training that a program can offer and are increasingly indicating it is a primary concern in evaluating programs. During the interview process, applicants are consistently asking specific questions about how and whether they will have access to abortion care training as part of their residency. One residency program leader in a restrictive state reported that when assisting students with residency applications, “It’s a number one question for me: Should [they] or should [they] not apply to programs in states with abortion bans?”38 Another program director from a restrictive state said that questions about abortion training were much more common now, stating “I didn’t have the conversation two [application] cycles ago... I don’t remember there being questions about it before.”

Several residency directors stated that they now affirmatively address the issue of abortion training during interviews because they know it is of greater importance for applicants than before Dobbs. One reported that a large portion of interviews is now dedicated to answering applicants’ questions related to access to abortion care training, saying, “it’s very top of mind.” Another described applicants as “specific and intentional” about their desire to be trained in abortion care and that it is one of the most common questions they received in recent residency interviews. Another said, “It’s a very hot topic because [residents] feel that it’s so crucial to their training and they want to make sure they receive it and leave residency able to provide abortion care.” Yet another from a restrictive state said they “sat in on two interview days and every applicant asked about abortion services...They wanted to know about training and would they be trained to competence. This was the first year that I had to say no, we would not be able to train you to competence.”

One resident training in a restrictive Southern state characterized access to abortion training as very important in their application process because it is central to achieving competency in the skills that are necessary to provide patients with medically appropriate care. The resident stated that the biggest concern about training in a restrictive state is “getting used to something that is not standard of care.” Given the current limitations on the training that the residency program can offer due to state restrictions, the resident added, “I don’t know what I’m missing.”

38 As discussed in Section II, all quotations in this report are from interviews conducted by Democratic Committee staff unless otherwise noted.
This investigation found that abortion training was especially important to residents seeking fellowships in an OBGYN specialty after completing their residency. Residents and program directors from restrictive states are now concerned about residents’ ability to compete for limited, highly competitive fellowships if they cannot demonstrate that they have been thoroughly trained on all the skills necessary to provide comprehensive patient care.

One residency director in the Midwest reported that educators in their program had to seek out supplemental training opportunities for a resident who wanted to apply for a family planning fellowship because the availability of abortion training in the residency program was reduced after Dobbs. The discrepancy between training opportunities puts residents in restrictive states at a disadvantage when trying to advance their careers in more specialized OBGYN fields.

One resident described the challenges faced by graduating residents in restrictive states when pursuing a complex family planning fellowship. The resident said they “competing with a bunch of applicants who have experience because they’re not from restricted states... the obstacles pile[e] on top of one another.”

A family planning fellowship program director echoed these concerns and reported already noticing a difference in the skill level and motivations of applicants, saying that before Dobbs, graduating residents who were pursuing a family planning fellowship had “strong family planning training in residency and wanted to get even stronger,” but since the Dobbs decision, more applicants are “not competent in [abortion care] yet and want to be.” This trend is of particular concern because OBGYN specialists in complex family planning or maternal fetal medicine, for instance, are already difficult to find in many areas of the country.\(^3^9\) Fewer or less skilled providers in these fields exacerbate existing health care crises like maternal mortality and morbidity.\(^4^0\)

Aspiring physicians dedicate significant time and money obtaining education and training in their pursuit of a career in medicine. For those who are applying to OBGYN residencies, the increased interest in abortion training opportunities demonstrates an awareness that the skills necessary to provide abortion care are applicable to a broad range of reproductive health care. Several providers explained that certain skills learned in abortion training are the same skills required to treat pregnancy complications including premature rupture of membranes, ectopic pregnancy, and miscarriage management. Residents understand that developing these skills will make them more competent doctors and is key to serving patients with pregnancy complications and other routine reproductive health care needs. In other words, these are skills all OBGYNs need and are skills that early-career OBGYNs want to be sure they can practice.


\(^4^0\) March of Dimes, Nowhere to Go: Maternity Care Deserts Across the U.S. Report (2022).
Finding 2

OBGYN residents and program directors are seeing sicker patients suffering from greater complications due to delayed care caused by Dobbs.

“(S)eeing only the hard and challenging cases is really hard for the learners to process.”

Residency program leaders report that abortion restrictions across the country have resulted in patients suffering worse health conditions than before Dobbs. Doctors in restrictive states are increasingly prohibited from providing timely care for pregnancy complications unless and until a statutory exception applies, at which point appropriate care can finally be legally provided. And patients traveling from restrictive states to protective states are often seeking care later in their pregnancies due to the financial and logistical challenges associated with locating out-of-state care and travel, which can exacerbate pregnancy complications.

One residency program director in a Southern restrictive state described a case where a pregnant woman was admitted to the hospital with serious pregnancy complications, but her physicians were prohibited from discussing and providing appropriate medical care. Despite requesting an abortion weeks before the fetus’s viability, “her doctor couldn’t talk to her about it; couldn’t tell her she could get it in another state.” The program director said that every resident that participated in this case had cried and was traumatized because the woman would likely die, and the fetus may not survive due to the delay in appropriate care. Another residency program leader acknowledged the impact of acute cases on residents, stating that, “seeing only the hard and challenging cases is really hard for the learners to process.”

“Her doctor couldn’t talk to her about it; couldn’t tell her she could get it in another state.” The program director said that every resident that participated in this case had cried and was traumatized because the woman would likely die, and the fetus may not survive due to the delay in appropriate care.

- Residency Director in Southern Restrictive State

A different residency program leader in a Southern restrictive state said their institution is seeing an increase in “very complex” cases that have “bounced around” from clinic to clinic because the laws restricting abortion are so poorly written that other institutions are apprehensive to allow their physicians to provide the appropriate care. Another program director described one harrowing case where a pregnant patient was transferred to their emergency room with an infection and with no fetal heartbeat. Because an abortion could not be provided earlier due to restrictive state laws, the patient became increasingly sick and ultimately died in the Intensive Care Unit (ICU) from sepsis.

Residency directors also conveyed that they were repeatedly unable to provide the standard of care necessary to prevent further complications from developing. The residency
director characterized the situation of a patient in pre-term labor as a “common, everyday thing” that OBGYNs encounter, but these complications present a greater threat to patients because physicians cannot provide timely and clinically appropriate care. Similarly, another residency program director from a restrictive state said waiting until someone is gravely ill to administer appropriate care is “not practicing good medicine.”

One residency director in a restrictive state described a patient in their hospital who was admitted after her amniotic sac had ruptured around 20 weeks of pregnancy. The residency director was distressed that the only thing they were permitted to do was wait for the patient’s condition to stabilize or get much worse. Unless the patient’s condition worsened to meet the vague and otherwise undefined exception of threatening the “life of the pregnant person,” they were prohibited from providing or discussing abortion care that could be necessary to save the patient’s life.41

One recent publicly reported case painfully illustrates the impossible situation that doctors and patients in restrictive states face. In Oklahoma, a woman was suffering from a cancerous molar pregnancy but when she arrived at the hospital, she was told that she would not be able to receive any care until she became “much sicker.”42 She was advised by providers to “sit in the parking lot,” and that they would be able to help her “if anything else happened.”43

Due to the state’s unclear and restrictive laws, Oklahoma providers told her that they were unable to touch her unless she was “crashing in front of us or [her] blood pressure goes so high that [she was] fixing to have a heart attack.”44 The providers and the patient knew that the pregnancy was not viable and cancerous. Over the course of a week, she was transferred to three different hospitals and ultimately

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42 In Oklahoma, a Woman was Told to Wait Until She’s ‘Crashing’ for Abortion Care, NPR (Apr. 25, 2023).
43 Id.
44 Id.
drove to another state to receive the necessary care. This patient now faces additional surgery to remove cancerous tissue, as well as potential chemotherapy.

Even in protective states, residency program leaders are concerned that they will have to care for “sicker and sicker patients” with worse outcomes and what that means for a physician’s ability to manage and absorb the extra stress. A Midwestern residency program director in a protective state reported seeing triple the volume of patients since Dobbs who were increasingly medically and surgically complicated as a result of having to travel from other states for care. They reported treating out-of-state patients weekly for ruptured membranes, infections requiring stays in the ICU, and other complex conditions. Another residency program director in a protective Northeastern state agreed that their patients were increasingly delaying care and presenting in the hospital with more complications. These cases would have been easily treated if the necessary care was provided earlier in the pregnancy.

The challenges of providing care for patients in increasingly dire conditions not only results in an increased likelihood of poor patient outcomes but also has a distorting effect on the training of residents and their well-being. Instead of receiving training on a wide array of patients in varying health conditions, residents are regularly exposed to worse and more complicated cases. This limits a resident’s experience practicing routine obstetric care, which is essential to preventing complications.
**Finding 3**

**Dobbs has harmed the training of OBGYN residents in restrictive states.**

“[Residents are] basically memorizing steps of something that requires learning by feel.”

Our investigation found that *Dobbs* has negatively impacted the comprehensiveness of OBGYN residents’ training across the country in states with and without restrictions. The Supreme Court’s decision overturning *Roe* resulted in significant and often immediate changes to states’ laws on abortion, and the ability for many OBGYN residency programs to train their students in abortion practices was seriously and quickly curtailed.

Prior to *Dobbs*, some residency programs were already prohibited from providing comprehensive training at their programs due to institutional or state restrictions. Residency program leaders said that in those instances, residency programs often relied on outside clinics to provide abortion care training opportunities for their residents. *Dobbs*, however, forced many of these outside clinics to close their doors either immediately or after subsequent state restrictions led to clinic closures. This left some residents and residency programs without access to any comprehensive abortion training. One residency program director in a restrictive Southern state reported that in the immediate aftermath of *Dobbs*, they were not able to offer direct abortion training to a majority of the residents in their program. When the outside clinic that residency program partnered with closed in 2023, residents also lost a critical opportunity to practice diagnosing, counseling, and performing ultrasounds. Another residency director in a different restrictive Southern state said that as a result of their outside clinic closing, the “2024 graduates won’t have the training.”

Several states that allowed access to abortion before *Dobbs* enacted abortion restrictions after *Dobbs* that weakened abortion training for residents in those states. In some cases, training has been practically eliminated, and in other cases, it has been limited to simulations and textbooks. One residency director from a restrictive Southern state said that after their complex family planning specialists left following *Dobbs*, the program relied on general OBGYNs to teach the majority of family planning education to residents and that they “provide a curriculum online, simulations, but it’s not the same” as receiving instruction from specialists. Another residency program director shared that many educators are “afraid to tell people to even read certain literature. There are workarounds on how to simulate surgical management of these situations but it’s not really possible to simulate a first or second trimester uterine evacuation in a realistic way. [Residents are] basically memorizing steps of something that requires learning by feel.”

When changes to state laws prevented some residency programs from offering comprehensive in-state abortion training, many programs sought partnerships with out-of-state residency programs that would take on outside residents and provide several weeks of training that included abortion training. These partnerships with outside institutions enable residents from restrictive states to complete family planning rotations. Depending on the location of a residency program and the status of abortion access in surrounding states, these external rotations can require residents to travel significant distances to receive this essential training.
These arrangements allow for exposure to some clinical abortion training for residents in restrictive states but are not without challenges. First, these programs usually last only a few weeks, which program leaders repeatedly expressed does not constitute adequate training in abortion care. One residency program director said they were concerned about the amount and variety of experience their residents can receive during these abbreviated rotations. Another residency director from a restrictive Midwestern state reported that before Dobbs, they provided two family planning rotations for residents but, after the decision, they could only offer one six-week rotation out-of-state. These out-of-state alternative arrangements generally do not serve as a full substitute for experiences a resident would have received if abortion care was integrated into their training at their home residency program. While residents gain valuable experience during out-of-state rotations, residency program leaders expressed concern that the experience would not consistently result in competency in abortion and related care.

In addition to locating an out-of-state program with the capacity to take on additional residents, program directors must also obtain state-specific medical licenses, liability insurance, and coordinate accommodations for traveling residents—a complicated and detailed process that can take many months to complete. A residency director in a restrictive state called it a “huge administrative burden” to send trainees out of state for rotations lasting over a month. Another residency program leader reported that it could take nearly nine months for a resident to apply for and receive the license necessary to practice in another state for training purposes. One residency program leader lamented the impact that coordinating training opportunities has on their patient load, stating, “another thing that has gone overlooked is the amount of work, time, and drag on resources these [training accommodations] have created. What it means is that there are 40-45 other patients that don’t get my attention.”

Securing out-of-state training is also costly. While outside funding is sometimes available to defray these costs, in many locations that funding is not nearly enough to cover travel and housing for several weeks. Often this forces residency program leaders to request funds from their institution or seek other private funds from donors to bridge the financial gap.

"Another thing that has gone overlooked is the amount of work, time, and drag on resources these [training accommodations] have created. What it means is that there are 40-45 other patients that don’t get my attention."

- Residency Leader

Even in the cases where this training is secured by coordinating with another state’s residency program or hospital, institutions in some restrictive states reluctantly support these efforts to satisfy the Accreditation Council for Graduate Medical Education (ACGME) accreditation requirements. One residency director in a restrictive state reported that their institution was so fearful of running afoul of state law or of becoming a target for anti-abortion groups that it was unwilling to fund the training and their program was forced to secure
outside private funding to ensure the necessary training could occur. Some residency programs are also part of hospital systems that are reluctant to assume legal or political risks associated with coordinating out-of-state abortion training for their residents when the liabilities are uncertain.

Finally, many residents simply cannot afford the costs of out-of-state training or have families and other obligations that do not allow them to be away from home for several weeks. One residency director reported that after painstakingly arranging training in another state, approximately 40 percent of the class could not participate due to personal obligations.

In addition to the effort and complications required to secure out-of-state locations for residents to receive their training, the programs in restrictive states face challenges caused by the absence of their residents for prolonged periods of time. Every residency program that sends its residents out of state reported challenges maintaining continuity of staffing during residents’ absences. The residents who remain while other residents travel for training shoulder the burden of covering for their out-of-state colleagues and caring for additional patients, increasing their already demanding workload.
Finding 4

Counseling restrictions severely complicate the training and development of OBGYN residents in restrictive states and are having a negative impact on the patient-provider relationship.

“We’re going to be creating a generation of doctors who have no idea how to counsel on options because they’ve never sat down with a patient who is trying to make a decision.”

In some restrictive states, physicians are prohibited from providing complete medical advice to pregnant patients. These so-called counseling restrictions can include restrictions on discussing abortion or referrals for abortion care. Residency program leaders in states with counseling restrictions are frustrated by ambiguous laws and threats of prosecution over having honest, medically accurate discussions with patients. They worry that these laws erode the patient-provider relationship and prevent them from modeling comprehensive counseling for their residents. Providing patients with complete information about their treatment options is fundamental for strong patient-provider relationships and a necessary skill that residents should observe and practice throughout their training. Counseling restrictions deprive residents of skill development and will contribute to poorer patient care and outcomes over time.

In states with counseling restrictions, some residency directors have made deliberate efforts to shield residents from legal risk by excluding them from clinical decision-making discussions about cases where abortion would be a clinically appropriate option. While the extra precaution may be well-intentioned, it is detrimental to the professional development of residents because it denies them the experience of observing and contributing to deliberations about patient care. One residency director said that residents’ participation in these patient interactions helps ensure the development of “more complete physicians.” As another explained, “we’re going to be creating a generation of doctors who have no idea how to counsel on options because they’ve never sat down with a patient who is trying to make a decision. There is no other equivalent that challenges a learner to reflect on the options, hold onto your own biases, and support a patient with evidence-based counseling.”

Residency program leaders described the confusion created by situations in which patients must leave their home state to obtain an abortion, particularly if the patient’s home state has laws and threats from prosecutors that have led to guidance prohibiting providers from assisting patients in locating out-of-state care. This leaves patients on their own to determine where they might obtain an abortion and make travel arrangements, often across long distances. Providers in protective states who then treat these patients from states with

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45 Efforts by states to limit the ability of providers to communicate complete medical advice to their patients are being actively litigated. For example, in Idaho, a federal court enjoined that state’s Attorney General from barring providers from providing patients with information about seeking abortions outside of Idaho, and in Alabama, a federal court permitted a lawsuit to proceed that would block that state’s Attorney General from criminalizing individuals who help patients receive abortions out of state. See Planned Parenthood Greater Northwest v. Labrador, 684 F.Supp. 2d 1062 (D. Idaho July 31, 2023); Yellowhammer Fund v. Attorney General of Alabama Steve Marshall, Nos. 2:23cv450-MHT, 2:23cv451-MHT, 2024 WL 1999546 (M.D. Ala. May 6, 2024). See also note 29.
counseling restrictions struggle with limited visibility into the patients’ medical history. One residency director whose institution treats out-of-state patients said that it can even be unclear what physicians are able to ask a patient from a restrictive state and if they are able to consult with the patient’s home-state physician.

Residency program leaders told us that counseling restrictions erode trust between patient and provider. They stressed that explaining all potential procedures and treatments to patients is integral to providing comprehensive care. One residency director who works in a restrictive state said because of their state’s counseling restrictions, they cannot offer what they consider to be “full care,” and described that situation as “stressful.”

Another residency director expressed concern about what residents learn when they observe incomplete counseling by their educators. With the risk of prosecution hanging over providers, resident educators in states with counseling restrictions are simultaneously weighing their own personal risk of liability, how to best train a resident in patient counseling, and how to advise their patient on appropriate treatment.

A residency program director in a restrictive state noted that laws restricting abortion and chilling communication with patients gives the patient less of a say in their own health care, adding “if we stop listening to patients, we’re not treating them well.” When physicians are being trained to consider patient communication as a liability instead of a fundamental component of patient care, the result is poorer quality of care and patients’ inability to make fully informed health care decisions.
Finding 5

Dobbs has also harmed the training of OBGYN residents in protective states.

“A lot of us are grateful and honored we can provide the care, but from a minute-to-minute perspective, it’s much harder.”

OBGYN residency programs in protective states are also negatively impacted by Dobbs. Programs that accept out-of-state residents provide them with abortion training in addition to the regular training for their own residents, which can strain resources of the host program. One residency program director from a protective state said they “have been overwhelmed with patients from neighboring states.” And another resident educator said that their “colleagues in [nearby protective states] are inundated with patients from [restrictive states] and the workload has tripled...they’re taking care of everyone from multiple states.” The caseload in protective states can be overwhelming.

“Colleagues in [nearby protective states] are inundated with patients from [restrictive states] and the workload has tripled...they’re taking care of everyone from multiple states.”

- Resident Educator

While some programs want to accommodate out-of-state residents, residency program leaders are wary that adding more residents results in a diluted experience when an increased number of residents share the same patient load. Program leaders in protective states report this impacts the experience and opportunities available to residents across the board. One residency program director said that taking on extra trainees has required extensive after-hours administrative work with no additional resources or financial compensation and has “stretched everyone thin.” A fellowship director from a protective state described added difficulty providing care to out-of-state patients, saying “we have to consider what happens when they go back home...how do we get them follow up care? Patients are so much more emotionally distressed that it makes our encounters with them harder. A lot of us are grateful and honored we can provide the care, but from a minute-to-minute perspective, it’s much harder.”

Some residents in protective states receive training at outside clinics, but these clinics have their own limited resources and often cannot provide training opportunities for all in-and out-of-state residents. Religiously affiliated hospitals, for example, generally do not
provide abortion care or direct abortion care training as part of their residency programs. Other institutions have a very small number of providers who can train residents in abortion care or their patient load is too small to allow residents to achieve competency. The institutions in any of these circumstances would commonly have residents obtain their training at an outside clinic in the same state, but since Dobbs, capacity to accommodate the increased demand for such training is more limited. One residency director of a religiously affiliated program in a protective state was unable to find a new in-state training site for their residents because of competing requests for training for residents coming in from restrictive states.

Finding 6

*Dobbs* and restrictive state laws will lead to a workforce less prepared to provide comprehensive reproductive health care.

“There is a gap in how they’d manage patients, and you can already see it. You can tell who knows the book answer and who can think on their feet and really know that answer.”

All providers interviewed for this report, regardless of where they practice, said that abortion restrictions negatively affect the OBGYN profession and patients. Residents are concerned about obstacles to obtaining comprehensive training if they complete their residency in a state where they cannot routinely practice abortion care. The current legal landscape is causing great concern among residency program leaders about the quality of physicians finishing their residencies and the future of OBGYN education and practice.

The interference in medical care by right-wing judges and lawmakers will have grave long-term consequences on reproductive health care providers. The more restrictions on abortion that are added across states and the longer restrictions remain in place, the harder it will be to repair the damage. Limiting the training of prospective OBGYNs will attract fewer doctors to a specialty that is already in shortage, which ultimately will increase risks to patients.47 Abortion restrictions have already harmed patients and residency program leaders expressed that conditions will continue to worsen.48 One residency program director observed that years of political efforts to isolate abortion care from other obstetric care has reduced access to abortion in many areas of the country because providers do not have the necessary skills to provide comprehensive care. They described the sobering reality that if more patients seek care in areas “without a trained person, someone is going to die.”

Some residency program leaders described confusion in restrictive states about what educators are legally permitted to teach and discuss with their trainees, creating a chilling effect.

One residency director said there is concern that residents are learning the wrong skills and reported that educators in restrictive states were reluctant to even refer to peer-reviewed medical literature for fear that it could be perceived as teaching about abortion.

Residency directors in restrictive states are concerned that their programs are less capable of producing OBGYNs with mastery of comprehensive reproductive health care. A residency director who conducts board exams with the American Board of Obstetrics and Gynecology (ABOG) is already observing differences in the knowledge demonstrated by doctors trained in restrictive states compared to those trained in protective states. They

47 See note 39.

explained, “you can tell who has done it and who has learned it from a book. There is a gap in how they’d manage patients, and you can already see it. You can tell who knows the book answer and who can think on their feet and really know that answer.” These fears about a decline in competency in the future workforce are being realized now and will only get worse.

Despite the immense impact that state abortion restrictions are already having on patients and providers, one residency director warned that these effects on education are “the tip of the iceberg.” While there is already clear evidence that Dobbs has dramatically shifted practice of reproductive health care for the worse, researchers anticipate the total impact of reduced experience and capability of OBGYNs will become more measurable over time and have even more devastating consequences.\(^{49}\) As one provider shared, the concern is “when you don’t do a procedure, you no longer have the skills to pick it up again. It’s not just the future workforce but maintaining [the skills] in the current workforce in the restricted states.” Another echoed this concern, saying “it’s going to look different in 20, 30, 40 years. You don’t want to lose that workforce; you don’t want to lose the gains women had; you don’t want to lose the compassion. It is a hard enough lifestyle and profession to be in that you don’t want to lose the next generation.” Yet another reported a scenario where a resident moved to another country and now wants to retrain to provide care, noting that “the skills got rusty.”

“It’s going to look different in 20, 30, 40 years. You don’t want to lose that workforce; you don’t want to lose the gains women had; you don’t want to lose the compassion. It is a hard enough lifestyle and profession to be in that you don’t want to lose the next generation.”

- Residency Director

Finding 7

OBGYN residents and program directors are more frustrated, more discouraged, and experiencing more negative mental health effects because of Dobbs.

“[C]haos and confusion . . . that is the intent of the laws.”
“The fear is overwhelming.”

Every residency program director we spoke to from a restrictive state reported personally experiencing or observing in residents and colleagues an increase in frustration, discouragement, and negative impacts to their mental health since Dobbs. They attributed this to several causes including a pervasive sense of moral injury; unclear and confusing laws and regulations; caring for patients who are overall sicker; concerns about personal liability, security, and safety; and impacts abortion restrictions may have on physicians’ own family planning decisions.

Many residency program leaders reported experiencing “moral injury” when the law forbids medically appropriate and necessary treatment. One program director said the most stressful aspect of their practice is that they now feel like they are violating the oath they took when becoming a physician. One director described feeling moral injury when laws restricting access to medical care are not based on evidence, stating that “you don’t feel safe, you don’t feel valued...you feel betrayed.” Another described the injury as negatively impacting resident education because since Dobbs, residents are worrying about what they can and cannot legally say to a patient when they should be focused on learning how to be the best doctor.

Residency program educators’ moral injury is compounded by the fact that they are watching their trainees sustain the injury as well. One residency program director said “[o]ne thing I find most difficult is the moral injury and how do I teach a resident to be resilient? It’s an education I didn’t receive.” Another residency program leader from a restrictive state described the moral injury experienced by some residents who return after an away rotation where they have practiced abortion care because, “they see what it should be and then you come back to [a restrictive state] and you’re back in the situation where you can’t and it leads to burnout, frustration...I talk about moral injury all the time. To be back in a place where you have the skills, but you can’t do it.” Guiding residents through the uncertainty, legal jeopardy, and care limitations imposed after Dobbs has felt like a burden to many educators, with one program director describing it as a “black cloud...constantly following you.”

RESIDENCY LEADERS FROM RESTRICTIVE STATES:

"They see what it should be and then you come back to [a restrictive state] and you’re back in the situation where you can’t and it leads to burnout, frustration...I talk about moral injury all the time...To be back in a place where you have the skills, but you can’t do it..."

Dobbs has felt like a "black cloud...constantly following you."
It is unsurprising then that every residency program leader we asked said that their residents are experiencing frustration as a result of *Dobbs*, which is consistent with other studies. Residency program leaders conveyed that their residents are very worried about the future and are concerned that health care providers will no longer be able to make informed decisions about what constitutes sound and appropriate care for patients. One residency director reported that residents are frustrated because people making decisions about abortion restrictions “do not see how it is affecting patients or happening in real life.” Another said that it is “so disheartening for young physicians who are just starting their career to watch their [legislators] hurt the patients they are trying to take care of,” and that residents “become jaded much faster, cynical, angry because they spent all their time, money, youth. They’ve given it all away to do this.” When asked, 93 percent of interview participants agreed that the general outlook of OBGYN residents has been negatively affected by the efforts of state legislatures and politicians who are restricting access to abortion.

Many residency program leaders described an intensifying culture of fear surrounding the practice of obstetrics and gynecology in many states. They said that fear of liability was palpable and impacted many aspects of a resident’s practice and training, especially in restrictive states. One program director described how their institution gathered all the residents to hear the new state abortion law read aloud. The director reported they felt this session was intended to inform, but also sowed fear.

A director from a restrictive state described fear among practitioners that they could be arrested simply for not completing paperwork properly, even when providing legally permissible care. One program leader said their job is complicated by the fact that the state’s required forms are poorly written, and when seeking institutional guidance, “no lawyer can give you an answer because these aren’t medical terms and no one can tell you what they mean.”

Every residency program leader we asked from restrictive states agreed that there is increased confusion about the application of clinical training. Many restrictive states have legal exceptions when abortions are theoretically permissible, most commonly in situations where the pregnant woman's life is at risk. However, these exceptions are often unclear and not written in medical terms, making it difficult to determine when the exceptions apply. Another residency director described the vagueness in these laws as “paralyzing.” Multiple physicians reported that they are regularly asking the question, “how sick does my patient have to get before I can discuss, recommend, or perform an abortion?” Another residency program director reported that the discussions among their residents often amounted to asking, “how close to death does my patient have to be to convince a non-physician that we can take care of her?” The determination is very subjective, with one director explaining that non-doctors might say “10 percent [risk of patient death] doesn’t seem like a lot to me,’ and I have to respond ‘10 percent sounds like a lot to a mother of five.’”

As a result of this uncertainty and the accompanying threat of prosecution, these restrictive laws are having impacts not only on patients but on the physicians themselves.

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50 See note 29.
One program director described the new restrictive laws in their state as having “far reaching ramifications that weren’t thought out.” A residency program leader from a restrictive state said the legal situation since *Dobbs* created “chaos and confusion and I would argue that is the intent of the laws.”

Providers are also more concerned about their personal legal liability since *Dobbs*. Many residency program leaders said their residents are worried about potential legal ramifications of their clinical decisions. Seventy-nine percent of residency program leaders we asked have observed increased fear of personal liability among prospective or current residents because of restrictions to abortion access. One program director said their OBGYN residents and colleagues are “terrified” about risks of criminal prosecution and that “we didn’t go to medical school to be lawyers, detectives, or police officers.” A residency program director in a restrictive state reported that they are especially careful in the way they interact with patients and other providers for fear that they will be accused of violating state law. Another residency program leader in the South reported that their employer saw it necessary to retain a criminal defense attorney in case any physicians were arrested.

Physicians are worried about their personal safety as well, especially when traveling to restrictive states. ABOG, headquartered in Texas, administers board certification that requires physicians to pass additional tests and oral examinations in person. One residency program director reported that traveling to Texas for board exams caused apprehension among OBGYNs who were advised to remove their name badges and white coats whenever they left the board office to avoid being identified as an OBGYN. Another described the presence of armed guards at OBGYN medical conferences since *Dobbs*.

“We didn’t go to medical school to be lawyers, detectives, or police officers.”

- Residency Director

Several different residency program leaders reported that their residents do not want to practice in restrictive states because they were concerned about their own future family planning. Residents are aware that they would be a patient wherever they live and often are in the phase of life where they may be deciding to start families. They want to be sure the full spectrum of reproductive care is available to them and their own families. One residency program director reported that some residents are not coming to their program because of their own reproductive health asking the question, “what if something happens to me?” Another director similarly reported that some residents “won’t live in a state where their reproductive rights are curtailed.”

OBGYNs also have the well-being of their families top of mind. A residency program director said they were worried about raising daughters in a restrictive Southern state, saying “I don’t want them to get into a position that they can’t get out of.” Relatedly, one director described a colleague who refused to attend a national conference in a restrictive state when
she was 18 weeks pregnant because she was concerned about having access to necessary care if she had a medical emergency.

Many of the providers we interviewed have long considered patient advocacy an important part of their jobs. Residency program directors have noticed that residents who have started their programs since Dobbs are especially motivated to make positive change that alleviates the harms inflicted on patient care. This can include political advocacy with government leaders or taking advantage of comprehensive training opportunities so they can best serve states or regions that are losing access to OBGYNs. One residency director said residents are “super excited any time there is an opportunity to engage in advocacy to improve access to care.” Another residency director in a restrictive state said, “this generation knows they have to fight for access to care and I hope their motivation and fire and drive helps us in the long term.”

The resilience of aspiring OBGYNs has been a bright spot during a particularly challenging time for the profession. However, the energy to fight to ensure the ability to provide evidence-based care could become hard to sustain. A residency program leader in a restrictive state worries that while some residents are able to take their frustration with the current legal landscape and “channel that into positive change...for the majority, it’s going to be an immense burden and dark fog that hangs over them.”

Unfortunately, doctors risk negative repercussions when they publicly fight for access to abortion. A residency director said they worked as an advocate for women in their state but the negative social media attention and publicity that they suffered as a result took a physical and emotional toll. Another director told us they were a vocal advocate for women’s reproductive rights in the past, but “the fear is overwhelming” now that they have small children.

Even in the best of circumstances, physicians have high-pressure jobs. State restrictions in the wake of Dobbs are causing providers to feel greater legal and personal risk for trying to provide comprehensive health care. OBGYNs are saying that the current legal landscape is an impediment to patient care which is leading to emotional stress, frustration, and discouragement. One residency director expressed disbelief about what is happening in restrictive states, saying that they “would not be able to practice on a daily basis if I believed this is what we are going to be stuck with forever.” These negative effects are not limited to OBGYNs in restrictive states but are taking a toll on the workforce nationwide. One resident training in a protective state felt that “morale is still very low because we’re thinking about the whole country, and we may not have those privileges [of practicing without abortion restrictions] forever.”
Finding 8

OBGYN residency program standards, which include abortion care training, are essential to comprehensive resident education across the country.

“Abortion care is OBGYN care.”

Residency program leaders emphatically support accreditation standards that reflect the essential nature of abortion training for comprehensive resident education. ACGME has long required that OBGYN residency programs provide a minimum amount of abortion training to residents.\(^5\) After Dobbs, the ACGME revised its Program Requirements for Graduate Medical Education in Obstetrics and Gynecology document to reiterate the need to preserve this requirement with the explanation that abortion training is “directly relevant to preserving the life and health of pregnant patients in some instances and equips residents with the skills and knowledge necessary for providing care in other reproductive health care contexts.”\(^6\) The requirements apply to all U.S. OBGYN residency programs regardless of state law. In restrictive states, programs must provide residents with equivalent experience in another jurisdiction where abortion is legal. As has always been the case, residents can opt-out of abortion training on moral or religious grounds.

When asked, all residency program leaders agreed that abortion care training is integrally related to other training necessary for an OBGYN resident. One Midwestern residency director reported that residents who receive training that includes abortion are “more complete” and better able to help patients compared to those who do not. Another Midwestern residency director echoed that point, stating that comprehensive training that included abortion training helped their residents develop “foundational skills.” For example, practicing cervix dilation is necessary for intrauterine device (IUD) insertion and hysteroscopy procedures. That director explained that because Dobbs forced limitations on the program’s abortion training, residents are less proficient in these skills.

OBGYN educators stress that it is impossible to isolate abortion care training from training necessary for general obstetric or gynecologic care without dramatically reducing the level of mastery residents will achieve. One residency director from the South said that abortion training “is not a separate entity” and another simply put it as “abortion care is OBGYN care.” This training is not just to educate a physician who might go on to provide abortion care in their practice but in fact, necessary for all OBGYNs who care for pregnant patients.

The residency program leaders we asked unanimously agreed that the accreditation standards are important to maintain. One residency director from a restrictive Midwestern

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state said the required training in the termination of pregnancy “protects patients and produces excellent OBGYNs.” A residency director from the Northeast, describing the need for residents to have comprehensive procedural training, said those “who didn’t have the opportunity...won’t be able to take care of a patient in an emergency.”

Residency programs in restrictive states have been forced to develop complicated, expensive, and time-consuming accommodations for residents to get the required training. These programs have created partnerships with programs in protective states whereby residents travel to those programs for a limited number of weeks to obtain training. In the aftermath of Dobbs, some institutions were resistant to establishing such arrangements for fear of legal, political, and financial risk. A residency program leader from the South found that the accreditation standards bolstered their ability to secure approval from their institution to establish an off-site rotation for their residents.

While residency directors in restrictive states accept the importance of residents meeting the minimum ACGME requirements, they reported that the standards are only a baseline and represent less training than what they were previously able to provide before Dobbs. Several interview participants reported that achieving the threshold training requirement does not guarantee competence. One residency director from the South called it “absurd” to equate the minimum required training to competency.

Those “who didn’t have the opportunity [to receive comprehensive procedural training]...won’t be able to take care of a patient in an emergency.”

- Residency Director from the Northeast
Finding 9

After Dobbs, OBGYN residency applicants more strongly prefer programs in states that permit abortion care.

“Now [applicants] feel like they can graduate and go certain places if they want to feel safe in their practice and there are certain [other] places they’ve crossed off their list.”

Conversations with residency program leaders, survey data, and recent application data all indicate that Dobbs is having an impact on where OBGYN residency applicants prefer to pursue residency, with restrictive states now seeing fewer and less competitive candidates than protective states.53

Residency program leaders in states where abortion access became more limited after Dobbs reported a decrease in applications. Two residency directors from different programs in a restrictive Southern state reported approximately 20 percent decreases in the number of applications they received. A residency director from a restrictive Midwestern state also reported a decrease in applications, explaining that “since Dobbs, we’ve had to focus on recruitment where before, name alone was enough.”

Another residency director reported that after Dobbs triggered a restrictive abortion law in their state, their program’s decrease in applications was “significant.” In the first year after Dobbs, applications to their program fell by eight percent, and in the following year, applications fell by yet another eight percent.

Most residency program leaders we spoke with in protective states, conversely, reported steady or increased application numbers. One program that had historically received fewer than 300 applications now receives nearly double that number. Another residency director in a protective state reported receiving 1,000 applications in the recruitment season following Dobbs when five years earlier they received only 750. Residency program directors in protective states, however, see the impact of Dobbs on their residents’ career decisions. One director said that their residents now “feel like they can graduate and go certain places if they want to feel safe in their practice and there are certain [other] places they’ve crossed off their list” due to Dobbs.

Residency program leaders in restrictive states also reported more difficulty recruiting residents and filling program spots after Dobbs. Residency program leaders told us that applicants are less interested in programs in states with abortion restrictions because of the minimal access to abortion care training.

Residency program leaders do not have information on how applicants are ranking their programs, but recent data shows that residency programs in protective states are seeing an increase in residency applications across specialties while programs in restrictive states are

receiving fewer applications since Dobbs. One residency director from a state where abortion access has fluctuated since Dobbs said, “in the last two years, we have fallen further down on our rank list than we ever have before. Normally, we would match our top 20 [applicants] and last year we went to 45,” meaning that while residency slots were normally filled in the past by applicants the program had ranked among their top 20 candidates, the program now matches with applicants that had been ranked far lower by the program. This suggests that the program is now being ranked lower by applicants. Conversely, a program in a state that affirmatively protected abortion rights after Dobbs reported that, for the first time, their residency program matched with candidates who the program had ranked in their top 10. They stated that in the past, they have matched with candidates much lower on their list. A residency director from a restrictive state shared that their program which typically matches with graduates from the institution’s medical school matched with none in 2024.

While applicants have begun to show a preference for protective states, admission to OBGYN residency programs remains competitive with many more candidates seeking positions than are available. In 2024, there were 2,143 applicants for 1,539 available positions in OBGYN residencies across the country. The match rate for OBGYN residencies remains high at 99.6 percent and only six positions remained unfilled nationally after the initial 2024 Match process was completed.

Program directors also told us that it is becoming more common for residency programs in restrictive states to receive more local than out-of-state applicants. Even residency program leaders who have not seen their number of applications decrease significantly are noticing there is less geographic diversity among the applicants. The applicants for programs in Southern restrictive states are more likely to be from the South or to have attended college or medical school in the region. This trend has long-term implications as physicians tend to practice where they train. And residency program leaders in more restrictive states noted that even residents with family ties to their states are increasingly doubtful that they want to practice in those states due to increased fear of legal liability and concerns about limited ability to care for patients.

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Finding 10

A patchwork of restrictions is leading to disparate systems of reproductive health care, worsening reproductive and maternal health care shortages, and a fractured OBGYN workforce.

“Dobbs is changing the landscape for the next stages in [residents’] careers”

The vast majority of OBGYNs and residency program directors have extensive experience developed over years before Dobbs. If Dobbs or individual state restrictions were to be overturned, these providers could return to providing comprehensive care without additional training. For the generation of OBGYNs being trained today that may not be the case. Current OBGYN residents are receiving reduced training, and their careers are limited by the restrictions in the states where they train and practice. For example, a resident who trains and begins working in Texas today but moves to a protective state later in their career may not be able to provide the standard of care because they never learned or practiced it. One resident from a restrictive state described concern about the loss of providers’ “collective memory” explaining that “we do worry that long term, people will collectively forget that these procedures even exist and that it is the standard of care. There are lots of people in programs who don’t have people who trained in [protective states] and... won’t get exposure.” The location of residency and practice is dictating who can and cannot reliably develop skills in comprehensive reproductive health care.

Each year hundreds of OBGYNs complete their residency and practice in states with extensive restrictions, shrinking the pool of practicing OBGYNs who have training and experience providing a complete range of reproductive health care. A likely possibility is that new OBGYNs will be separated into two groups based on where they completed their residency and began to practice—one set of OBGYNs that have only experienced providing care in restrictive states and another set of OBGYNs that have experienced providing complete care in protective states. Over time, the disparity in skills will become more entrenched, effectively creating two different pools of OBGYNs with entirely different sets of training, knowledge, and norms for care.

There are early indications of self-segregation where providers with experience are already leaving restrictive states. Residency program leaders are already seeing abortion restrictions drive their colleagues out of restrictive states and impede efforts to recruit faculty to fill those vacancies. One described their concern about the future, saying that “those experts can no longer practice to the extent of their licensure [in restrictive states] so they’re leaving and then the states would be without the expertise [in a few years].”
Many providers in restrictive states are seeing the loss of specialists. One residency director working in a Southern restrictive state typically had complex family planning specialists educating residents. This specialized training is now led by OBGYN generalists due to more of those specialized providers leaving the state because of restrictions. As more classes of residents are affected by state abortion restrictions, an increasing proportion of the practicing workforce will have received substandard training, by less skilled educators. One residency program director ominously predicted that, “I think we’re just going to have a bunch of untrained providers and they’re going to shy away from [complex family planning] care.”

Some programs have had to supplement or replace in-person abortion training experience with online and surgical simulations with models or fruit that hardly serve as an adequate substitute for direct patient care. One resident described their concern about abortion training in a restrictive state saying, “I’m never going to see it, get to counsel, or learn the standard of care. For other niche procedures, we get simulation, but I don’t think I’m going to ever get to [perform one] on a person and not a dragon fruit.” One residency program leader explained that “trainees don’t understand why [some dire cases are] unusual. Trainees will not be able to practice standard-of-care medicine because they’ve never seen it.”

“I’m never going to see it, get to counsel, or learn the standard of care. For other niche procedures, we get simulation, but I don’t think I’m going to ever get to [perform one] on a person and not a dragon fruit.”

- Resident

The drain of talent and experience from restrictive states is creating a growing number of reproductive health care deserts.\(^{58}\) Idaho, for instance, has one of the nation’s strictest laws against abortion, and since 2022, its rapidly dwindling OBGYN workforce places Idaho women at increased health risk and serves as a stark example of how difficult it is for physicians to work under constant threat and fear of criminal charges for providing medically necessary care.\(^{59}\) Since Dobbs, Idaho has lost 22 percent of its practicing OBGYNs, pushing necessary health care further out of reach for the women living in the state.\(^{60}\)

\(^{58}\) See note 40.


\(^{60}\) Idaho’s OB-GYN Exodus Throws Women in Rural Towns into a Care Void, Idaho Capital Sun (June 25, 2024).
Interviewees expressed the viewpoint that they expect similar trends in other restrictive states where doctors are subject to large fines or jail time. One residency program director said residents are increasingly unwilling to stay in states that feel “hostile to their career choice,” and predicted that this will cause reproductive health care deserts to grow. Another residency program director in a restrictive state said that they cannot recruit OBGYNs to their state, making it difficult to manage an increasing volume of patients. A residency program director from a Northeastern protective state said that “Dobbs is changing the landscape for the next stages in [residents’] careers” as residents leave restrictive states for training and do not go back to practice there.

Taken together, these factors project a bleak picture for reproductive health care in restrictive states. New generations of OBGYNs trained in those states will be incapable of providing comprehensive care through no fault of their own, existing OBGYNs with valuable experience will continue to leave those states, and what will be left is a reduced number of OBGYNs with more limited training seeing more patients per provider. And, as has already been observed in restrictive states, the average patient will be in worse health than before Dobbs due to delayed care or the inability to receive necessary care until a strict statutory exception involving a threat to the patient’s life is met.
Next Steps

IV. Congressional Action is Necessary to Restore Access to Comprehensive Reproductive Health Care Nationwide

*Dobbs* and the swift enactment of dangerous state laws eliminating or severely restricting abortion have devastated the ability of OBGYNs and other health care providers to offer comprehensive reproductive health care. As this report finds, *Dobbs* has led to consequences that are severely damaging medical education for OBGYNs who are currently in training. Every year that outrageous abortion restrictions remain in place is another year that hundreds of OBGYNs begin practicing with limited knowledge and training in abortion care. Declining expertise in this segment of the health care workforce can only lead to poorer health outcomes for patients.

The only way to effectively halt the detrimental impacts of *Dobbs* is by establishing a federal statutory right to abortion. Health care providers must be free to provide abortion care in accordance with their medical judgment and patients must have full access to timely abortion care when they need it. Such a statutory right would also restore the ability for OBGYN residents to receive comprehensive training in any program across the country that enables them to provide high quality care.

H.R. 12, the Women’s Health Protection Act (WHPA), sponsored by over 200 House Democrats, restores the right to abortion nationwide, ensuring that people can access the care they need from health care providers regardless of where they live.61

Without this federal statutory right, reproductive autonomy is not secure. When abortion access is cut off in half the country and under constant threat, providers are prohibited from learning and practicing comprehensive reproductive health care and millions of patients are deprived of access to lifesaving care. This is dangerous and untenable. Congressional action is required to remedy this grave health care injustice. For these reasons, it is imperative that Congress pass the Women’s Health Protection Act, and finally restore a federal right to abortion without further delay.

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61 See note 7.