The Impact of *Dobbs* on US Graduate Medical Education

Amirala S. Pasha,[1] *Daniel Breitkopf,*[1] *and Gretchen Glaser*[1]

1: MAYO CLINIC, ROCHESTER, MN, USA.

Keywords: Abortion, Gynecology and Obstetrics Education, Graduate Medical Education, Physician Workforce, Women's Health

Abstract: The *Dobbs* decision will directly affect patients and reproductive rights; it will also impact patients indirectly in many ways, one of which will be changes in the physician workforce through its impact on graduate medical education. Current residency accreditation standards require training in all forms of contraception in addition to training in the provision of abortion. State bans on abortions may diminish access to training as approximately half of obstetrics and gynecology residency programs are in states with significant abortion restrictions. The *Dobbs* decision creates numerous hurdles for trainees and their programs. Trainees in restrictive states will have to travel to learn in a different program in a protective state. As training opportunities diminish, potentially leading to a decline in clinical skills, knowledge, and experience in the provision of abortion, the rate of complications and maternal mortality are likely to rise. This will likely have a disproportionately negative effect on preexisting disparities in reproductive health fueled by a longstanding history of systemic racism and inequities. This work aims to both define the looming problem in abortion training created by Dobbs and propose solutions to ensure that an adequate workforce is available in the future to serve patient needs.

Introduction

The *Dobbs* decision will directly affect patients and their reproductive rights, but it will also affect patients indirectly in many ways, one of which will be changes in the physician workforce through its impact on graduate medical education (GME). Multiple states have already banned or restricted abortions and others are in the process of doing so. Abortions are predicted to be banned or restricted in around half of states.[1] Furthermore, a subset of these states, intentionally or unintentionally, may attempt to institute limitations and potential bans on contraceptive care as well as

Amirala S. Pasha, D.O., J.D., *is an Assistant Professor, General Internal Medicine, Mayo Clinic, Rochester, MN;* **Daniel Breitkopf, M.D.**, *is an Associate Professor, Chair, Obstetrics & Gynecology, Mayo Clinic, Rochester, MN;* **Gretchen Glaser, M.D.**, *is an Associate Professor, Program Director of Obstetrics & Gynecology Residency Program, Mayo Clinic, Rochester, MN.*

The Journal of Law, Medicine & Ethics, 51 (2023): 497-503. © 2023 The Author(s)
DOI: 10.1017/jme.2023.89

other reproductive health services, including assisted reproductive technology (ART) such as in vitro fertilization (IVF).[2] For instance, Oklahoma already passed a law banning abortions and defining life to begin at "fertilization."[3]

Such policies will directly affect clinical training programs, particularly graduate medical education programs in Obstetrics and Gynecology (Ob/Gyn) and Family Medicine. For instance, current accreditation standards set forth by the Accreditation Council for Graduate Medical Education (ACGME) require training in all forms of contraception in addition to training, or at minimum access to training, in the provision of abortion as part of the planned curriculum with the possibility of religious exemptions for trainees.[4]

The *Dobbs* decision will affect training programs' ability to meet ACGME standards and may necessitate revision of these requirements. Researchers estimate that 44% of the 286 accredited Ob/Gyn residency programs are in states that have already banned or will soon ban or severely restrict abortions.[5] While programs in restrictive states may seek opportunities for abortion training in protective states, training capacity will likely be overwhelmed by demand. Furthermore, such restrictions will likely directly affect trainees' choice in seeking further specialization and subspecialization in fields that are potentially banned or restrictive in approximately half of the states.[6] Therefore, state-wide bans can profoundly impact the future of the physician workforce in certain specialties and subspecialties in decades to come as well as access to family planning services nationally. Consequently, it is anticipated that preexisting systemic racism and inequities in reproductive health, including maternal mortality, will worsen.

This article will (1) assess and analyze the effects of *Dobbs* on clinical training in abortion and other reproductive health services, (2) suggest practical solutions to alter relevant training standards, (3) recommend ways to protect trainees and training programs from government enforcement actions while meeting training standards for trainees, and (4) propose steps to minimize the national effect of the state bans.

This article will (1) assess and analyze the effects of Dobbs on clinical training in abortion and other reproductive health services, (2) suggest practical solutions to alter relevant training standards, (3) recommend ways to protect trainees and training programs from government enforcement actions while meeting training standards for trainees, and (4) propose steps to minimize the national effect of the state bans.

Discussion

To better understand the impact *Dobbs* will have on clinical training, it is important to first look at effects on clinical care, contextualized by pre-*Roe* training, and then examine the post-*Dobbs* training landscape.

Effects on Clinical Care

Without constitutional protection, the landscape for restrictions placed on abortion and related services varies widely across states. Several states have completely banned abortions. Others have enacted bans that allow the procedure until six, eight, ten, twelve, or fifteen weeks of gestation.[7] In some states, exceptions are permitted for the life of the pregnant person or for pregnancies resulting from rape or incest.[8] Other limitations placed on abortion care include requiring performance by a physician rather than advanced practice clinicians, limiting Medicaid coverage, requiring parental notification, waiting periods after counseling, and telehealth bans.[9]

The impact of state laws limiting abortion on IVF is also uncertain. As Daar notes in her article for this symposium, IVF often involves the freezing of embryos and discarding nonviable ones, but discarding unused embryos might be considered abortion, depending on the language used in a statute.

Ectopic pregnancy presents additional problems, specifically whether abortion laws, particularly ones that ban abortion upon detection of fetal heartbeat, could interfere with providing the clinical standard of care.[10] In cases of ectopic pregnancy where a heartbeat is detected, ending the pregnancy may constitute an abortion under state law, depending on the law's language. Medications used to treat ectopic pregnancy, such as methotrexate, are also used for medical abortions. Ectopic pregnancy is considered a potentially life-threatening condition; therefore, some jurisdictions have considered the treatment of ectopic preg-

The Journal of Law, Medicine & Ethics, 51 (2023): 497-503. © 2023 The Author(s)

https://doi.org/10.1017/jme.2023.89 Published online by Cambridge University Press

nancy outside of the scope of abortion bans, explicitly as part of the statute or as part of excluding lifesaving treatments from abortion bans.[11]

Within the subspecialty of Maternal-Fetal Medicine (MFM), abortion bans are likely to impact routine practice. MFM subspecialists often must weigh the impact of the risks of pregnancy to the mother versus the benefits of continuing the pregnancy for the fetus. In higher-order multiple gestations, fetal reduction procedures, which benefit the remaining fetus but ultimately lead to abortion of the reduced fetus, are standard practice.[12] Procedures such as multifetal reduction would likely be prohibited in many states with restrictive abortion laws.[13] Furthermore, fetal intervention procedures offer the possibility of correcting or limiting the impact of congenital anomalies *in utero*. Examples of such procedures include fetal tracheal occlusion for diaphragmatic hernia, shunting of the fetal thorax or bladder, laser therapy for twin-to-twin transfusion, and closure of open neural tube defects. These procedures offer the promise of significant benefits for the fetus, however, significant risk of fetal loss due to complications exists. Physicians performing these procedures could be endangering their license or even prosecuted if a complication leading to termination of pregnancy occurs.

Effects of Dobbs on Clinical Training

As the *Dobbs* decision is implemented, decisions from federal and state courts will affect clinical practice and education. Multiple medical specialties are already affected, with the potential for even greater impact as states pass additional laws to restrict or ban abortion — or protect access. The extent of this effect is not yet fully known and is beginning to be investigated. For example, researchers through the Ryan Program (a national initiative to integrate and enhance family planning training for Ob/Gyn residents)[14] and the Society of Gynecologic Surgeons (SGS)[15] recently launched a survey for Ob/Gyn residency program directors, program coordinators, and educators to query experiences in abnormal early pregnancy and abortion care training. Legal experts are also compiling the consequences to help those navigating the clinical, educational, and research-related tasks before them.[16]

ACGME sets the Common Requirements and Program Requirements for all ACGME-accredited medical specialties and recently updated the Ob/Gyn Program Requirements relating to Family Planning and abortion training. This included two statements specifically written for Ob/Gyn programs in "a jurisdiction where resident access to this clinical experience is unlawful" and states "the program must provide access to this clinical experience in a different jurisdiction where it is lawful."[17] Furthermore, ACGME states "For programs that must provide residents with this clinical experience in a different jurisdiction due to induced abortion being unlawful in the jurisdiction of the program, support must be provided for this experience by the program, in partnership with the Sponsoring Institution."[18]

In addition, the American Board of Obstetrics and Gynecology (ABOG) requires residency graduates to fulfill certain requirements in order to take specialty qualifying and certifying examinations. In response to the *Dobbs* decision, ABOG outlined more defined metrics for abortion training, noting that "residents seeking ABOG certification will be required to have satisfactorily completed a minimum of two months, two four-week blocks, or the equivalent of these experiences in family planning (also called comprehensive reproductive health care). This includes abortion-related health care. This represents approximately 4% of the time in residency and correlates with the proportion of these areas in the testing blueprints for Ob/Gyn certification."[19] Before the Dobbs decision, ABOG certification standards required that "physicians have the knowledge and ability to perform and care for patients who have had an abortion, regardless of if a physician chooses to perform one or practices in a state with restrictions," but did not outline training requirements more specifically.[20]

The subspecialty of complex family planning is relatively new, with board certification starting in 2022. The subspecialty involves abortion practice, provision of advanced contraceptive services to patients with complex medical issues, and treatment of complications of contraceptive devices.[21] Many of these subspecialists provide care within residency training programs. In states with restrictive laws, it is unlikely that complex family planning subspecialists will be retained, leading to gaps in residency training.[22] These subspecialists offer additional instruction to residents beyond abortion, namely management of contraception and technical skills in uterine evacuation. With the potential loss of skills in advanced techniques such as dilation and evacuation, residents may be poorly prepared to manage pregnancy complications in the late second trimester.

Residency program directors, program coordinators, and trainees are concerned about the downstream impact on multiple facets of training in restrictive states and in protective states. For example, the physical and emotional hardship for a trainee associated with traveling to and temporarily living in another geographic location will have a negative impact.

The Journal of Law, Medicine & Ethics, 51 (2023): 497-503. © 2023 The Author(s)

Moreover, available capacity in states where abortion is being performed must be considered when finding a partnering institution.[23] Ob/Gyn programs are also likely to experience hardship associated with needing to send trainees offsite for an extended period to gain abortion experience, with the attendant financial and clinical coverage challenges. Furthermore, many programs currently integrate termination of pregnancy training into standard clinical rotations, focusing on the breadth and depth of the specialty beyond abortion. If a resident is required to travel to another state for dedicated abortion training, they may lose out on opportunities to learn other clinical and surgical skills they would have obtained while rotating in their home program.

In the past, 92% of Ob/Gyn residents had access to some level of abortion training in their home programs, even in states where abortion was more restricted.[24] Pre-*Dobbs*, individual hospital policies were the most significant barrier to abortion training in programs that did not offer it.[25] Post-*Dobbs*, it is projected that 2,638 of the 6,007 current Ob/Gyn residents (43.9%) are likely or certain to lose access to abortion training in their states.[26] Even though Ob/Gyn as a specialty will be the most heavily affected by this change, other specialties also provide abortion care. They will also need to reallocate resident resources to out-of-state locales to continue offering pregnancy termination training. For example, Family Medicine offers residents first-trimester abortion training. While the Family Medicine Program Requirements do not specifically include minimums for abortion procedures, they do include a requirement for learning "family planning, contraception, and options counseling for unintended pregnancy."[27]

Ob/Gyn residency training prepares most graduates for first trimester abortion, which comprises approximately 93% of abortions performed in the United States.[28] The small proportion of abortions that occur later in pregnancy requires additional training and experience. Ob/Gyn residents interested in second trimester abortion practice often pursue additional subspecialty training through Complex Family Planning and MFM fellowships. With restrictive state laws, these fellowships may struggle to recruit trainees and be required to send fellows to other states to pursue the most basic parts of that training.

Effects of *Dobbs* on the Ob/Gyn Workforce

Although the long-term effects of reduced training opportunities on the overall future of abortion care is unclear, history may serve as useful in predicting that future. In 1970, just before the *Roe* decision, New York State implemented a law permitting abortion up to twenty-four weeks. The law went into effect eighty days after it was signed by the governor, leaving little time for physician education and preparation. Most Ob/Gyn physicians were not skilled in abortion techniques. Overall, residents did not want to participate in abortions as they felt it would "ruin the residency." Hospitals became overrun with complications of abortions performed by unskilled clinicians. A gap between the training of clinicians and the needs of the community made care harder to access for all.[29] After *Dobbs*, low volumes of abortion procedures may lead to the same issues in training and clinical experience that existed prior to *Roe*.

There are unanswered questions, like whether overall applications to Ob/Gyn residency will decrease and if those decreases will be more noticeable in restrictive states. Preliminary data indicates that Ob/Gyn residency applications for the 2022–2023 cycle decreased by approximately five percent for MD applicants.[30] While the Ob/Gyn match remains highly competitive, with far more applications than positions available, it is possible that programs in restrictive states will have trouble filling their slots. The consequences will continue to ripple through training programs nationwide in ways we cannot yet even anticipate.[31]

Restrictive abortion laws are most prevalent in states where current or projected shortages in Ob/Gyn workforce already exist.[32] The current supply of Ob/Gyns is maldistributed regionally, with an overall modest shortage of clinicians.[33] By 2030, government projections indicate a likely nationwide shortage given the current training output. The deficit is likely to be regional, with the Northeast having an adequate supply, while the West, Midwest, and South will likely have deficits.[34]

Most Ob/Gyns in practice support patients who desire abortions,[35] and Ob/Gyns may begin to make decisions regarding practice location or relocation based in part on state restrictions.[36] Therefore, this could worsen regional or local workforce shortages. Similar concerns exist regarding the advanced practice clinicians workforce, including nurse midwives and nurse practitioners. Policymakers at all levels of government should consider these overall effects of abortion restrictions when deciding future steps.

Finally, systemic racism and inequities have long fueled disparities in reproductive health, including maternal mortality, even before *Dobbs*. For instance, estimates show Black and Indigenous people have two to four times the rate of maternal mortality compared to white people, while others have noted that a Black person in Mississippi is 118 times more likely to die

The Journal of Law, Medicine & Ethics, 51 (2023): 497-503. © 2023 The Author(s)

from carrying a pregnancy to term than from having a legal abortion.[37] Undoubtedly, *Dobbs* will significantly affect vulnerable populations and worsen disparities. Therefore, if training institutions truly aim to address societal injustices and meet the needs of vulnerable and underserved populations, it is more important than ever for these institutions to take a more active role in provision of abortion care and other reproductive healthcare services as well as providing training opportunities in those areas. Even in restrictive states, no limits can be imposed on advocating for their trainees and patients to ensure they receive the training and care that they need. Their advocacy is indispensable in this new reality.[38]

Changes to Training Standards

When the *Dobbs* decision was issued, the ACGME circulated proposed Program Requirements changes which allowed for simulation of uterine evacuation if a resident is unable to travel for a structured clinical experience. Simulation has been used for many years to augment clinical training in pregnancy termination. Several good models exist, including a papaya-based simulation and didactic scenarios for abortion-related complications.[39] ACGME removed the option for simulation as primary training. However, this form of education will be invaluable, especially as the numbers of pregnancy termination procedures will undoubtedly decrease, especially for residents who must travel to different states for exposure to these procedures.

In addition, residency programs must thoughtfully plan their didactic curricula to include pregnancy termination procedures in a structured way. This is important for a full breadth of learning and to fulfill ABOG requirements. Didactic sessions devoted to uterine evacuation procedures for pregnancy and other indications should focus on discussing the nuances of management as it relates to abortion care while also simulating possible complications associated with uterine manipulation. As these complications have always been rare, simulations have provided a robust learning opportunity for many years. Although simulation and didactics need to become an integral part of training, they are unlikely to be able to fully replace real-life clinical experience. Abortions performed in an operating room setting under anesthesia are critical to learn, as is the office-based procedure of manual vacuum aspiration, which may allow graduates to provide access in a range of locations and practice situations in the future.

For creating clinical access to abortion procedures for residents in restrictive states, a network of abortion care facilities that could accommodate trainees would greatly assist programs in locating training experiences. This could be coordinated through ABOG, American College of Obstetricians and Gynecologists (ACOG), American Board of Family Medicine (ABFM), American Academy of Family Physicians (AAFP), ACGME, and the Society for Family Planning (SFP), or a consortium of these organizations. In addition, if Family Medicine amended their requirements to include an opt-in for abortion training, more clinicians could be trained to provide abortion services. As the challenges of placing residents outside of their programs for abortion training become evident in the next few years, other creative solutions will be needed.

Training and Licensure Standards

Given the workforce implications of *Dobbs* at the national level, it is in the interest of states where abortion remains legal to facilitate abortion training. During the COVID-19 pandemic public health emergency (PHE), states demonstrated flexibility in licensure requirements for out-of-state clinicians to meet medical need within their borders.[40] At the federal level, this was facilitated by the Centers for Medicare and Medicaid Services (CMS) waiving certain licensure requirements as well as requirements for new and amended Medicare Graduate Medical Education (GME) Affiliation Agreements.[41] As discussed earlier, training will need to take place across state lines, therefore, similar flexibilities and innovative approaches should be explored to facilitate training across state lines.

During the PHE, most states authorized the practice of medicine based on holding a valid medical license from a different jurisdiction without any additional rules. However, abortion is different from the PHE, as the procedure for which the medical license is being used is banned in the issuing state. This risks adverse action taken by the home state against the licensee, especially if the authority to practice medicine is solely based on the home state's license.[42] Consequently, in lieu of waiving licensure requirements by the guest (protective) state and simply recognizing a license from the home (restrictive) state, the guest states could issue a separate training license through an expedited and simplified process. Although the home restrictive state could still sanction a licensee for providing banned services, this proposed approach may decrease the risk of such action. Furthermore, in anticipation of training shifts, CMS should take steps to reduce the administrative burden for trainees and programs for traveling residents especially with regards to a Medicare GME Affiliation Agreements.

The Journal of Law, Medicine & Ethics, 51 (2023): 497-503. © 2023 The Author(s)

President Biden issued an Executive Order to protect access to reproductive health services and protect clinicians.[43] However, its real-world effectiveness has been questioned, and legal challenges have been mounted against the Executive Order. Executive orders are subject to revocation or modification when a new administration takes office, potentially disrupting clinical care and training.

Similarly, some protective states have enacted laws to limit the effects of adverse actions taken by restrictive states on professional licenses related to reproductive health services, called shield laws, as discussed in the Cohen et al. article in this symposium.[44]Some states rely on executive orders to protect clinicians, which are subject to legal challenges and easily revocable and modifiable, like federal executive orders.[45] More importantly, the implementation of these protections is unclear, adding to uncertainty for trainees and training programs.[46] For instance, the overall process as well as administrative and financial burdens for licensees who must rely on these statutes and executive orders to be shielded from out-of-state adverse action remain unclear. This issue is even more relevant to trainees since many lack full medical licenses and will apply for an unrestricted medical license post-training. Any previous adverse medical board action could hinder the chance of securing a full medical license and thus the ability to practice anywhere in the country, further disincentivizing training and practicing in the provision of abortion or other banned health services. The Federation of State Medical Boards plays a central role in sharing physician disciplinary data between states and could assist states in determining whether an out-of-state adverse action falls under the protective states' exemptions to reduce burdens on licensees and state medical boards.[47]

Conclusion

Dobbs has dramatically changed the national landscape for abortion care and has already had a marked effect on clinical training. When states ban or restrict abortion access, training opportunities in abortion and other reproductive health services are reduced. This will have a negative national impact on Ob/Gyn and other specialties. Furthermore, the decision creates numerous hurdles for trainees and their programs. Trainees in restrictive states must travel to learn in a different program in a protective state. This creates a number of hardships for trainees and training programs alike and may decrease the overall quality of education due to the oversaturation of programs in protective states. Meanwhile, Ob/Gyn residency programs in restrictive states must scramble to find additional training slots elsewhere to meet ACGME requirements, which ACGME should reevaluate while considering alternative learning models. Training programs in protective states, as well as relevant state and federal agencies, should facilitate a cross-state training model and protect trainees from restrictive states through simplified licensure processes and legal protections.

If history is any indication, as training opportunities diminish, potentially leading to a decline in clinical skills, knowledge, and experience in the provision of abortion, the rate of complications and maternal mortality are likely to rise. This will likely have a disproportionate negative effect on preexisting disparities in reproductive health fueled by long-standing history of systemic racism and inequities. Unless appropriate steps are taken to ensure that an adequate number of well-trained abortion care clinicians are available, we are headed toward a crisis of our own making. Now is the time to act collectively to prevent this disastrous future.

Note

Amirala S. Pasha reports royalties from Springer Nature as an editor for the book titled *Laws of Medicine: Laws of Medicine: Core Legal Aspects for the Healthcare Professional* and reimbursement from Boston University for travel expenses to present this manuscript as part of the symposium. Daniel Breitkopf is a Board of Directors member, American College of Obstetricians and Gynecologists. Any expressed or implied opinions in this article are those of the authors. They do not purport to reflect the opinions, views, or position of any other entity.

References

1. Guttmacher Institute, Interactive Map: US Abortion Policies and Access After Roe, *available at* <https://states.guttmacher.org/policies/> (last visited October 15, 2022).
2. American Society for Reproductive Medicine (ASRM), State Abortion Trigger Laws, July 1, 2022, *available at* <https://www.asrm.org/globalassets/_asrm/advocacy-and-policy/dobbs/cpl-report_impact-of-state-trigger-laws-on-reproductive-medicine_final.pdf> (last visited Sept. 19, 2023).
3. Okla. Stat. tit. 63, § 1-745.31.
4. Accreditation Council for Graduate Medical Education (ACGME), ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology, September 17, 2022, *available at* <https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_9-17-2022.pdfÿÿP8> (last visited August 4, 2023).
5. K. Vinekar et al., "Projected Implications of Overturning Roe v Wade on Abortion Training in U.S. Obstetrics and Gynecology Residency Programs," *Obstetrics and Gynecology* 140, no. 2 (2022): 146–149.
6. H. J. Gyuras et al., "The Double-Edged Sword of Abortion Regulations: Decreasing Training Opportunities While Increasing Knowledge Requirements," *Medical Education Online* 28, no. 1 (2023): 1-10.
7. See Guttmacher Institute, *supra* note 1.
8. W. Va. Code § 61-2-8 (2022); La. Stat. Ann. § 40:1061 (2022).
9. See Guttmacher Institute, *supra* note 1.
10. American College of Obstetricians and Gynecologists' Committee on Practice Bulletins. "ACOG Practice Bulletin No. 193: Tubal Ectopic Pregnancy," *Obstetrics and Gynecology* 131, no. 3 (2018): e91–e103.

The Journal of Law, Medicine & Ethics, 51 (2023): 497-503. © 2023 The Author(s)

11. Neb. Rev. Stat. § 71-6901 (2022).
12. American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Obstetrics, Society for Maternal-Fetal Medicine (2021); "Multifetal Gestations: Twin, Triplet, and Higher-Order Multifetal Pregnancies: ACOG Practice Bulletin, Number 231," *Obstetrics and Gynecology* 137, no. 6 (2021): e145–e162.
13. R. Rao, "Selective Reduction: 'A Soft Cover for Hard Choices' or Another Name for Abortion?" *Journal of Law, Medicine & Ethics* 43, no. 2 (2015): 196–205.
14. Ryan Program, The Ryan Residency Training Program, *available at* <https://ryanprogram.org/> (last visited October 27, 2022).
15. Society of Gynecologic Surgeons (SGS), Society of Gynecologic Surgeons (SGS), *available at* <https://www.sgsonline.org/> (last visited October 27, 2022).
16. See Guttmacher Institute, *supra* note 1.
17. See ACGME, *supra* note 4.
18. *Id.*
19. American Board of Obstetrics & Gynecology (ABOG), Bulletins & Dates, *available at* <https://www.abog.org/bulletins-dates> (last visited October 15, 2022).
20. American Board of Obstetrics & Gynecology (ABOG), ABOG Reiterates Support for OB GYNs and Reproductive Health Rights, *available at* <https://www.abog.org/about-abog/news-announcements/2022/06/24/abog-reiterates-support-for-ob-gyns-and-reproductive-health-rights> (last visited February 10, 2023).
21. American Board of Obstetrics & Gynecology (ABOG), Complex Family Planning FAQs, *available at* <https://www.abog.org/about-abog/faqs/complex-family-planning-faqs> (last visited October 15, 2022); See ACGME, *supra* note 4.
22. C. Rowland, "A Challenge for Antiabortion States: Doctors Reluctant to Work There," *Washington Post*, August 6, 2022.
23. American Association of Medical Colleges (AAMC), How the Repeal of Roe v. Wade Will Affect Training in Abortion and Reproductive Health, *available at* <https://www.aamc.org/news-insights/how-repeal-roe-v-wade-will-affect-training-abortion-and-reproductive-health> (last visited February 10, 2023).
24. S. Horvath et al., "Resident Abortion Care Training and Satisfaction: Results from the 2020 Council on Resident Education in Obstetrics and Gynecology in-Training Examination Survey," *Obstetrics and Gynecology* 138, no. 3 (2021): 472–474.
25. Bixby Center for Global Reproductive Health. Barriers to Abortion Training Persist in Ob-Gyn Residency Programs, *available at* <https://bixbycenter.ucsf.edu/news/barriers-abortion-training-persist-ob-gyn-residency-programs> (last visited February 10, 2023).
26. See Vinekar, *supra* note 5.
27. Accreditation Council for Graduate Medical Education (ACGME), ACGME Program Requirements for Graduate Medical Education in Family Medicine, June 12, 2022, *available at* <https://www.acgme.org/globalassets/pfassets/programrequirements/120_familymedicine_2022.pdf> (last visited October 7, 2022).
28. Centers for Disease Control and Prevention (CDC), Abortion Surveillance — United States, 2019, *available at* <https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm> (last visited October 7, 2022).
29. M. L. Stone, M. Gordon, and J. Rovinsky, "3. The Impact of a Liberalized Abortion Law on the Medical Schools," *American Journal of Obstetrics and Gynecology* 111, no. 5 (1971): 728–735.
30. American Association of Medical Colleges (AAMC), ERAS Statistics, *available at* <https://www.aamc.org/data-reports/interactive-data/eras-statistics-data> (last visited October 27, 2022).
31. J. Pollard, "Abortion Access Looms Over Medical Residency Applications," Associated Press (AP) News, October 19, 2022, *available at* <https://apnews.com/article/abortion-health-business-education-family-medicine-3fbeef4338fbdcaf48f4f-133055c9f78> (last visited October 27, 2022).
32. See Guttmacher Institute, *supra* note 1.
33. J. Stonehocker, J. Muruthi, and W. F. Rayburn, "Is There a Shortage of Obstetrician-Gynecologists?" *Obstetrics and Gynecology Clinics of North America* 44, no. 1 (2017): 121–132.
34. Health Resources and Services Administration (HRSA), "Projections of Supply and Demand for Women's Health Service Providers: 2018-2030," March 2021, *available at* <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/projections-supply-demand-2018-2030.pdf> (last visited August 8, 2023).
35. S. Daniel, J. Schulkin, and D. Grossman, "Abortion Referral Practices among a National Sample of Obstetrician-Gynecologists," *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health* 30, no. 6 (2020): 446–452.
36. See Gyuras, *supra* note 6.
37. A. J. Stevenson, "The Pregnancy-Related Mortality Impact of a Total Abortion Ban in the United States: A Research Note on Increased Deaths Due to Remaining Pregnant," *Demography* 58, no. 6 (2021): 2019–2028; K. B. Kozhimannil, A. Hassan, and R. R. Hardeman, "Abortion Access as a Racial Justice Issue," *The New England Journal of Medicine* 387, no. 17 (2022): 1537–1539.
38. Accreditation Council for Graduate Medical Education (ACGME), Common Program Requirements, a*vailable at* <https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements/> (last visited February 10, 2023).
39. A. Storey et al., "First-Trimester Abortion Complications: Simulation Cases for OB/GYN Residents in Sepsis and Hemorrhage," *MedEdPORTAL: The Journal of Teaching and Learning Resources* 16 (2020): 10995; L. M. Goldthwaite and K. Tocce, "Simulation Training for Family Planning Procedures," *Current Opinion in Obstetrics & Gynecology* 29, no. 6 (2017): 437–442; M. Paul and K. Nobel, "Papaya: a Simulation Model for Training in Uterine Aspiration," *Family Medicine* 37, no. 4 (2005): 242-244.
40. H. J. Chaudhry, "Expanding Licensure Portability and Access To Care: Lessons Learned During COVID-19," *Health Affairs* (Project Hope) 41, no. 8 (2022): 1136–1138.
41. Center for Medical and Medicaid Services (CMS), COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, May 24, 2021, *available at* <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf> (last visited October 27, 2022); Center for Medical and Medicaid Services (CMS), Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19, August 18, 2022, *available at* <https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf> (last visited October 27, 2022).
42. M. Messerly and A. M. Ollstein, "Abortion Bans and Penalties Would Vary Widely by State," POLITICO, *available at* <https://www.politico.com/news/2022/05/06/potential-abortion-bans-and-penalties-by-state-00030572> (last visited October 27, 2022).
43. Exec. Order No. 14076, 87 FR 42053 (2022).
44. See Guttmacher Institute, *supra* note 1.
45. *Id.*
46. K. Watson, "Biden Signs Executive Order to Support Travel for Abortions in Latest Move Aimed at Protecting Access," CBS News. August 3, 2022, *available at* <https://www.cbsnews.com/news/biden-abortion-executive-order-travel> (last visited October 27, 2022).
47. Federation of State Medical Boards (FSMB), Physician Discipline, *available at* <https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/physician-discipline> (last visited October 27, 2022).

The Journal of Law, Medicine & Ethics, 51 (2023): 497-503. © 2023 The Author(s)