

When the US Supreme Court issued its decision in Dobbs v Jackson Women’s Health Organization this June, overturning Roe v Wade and revoking the constitutional right to abortion, it drastically changed how obstetrician-gynecologists (ob-gyns) across the country would practice—as well as how future ob-gyns would be trained.

An estimated 45% of accredited US obstetrics and gynecology residency programs are located in the more than half of states that ban or severely restrict abortions, according to the latest state laws and an analysis published recently in Obstetrics & Gynecology. As a result, current and future medical students and residents attending those programs will lack in-state abortion education and training.

In interviews with JAMA, many educators said they fear that incomplete education and training will reduce residents’ ability to skillfully manage miscarriages and second-trimester pregnancy losses because, as with induced abortion, these scenarios require expertise in emptying the uterus. They also expressed concerns that medical students who want the full spectrum of training will apply in greater numbers to residency programs in nonrestricted states. This, they say, could lead to fewer ob-gyn trainees—and in-turn, fewer ob-gyns—in states with abortion restrictions and bans.

Less Hands-on Training

By the time they graduate, ob-gyn residents are “expected to have the skills they need to empty the uterus—for any reason, but especially for an emergency,” said Jody Steinauer, MD, PhD, a professor of obstetrics and gynecology and director of the Bixby Center for Global Reproductive Health at the University of California, San Francisco. “But the question is, how are they really going to get trained to competence? Because we know from many studies that residents who are trained in a program with routine abortion training end up being more skilled in miscarriage management.”

Currently, the Accreditation Council for Graduate Medical Education (ACGME) requires that all obstetrics and gynecology training programs provide access to clinical experience with abortion and comprehensive family planning, which includes education in contraception and counseling on abortion care. Although residents can opt out of abortion care training, the ACGME says that programs legally restricted from offering it must provide support for residents to obtain the training in another state.

In June, following the Dobbs decision, the ACGME proposed revised requirements clarifying that access to abortion education and clinical training is essential for physicians specializing in obstetrics and gynecology, and that simulation exercises are not a substitute for hands-on experience with patients. According to an emailed statement from the organization, the revisions, which were approved this September, are meant “to help ensure obstetrics and gynecology residency programs provide residents with the knowledge, skills, and abilities necessary to practice comprehensive reproductive health care in the United States without resulting in any resident, physician educator, or residency program violating the law.”

Medical students in restricted states, however, will likely be limited in their exposure to and understanding of abortion care, said Amanda P. Williams, MD, MPH, an ob-gyn in Oakland, California, and clinical innovation advisor for the California Maternal Quality Care Collaborative at Stanford University. And for residents who will not receive hands-on training in abortion care, “it is actually a loss of a critical skill to be an excellent obstetrician-gynecologist,” she said. “We know that volume and experience drives excellence.”

Williams noted that residents in obstetrics and gynecology are required to gain clinical training in dilation and curettage (D&C), a procedure that can be performed during the first trimester to extract tissue from the uterus in the case of miscarriage, pregnancy complications, or abortion. Residents in programs without abortion care training will have less access to this procedure, making it “harder for resident physicians to meet their numbers for graduation so that they can be board eligible in obstetrics and gynecology,” Williams said.
It’s also recommended but not required that residents receive clinical training in dilation and evacuation (D&E), a procedure typically performed in the second trimester to empty the uterus. In restricted states, it’s highly unlikely that residents will receive this clinical training; they may be taught through a simulation instead. According to Steinauer, however, this would not adequately prepare them to perform the procedure.

The Training Debate
Not all ob-gyns are worried about the Dobbs decision’s effect on education and training. Residents can learn the skills needed to empty the uterus by managing miscarriages, they say.

In an interview, Christina Francis, MD, an ob-gyn in Fort Wayne, Indiana, and a board member and chief executive officer-elect of the American Association of Pro-Life Obstetricians and Gynecologists, said she wasn’t exposed to induced abortions during her residency in obstetrics and gynecology at a Catholic hospital. But because early pregnancy losses are common, she said she was “well trained in how to manage even the most complicated of miscarriages.” What’s more, she noted, “I would’ve had all the technical training that I would’ve needed to have gone and done abortions, even though I did not train doing abortions. And the reason for that is because ob-gyns are trained in how to empty a uterus.”

Aileen Gariepy, MD, MSPH, the director of complex family planning in the Department of Obstetrics and Gynecology at Weill Cornell Medicine in New York City, questioned the notion that ob-gyn residents in restricted programs would be optimally trained to empty the uterus in all circumstances: “It wouldn’t be enough volume, in my opinion, to then go to a protected state and be able to integrate that into your practice,” she said.

Francis said that residents in states where abortion is banned or restricted “will still learn all of the basic procedures that all ob-gyn residents learn,” including those for miscarriages or ectopic pregnancies. “And,” she added, “they’ll learn how to intervene in situations where a woman’s life is in jeopardy, whether that be pre-viability—before a baby can survive outside the womb—or certainly if it’s after the point of viability. There’s no question. You just deliver the woman, and you take care of the woman and you take care of her child.”

But Gariepy pointed out that in certain situations during the second trimester—when a pregnant patient’s life is in danger, for instance, or when fetal demise occurs—it’s often safer and preferable to perform a D&E than to induce labor. Facilitating a vaginal delivery can take days and can lead to complications such as hemorrhaging or cesarean delivery. While some patients will choose to deliver a stillborn baby, others may not want to endure the risk of complications or the physical and emotional exertion of labor and delivery when they could instead opt for a D&E, a much faster procedure with a far shorter recovery time.

However, induced delivery may be the only option for patients in restricted states where physicians are not trained to perform D&Es, Gariepy said—and, by extension, that’s what residents in those states will learn about managing second-trimester pregnancy loss.

There’s also more to abortion care training than learning about the medical procedures, said Shannon M. Clark, MD, an ob-gyn in Texas. “It also involves learning how to counsel patients regarding induced abortion, understanding the societal and cultural implications, learning how to provide trauma-informed care, and the ability to understand the social determinants of health that play a role in a patient’s decision to have an induced abortion.” Those teachings will be lost in states where abortion is banned, she said. “Any restrictions to our ability to fully counsel patients on their options when it comes to pregnancy is going to be detrimental to the training of our residents,” she added.

In Texas, Senate Bill 8, enacted in September 2021, banned abortion after embryonic cardiac activity is detected, which typically occurs after about 6 weeks of pregnancy, when many people don’t yet know they’re pregnant. Clark said the law makes it difficult for physicians to provide evidence-based care and act in the best interest of the patient, which will affect how residents are taught to intervene.

For example, if a pregnant patient in their second trimester presents with cervical insufficiency or preterm rupture of membranes, “as long as there’s a fetal heartbeat, we cannot do anything,” Clark said. “We cannot intervene until there is a loss of fetal heart tones or there are signs of infection or hemorrhaging—until the patient’s clinical condition deteriorates, which contributes to maternal morbidity.”

Francis, however, countered that physicians are legally allowed to intervene when a pregnant patient is facing a potentially life-threatening complication. “There’s not a single state law that prevents that,” she said. “In fact, it is our duty as a physician. It would be medical malpractice not to intervene in that situation.”

But many physicians are now questioning what exactly constitutes a life-threatening complication. Williams said she’s concerned that these judgment calls are being made too late in states that allow abortions only when the pregnant person’s life is at risk.

As it stands now, many physicians remain confused about what they can and can’t do, Clark said. Because of this confusion, she worries that practitioners—fearing licensure loss, criminal or civil charges, or disciplinary action by their employers—will hesitate to act in emergency situations before their hospitals’ legal and ethics departments sign off. In fact, she’s seen this occur, to the detriment of patients. “These situations do happen,” she said.

With potential personal consequences looming, “You can’t tell me that’s not going to guide how some providers approach their patients,” she added. Training will also be affected as legal interference between patients and their physicians increases. “We’re tasked with teaching our residents. If we’re practicing defensive medicine, do you think that’s not going to trickle down to them?”

Complicated Logistics
For residents who now need to go out of state for training, the logistics are complicated at best. They’ll need funds to travel and stay in another state while they complete a weeks-long training rotation. And some residents will be forced to live apart from family, which can be particularly challenging for those with young children. Before that can happen, though, programs offering abortion training must plan to accommodate the influx of additional residents.

“Most residencies only have the capacity for their residents,” Gariepy said.

The ACGME decides how many residents each program can adequately train based on factors such as patient volume and faculty numbers, she noted. Weill Cornell, for instance, is expanding “to develop a comprehensive program that would allow us to take out-of-state residents,” she said. “But that’s not something that we’re able to accommodate immediately.”
Steinauer directs the Ryan Residency Training Program, which works to integrate abortion and contraception training into obstetrics and gynecology residency programs. Currently, the Ryan Program is helping to form partnerships between academic institutions to facilitate out-of-state resident travel and training.

Through the initiative, residents from about 10 Texas programs have traveled to partner universities in other states for training since Senate Bill 8 was enacted, according to Steinauer. But forming partnerships across residency programs is far from a simple solution: right now “it takes 6 to 9 months to set everything up,” she said.

Some medical students contemplating obstetrics and gynecology residencies are worried that the Supreme Court ruling will limit their training. They’re also concerned that they’ll have fewer choices of residency programs if they want to receive training that covers the full range of reproductive care, including induced abortion.

Kendra Lujan is a second-year medical student at Boston University School of Medicine and a co-leader of the university’s chapter of Medical Students for Choice (MSFC). She said that since the Supreme Court’s decision, she’s heard predictions about residency programs if they want to receive training that covers the full range of reproductive care, including induced abortion.

For all these reasons, Steinauer said, there eventually may be too few trainees in states with abortion bans: “Right now, we have more applicants than spots. But if we have fewer people applying to programs in banned states, we might not be able to attract enough residents.” And because more than half of residency graduates stay and practice in the state where they trained, this could lead to a shortage of ob-gyns in those states, she said.

Hannah Nguyen, also a second-year medical student at Boston University School of Medicine and a co-leader of the school’s MSFC chapter, has wanted to work in abortion care since she was a child growing up in Arizona with a family that was “more anti-choice,” she said. Her time working as a medical assistant and doula at an abortion clinic in New Mexico strengthened her desire to provide comprehensive abortion care to patients. Up until the Dobbs decision, she had hoped to train and work in Ohio to be closer to her partner’s family. But “that’s been thrown up in the air,” she said, by Ohio’s abortion ban. Now she’s trying to envision her life if she chooses a different medical specialty, leaving behind obstetrics and gynecology.

“Right now I really still hope to do it,” she said. “But I also have to factor in loans and future earnings into this. It’s a mess.”

Conflict of Interest Disclosures: Dr Clark reported membership with Doctorsforfertility.org. Dr Francis reported that she is a board member at Indiana Right to Life and an associate scholar at the Charlotte Lozier Institute. Dr Gariepy reported that she was the Yale Complex Family Planning fellowship director from 2018 to March 2022, for which she received salary support from her institution; taught undergraduate and medical students, ob-gyn residents, and Complex Family Planning fellows; and is a research mentor for Complex Family Planning fellows who received research grants from the Society of Family Planning Research Fund. Dr Gariepy also reported leadership positions on the board of directors for the Society of Family Planning and the Complex Family Planning Fellowship Council and membership with Physicians for Reproductive Health, the National Abortion Federation, and the Society of Family Planning. Dr Steinauer is a member of the Society of Family Planning. No other disclosures were reported.

Note: Source references are available through embedded hyperlinks in the article text online.