Implications of the *Dobbs* Decision for Medical Education

Inadequate Training and Moral Distress

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**Obstetrics and gynecology** training programs are responsible for ensuring that all graduates meet the Accreditation Council for Graduate Medical Education (ACGME) requirement to include integrated abortion training as a routine experience, with individual residents able to opt out. As more states ban or restrict abortion following the decision of *Dobbs v. Jackson Women’s Health Organization*, many students and residents will be at risk of insufficient training to safely provide critical reproductive health care, especially those planning careers in reproductive health. One study projects that as many as 2600 obstetrics and gynecology (ob-gyn) residents are currently training in states that have already banned or will ban abortion. Moreover, trainees may experience moral distress by being forced to provide unethical care that will harm patients, and this moral distress may affect their identity as physicians and career longevity.

In addition to the ACGME, other organizations that set educational standards, professional societies, and government health agencies have made the duty to provide abortion training and education very clear. The Association of Professors of Gynecology and Obstetrics recommends all medical students graduate with a “deep and thorough understanding of abortion,” provide compassionate, nondirective, pregnancy options counseling, and have the knowledge to explain abortion methods and rare complications to patients. Students are also expected to understand the public health importance of legal abortion and how policy, advocacy, and societal factors affect access.

According to the American College of Obstetricians and Gynecologists, all ob-gyn physicians must have the skills to perform an abortion and are obligated to provide an abortion if they are the only physician available for a pregnant person who needs lifesaving care. The US Department of Health and Human Services has reaffirmed the Emergency Medical Treatment & Labor Act (EMTALA), legally mandating that clinicians provide life-or health-saving abortion services in emergency situations, overriding any restrictive state laws.

Studies have documented benefits of routine, integrated abortion training on ob-gyn residents’ clinical skills and future practice. Residents in programs with routine abortion training, compared with those with optional or no abortion training, are more likely to be competent in all aspects of pregnancy loss care, including counseling, facilitating patient-centered care including both medical and surgical management options, and managing complications, according to a 2021 study of 883 final-year residents. In a 2020 study of 5582 residents, 29% reported their abortion training as optional and 8% reported no access to training. In a 2010 survey of 362 final-year residents, those with abortion training were more likely to report being competent in procedural techniques to terminate a pregnancy in the first and second trimesters. Studies from 2007 and 2011 that involved 2149 and 308 practicing ob-gyn physicians, respectively, indicated that graduates from residency programs with abortion training were more likely to provide abortion care and comprehensive pregnancy loss care.

As of September 30, 2022, at least 13 states have banned abortion. In these states, practicing physicians and residents are grappling with the inability to provide ethical care or provide necessary training. Some hospitals are not permitting clinicians to counsel or provide information about abortion, or to refer patients for abortion care, as this could be considered “aiding and abetting.” Clinicians are concerned about patients needing to travel to another state (many times long distances) for abortion care, or likely for many patients, being forced to continue the pregnancy. Health risks for patients are increased because many physicians in these states are not able to provide timely standard care for some ectopic pregnancies or pregnancy loss, based on their hospital leaders’ interpretations of the laws applied to specific circumstances. When caring for patients with premature rupture of membranes in previable pregnancies, health care teams are being told by hospital leadership they cannot offer an abortion until the patient experiences significant morbidity from hemorrhage or sepsis related to the pregnancy.

The inability for residents to obtain training in abortion services will create a gap in the number of ob-gyn physicians who are competent to provide routine, evidence-based abortion and pregnancy loss care. Inadequate training could also make it difficult, if not impossible, for trainees to uphold their professional duties to patients in times of need. Moral distress is the emotional state that occurs when an individual believes they know the ethically appropriate course of action but cannot carry it out, often due to external circumstances. Abortion bans challenge these core tenets of physician...
professionals and medical ethics: patient autonomy; primacy of patient welfare; social justice; patient-centered, evidence-based care; beneficence; nonmaleficence; and equity. Violations of these core medical profession principles heighten the risk of moral distress.

Health professions learners are particularly vulnerable to the effects of moral distress. Scenarios that cause moral distress include witnessing or participating in substandard care. As observed during the COVID-19 pandemic, substandard care that results in structural inequities for people of stigmatized or marginalized identities can contribute to higher levels of moral distress. Many studies have described the harmful effects of restricting and banning abortion, including increased pregnancy-related mortality, especially for those who are already subject to multiple intersecting injustices and violations of their reproductive autonomy, such as those with low income, immigrants, and those who identify as Black, Indigenous, or Latinx. Thus, medical students and residents who care for people that will experience these structural inequities as a result of the Dobbs decision during their training will be at significant risk of experiencing moral distress.

The effects of moral distress can be cumulative and lasting, potentially leading to clinicians feeling powerless and to moral injury by being unable to provide care that meets ethical standards. A study including 17 residents of diverse specialties described a “distinctive form of moral distress called structural distress,” when residents reportedly felt powerless as they witnessed adverse effects of policies that compromised care for structurally marginalized communities. These policies included restrictive visitor policies and limited access to linguistically appropriate services. In addition, residents’ perceptions of moral distress increased when supervising faculty invalidated their concerns and declined when faculty supported residents’ capacity and desire to make change. Furthermore, physicians supervising residents in states that have banned abortion are struggling with their own moral distress while needing to support trainees who are witnessing or unwillingly participating in this government-mandated unethical care.

Medical schools and residency training programs need to swiftly engage in structural interventions that facilitate strategies to mitigate moral distress and help learners navigate the ethical challenges they will inevitably encounter during their medical careers. A systematic review outlined interventions that have been successful in mitigating moral distress, including facilitated discussions, specialist consultation services, multidisciplinary rounds, self-reflection, and narrative writing. Educators should be trained in recognizing and responding to moral distress to best support learners through these challenging times.

While preparing to train resident physicians and medical students to meet the needs of future patients in this new landscape of reproductive injustices, educators and institutions need to adopt a variety of strategies. Medical schools must commit to ensuring teaching about abortion longitudinally throughout the educational curriculum, through clinical experiences or accessing virtual courses and simulation. Educators across the undergraduate and graduate medical education continuum should advocate for resources dedicated to curating and creating high-quality educational experiences and materials for learners affected by the deprivation of clinical care experiences in abortion and pregnancy loss. Clerkship directors and residency program directors need to be supported by national organizations that set standards for student and resident education with resources for providing this core competency; this task is too onerous for individual educators.

Training hospitals in states with restrictive laws should provide legally permissible abortion care, ensuring care for people with medical, obstetric, and psychiatric illness, fetal abnormalities, and other circumstances that qualify for abortion within their state. As facilities that provide abortion services are forced to close, hospitals will become increasingly critical for safeguarding patient care and maximizing resident training. Training institutions should also provide evidence-based and patient-centered pregnancy loss care, including offering outpatient uterine aspiration or mifepristone and misoprostol for people who desire medical management. Educators and institutional leaders must advocate for high-quality care, including timely care for people with ectopic pregnancies.

Skills in advocacy and leadership are also critical to advance reproductive equity and justice. Future physicians need to be able to navigate the complex sociopolitical landscape in promoting reproductive autonomy. Most medical schools offer a physician advocacy course, and both medical schools and residency programs should bolster their advocacy curricula to directly address the public health effects of abortion restrictions and ethical obligations around abortion care.

This new reproductive health landscape places educators and learners in a precarious position. There are unique challenges not only to continuing to provide high-quality educational experiences and equitable and just clinical care, but also to ensuring the long-term well-being of faculty, residents, and students, all occurring while being faced with ethical conflicts that inappropriately limit the duty of physicians to provide evidence-based care. Educators and clinicians will need to collectively engage in advocacy to achieve equitable abortion care provision, sufficient abortion education, and peer support to reduce moral distress in themselves and trainees.

**ARTICLE INFORMATION**

Conflict of Interest Disclosures: None reported.

**REFERENCES**


