UCLA School of Law
Center on Reproductive Health, Law, and Policy

State Abortion Policies and OB-GYN Residents

How Abortion Policies Influence Career Choices, Relocation Decisions, and Perceived Protection While Providing Care

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EXECUTIVE SUMMARY

OB-GYN residents are now training and making professional practice decisions in a landscape filled with bans, restrictions, and threats of criminal punishment and professional discipline.

OB-GYN residents face an array of policy environments when deciding where to practice post-residency, with the potential to determine their learning, restrict the care they provide their patients, and dictate the care they or their loved ones can receive if they become pregnant. Only nine states and the District of Columbia have no gestational (including viability) abortion bans. When we collected data for this study from March 2024 to June 2024, 13 states had total abortion bans, eight more states banned abortion before or up to 18 weeks of pregnancy, and 20 states banned abortion access after 18 weeks or at viability. Abortion bans and restrictions threaten to penalize physicians who provide abortions with professional discipline, fines, and, since *Dobbs,* lengthy prison time.

At the same time, many states have enacted constitutional amendments to enshrine the freedoms to give and get care into law and have passed other types of laws and policies meant to protect providers' ability to provide abortion care. These distinct policy environments not only cause significant disarray and confusion for patients, but they also weigh heavily on practicing physicians, residents, and medical students as they make vital decisions about their futures, caring for patients, and difficult personal and professional decisions.

This study sought to better understand the impact state abortion policies have on OB-GYN resident choices, perceptions, and concerns.

CRHLP fielded a survey from March to June 2024 and asked third- and fourth-year OB-GYN residents who had begun their training before *Dobbs* and were then making decisions in a post-*Dobbs* landscape an array of questions about:

- how state abortion policies and other factors informed their decisions regarding where to live and practice after residency,
- what types of state abortion policies would make them feel safer while providing care, and
- their concerns, fears, and thoughts regarding their state's abortion policies, practices, and patients.

The study team contacted residency program directors, managers, and coordinators who distributed the online survey to their cohorts of third- and fourth-year OB-GYN residents. The team also directly contacted residents when their emails were available on their program's website. We asked questions about post-residency planning and influences on decision-making. Respondents were also asked to detail the impacts of abortion policies on their practice, rate their agreement and concerns over the consequences of state abortion policies, and indicate whether certain policies would help them feel safer while providing care. See the appendix for the complete study methodology.

This study builds upon existing research on the effects abortion policies have on the health workforce, their ability to do their jobs, and the provision of care. This study adds to a growing body of research post-*Dobbs* that examines how the changing state abortion policy landscape—which often comes with significant professional and personal risk for providers—alters medical professionals' and particularly early career professionals' choices. This study adds insight into the impacts of state abortion policies on OB-GYN residents' decision-making about where to practice, their levels of concern about their ability to provide care or the harm that might come to their patients, and what policies, if any, make them feel safer and more confident while providing care.

KEY FINDINGS

152 residents from 32 states responded, and here are our key findings:

- **Most respondents (81.8%) who are moving out of state after residency are moving to states where abortion is not totally banned.** 56.4% of respondents who are moving post-residency are moving to states that either have a gestational ban after 18 weeks, a viability ban, or no abortion bans. Only 18.2% of residents are moving to states with total abortion bans, and only 25.4% are moving to states with bans up to 18 weeks.
- **Abortion policy matters to residents as they choose the location of their practice after residency. For 13% of them, it is the deciding factor.** Overall, 46% of respondents indicated that legal risk to providers has informed or will inform where they live post-residency.
- **Residents in all policy environments with gestational limits or abortion bans at any stage expressed concern about how limits would impact their practice.** Residents in ban states or states with less than 18 weeks bans are not the only groups of residents who expressed concern about the impact of abortion policy on their practice. Even respondents practicing in states with more policy protections for abortion providers, or practicing in states with bans after 18 weeks or viability bans, expressed concern about restrictions from policy or restrictions due to hospital/institutional policy
- **Residents expressed concern that state and health-system abortion policies will limit their practice and compliance with medical standards of care, especially those in states with total bans or bans up to 18 weeks.** Respondents intending to practice in states with total bans or bans up to 18 weeks indicated higher levels of concern that abortion policies will impede their abilities to provide care and that they will face conflict while trying to comply with state policies and medical ethical standards compared to respondents living in states with no abortion restrictions, viability bans or bans after 18 weeks.
- **Residents expressed concern that state abortion policies will put them at risk of facing criminalization, legal ramifications, and professional discipline. Concern was especially pronounced among those who will be practicing in states with total abortion bans or bans up to 18 weeks.** Respondents intending to practice in states with total bans or bans up to 18

weeks indicated higher levels of concern about facing criminalization, legal ramifications, and professional discipline due to abortion policies compared to respondents who will be living in states with no abortion restrictions, viability bans, or bans after 18 weeks.

- **Residents expressed concern that abortion policies negatively impact their patients' safety, health outcomes, and rights, especially those in states with total bans or bans up to 18 weeks.** Respondents intending to practice in states with total bans or bans up to 18 weeks indicated higher levels of concern for how abortion policies might cause patient harm through delays in care or negative effects on maternal health compared to respondents living in states with no abortion restrictions, viability bans, or bans after 18 weeks.
- **There is an array of abortion-protective policies that would make residents feel safer while providing abortions.** All or almost all participants indicated they would feel safer while providing abortions under policies that provide protections from professional discipline, harassment, or physical harm, and out-of-state investigations; policies that prohibit disclosure of medical information or reproductive health data related to abortions; and a state constitutional right to abortion.
- **We asked about protective abortion policies that are currently in effect in some states. Almost all residents stated each policy would make them feel safer in their practice, except abortion ban health exceptions.** While 100% or nearly 100% of all participants indicated each protective policy would make them feel safer when providing abortions, only 70% of participants indicated that health exceptions would make them feel safer.

Our findings contribute to our understanding that state abortion policies, and particularly abortion bans, are impacting where OB-GYNs want to live and practice. Our findings, though based on a limited sample that skewed more heavily toward respondents with residencies in states with less abortion restrictions, suggest that residents do not want to practice in states with abortion bans or severe restrictions and that few residents training in states with less restrictive laws want to or are choosing to practice in more restricted states. This means that we may see growing health care workforce shortages and growing care deserts in states that ban and severely restrict abortion, resulting in fewer available doctors to meet pregnant people's abortion needs, but also their needs for miscarriage care, pregnancy health, and births.

Our findings also suggest that a range of relevant positive policies and constitutional amendments that some states enact are perceived as helpful by early career providers and may have the impact of drawing more providers to states with fewer abortion restrictions and stronger protections. Our findings confirm that these early career professionals take less solace in abortion ban exceptions than in other positive protections.

Based on our findings, we echo the calls for further research on the impacts of state abortion policies on the current and future health workforce, including OB-GYN residents as we have in this study, but

also the wide array of other health professionals providing reproductive health care, such as nurse practitioners and physician assistants. Additionally, we have identified the critical need for ensuring comprehensive abortion training for every person entering the health profession, but certainly, at a minimum, for OB-GYNs and other health professionals who regularly provide pregnancy-related care in various settings. This includes enforcing accreditation requirements that demand OB-GYN residents obtain comprehensive reproductive health care training, including abortion training, even if training in ban and restrictive states. Finally, we call on policy makers to continue to enact and enforcement bodies to enforce and defend protective state policies that our study shows make reproductive health care providers feel safer while caring for patients and doing their jobs in often confusing and oft-changing legal and policy environments that now threaten potential professional, civil, and criminal punishment simply for doing their jobs.

FINDINGS

DEMOGRAPHICS

Of the 152 OB-GYN residents surveyed, 51.3% were 25-31 years old, 61.2% identified as white, 91.4% identified as cisgender female, 83.6% identified as straight/heterosexual, 56.6% were third-year residents, and 70.4% participated in the Ryan Residency program.[1] For complete demographic data, see Table 1a.

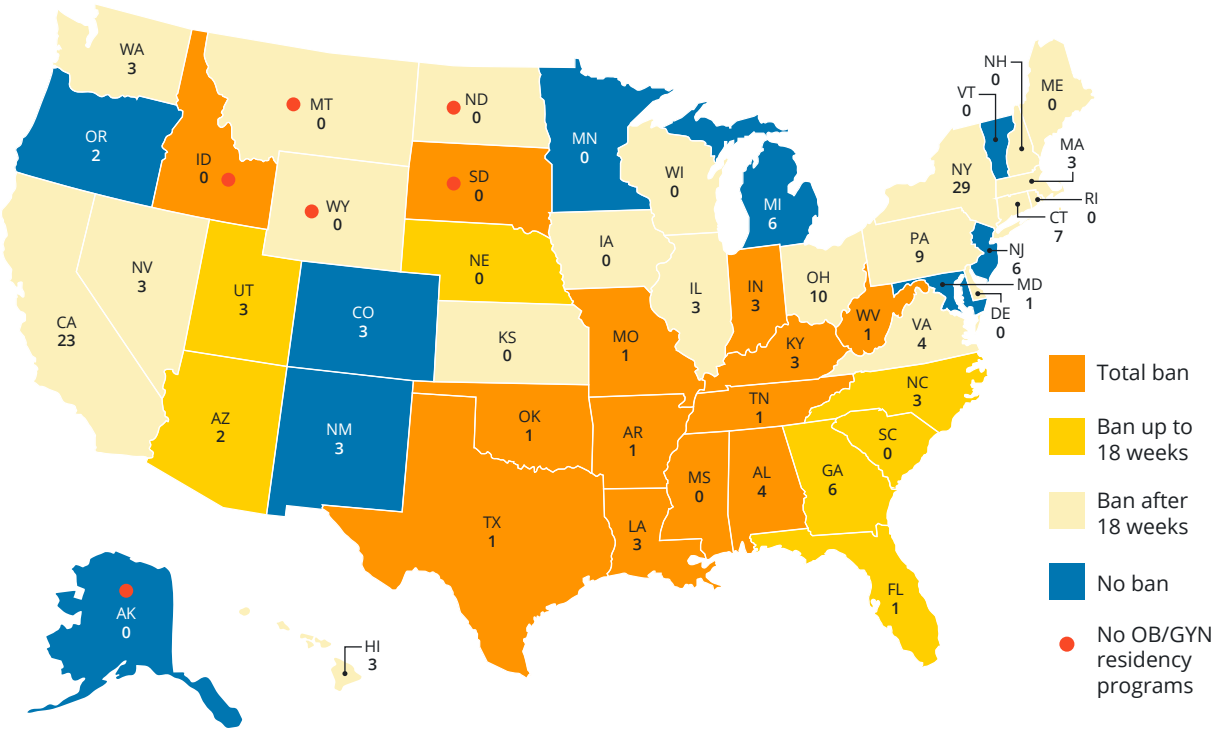
ABORTION TRAINING DURING RESIDENCY

Most respondents received abortion training (93.4%) during their residency, with many of them having practiced how to provide care via dilation and curettage (98.6%), medication abortion (97.9%), and dilation and evacuation (94.4%). Of the ten respondents who did not receive any abortion training, four indicated that they had no legal access to training, or their program did not offer training. Almost all respondents who received abortion training (96.5%) received it in-state. For complete data about abortion training, see Table 1b.

RESIDENTS' LOCATIONS DURING AND AFTER RESIDENCY

Before analysis, the team categorized states into four categories based on the states' abortion policies as of June 2024: (1) total abortion ban, (2) ban up to 18 weeks of pregnancy, (3) bans after 18 weeks of pregnancy, including at viability, and (4) no ban.

Figure 1. Distribution of the residency location of surveyed OB-GYN residents at the time of the survey

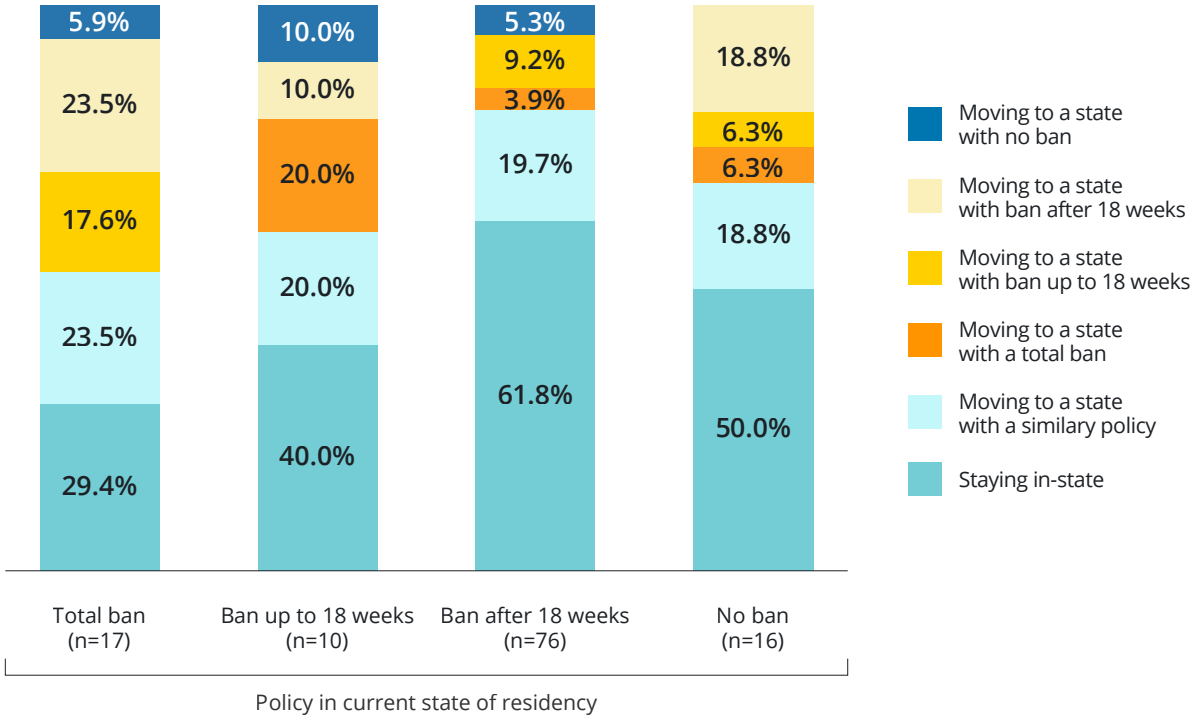


[1] The Ryan Residency Program is a national initiative to integrate and enhance abortion and family planning training in OB-GYN programs. *See* About the Ryan Program Ryan Program, https://ryanprogram.org/home/overview/

Over half of respondents (77.6%) completed or are completing their residency in a state with gestational bans after 18 weeks. For a full breakdown of where respondents were living at the point of the survey, see Table 3.

WHERE WILL RESIDENTS BE LIVING AFTER COMPLETING THEIR RESIDENCY

Figure 2. Where will respondents be living after residency? (n=119)[2]



Of the 152 respondents, 78.3% of them knew where they would be living after residency, and 21.7% were unsure of where they were going to be living. Of the OB-GYN residents who knew where they would be living after residency, 51.3% are staying in the same state where they completed their residency. Among respondents who know where they will be living post-residency, a greater proportion of residents who trained in states with an abortion ban after 18 weeks, viability ban, or no abortion ban are staying in-state after residency, compared to residents who trained in states with a ban before 18 weeks or a total ban. Of the 76 respondents completing their residency in states with bans after 18 weeks or a viability ban, 61.8% are staying in-state after residency. Similarly, out of the 16 residents living in states with no bans, half of them are staying in state. Meanwhile, only 29.4% of residents living in states with total bans and 40% of respondents living in states with gestational bans before 18 weeks reported they were staying in state.

[2] Charts visualize the results for a subsample of respondents (n=119) instead of the full sample (n=152) because the analysis was limited to people who know where they will be living post-residency

Notably, among all respondents who knew where they would be living after residency, many of them are moving out of state but moving to states with similar policy environments. We observed that within each state abortion policy environment, about 1/5 of respondents are moving to states with similar policy environments. 23.5% of respondents in total ban states are moving to other states with total bans. Likewise, 20% of respondents in states with bans before 18 weeks, 19.7% of respondents in states with bans after 18 weeks or viability bans, and 18.8% of respondents in states with no bans are moving to states with similar abortion policies.

AMONG RESIDENTS WHO ARE MOVING OUT OF STATE AFTER RESIDENCY

Overall, most respondents (81.8%) who are moving out of state after residency are moving to states where abortion is not banned; in other words, of the residents who are moving, a vast majority are choosing not to practice in total ban environments. Most respondents moving after residency are moving to less restrictive policy environments: 56.4% of respondents who are moving post-residency are moving to states that either have a gestational ban after 18 weeks, a viability ban, or no abortion bans. Only 18.2% of residents are moving to states with total abortion bans, and only 25.4% are moving to states with bans up to 18 weeks.

It is important to note that when examining the movement of OB-GYN residents, more than half of the respondents (66.6%) moving out of states with total abortion bans are moving to less restrictive states. Meanwhile, over half (62.1%) of the respondents who are moving out of states with gestational bans after 18 weeks or viability bans are moving to either other states with similar protective abortion policies or states with no bans. Most residents (75%) moving out of states with no abortion bans are moving to other states with no abortion bans or states where abortion is banned after 18 weeks. Respondents were also asked what factors informed or would inform their decision of where to live post-residency. “Personal considerations,” which included family, significant others, or lifestyle, was the most selected factor among residents (86.1%), followed by opportunities for advancement (44.1%) and legal risk for providers (46.1%). Notably, however, 55.7% of residents staying in-state after residency indicated a legal risk for providers as one of the reasons why they are staying in-state.

In open-text responses, residents also detailed how several factors inform where they will live post-residency. Many residents consider state abortion policies as crucial factors in decision-making about where to live post-residency—for 13% of respondents who answered the open text questions (n = 109), it was the deciding factor. Furthermore, some residents indicated that they would not live in states with abortion bans. One resident who is moving out of a state with a total ban said, “I was looking for a first job in which I could practice without restrictions.” Other respondents indicated that even if they did not plan to provide abortions, they still wanted to live in states with access to abortion. A few respondents discussed how, while they would want to live in a state where abortion was less restricted, other factors, such as being closer to family members or limited access to professional opportunities in an access state, won out in the end. For instance, one resident moving

to Texas said, "I preferred to go to a state with more open abortion access and mostly applied to fellowships in such states, but ended up matching in Texas." Notably, three respondents indicated that the restrictive abortion policies in their state inspired them to stay and serve as advocates for abortion. One resident who plans to return home after their fellowship stated,

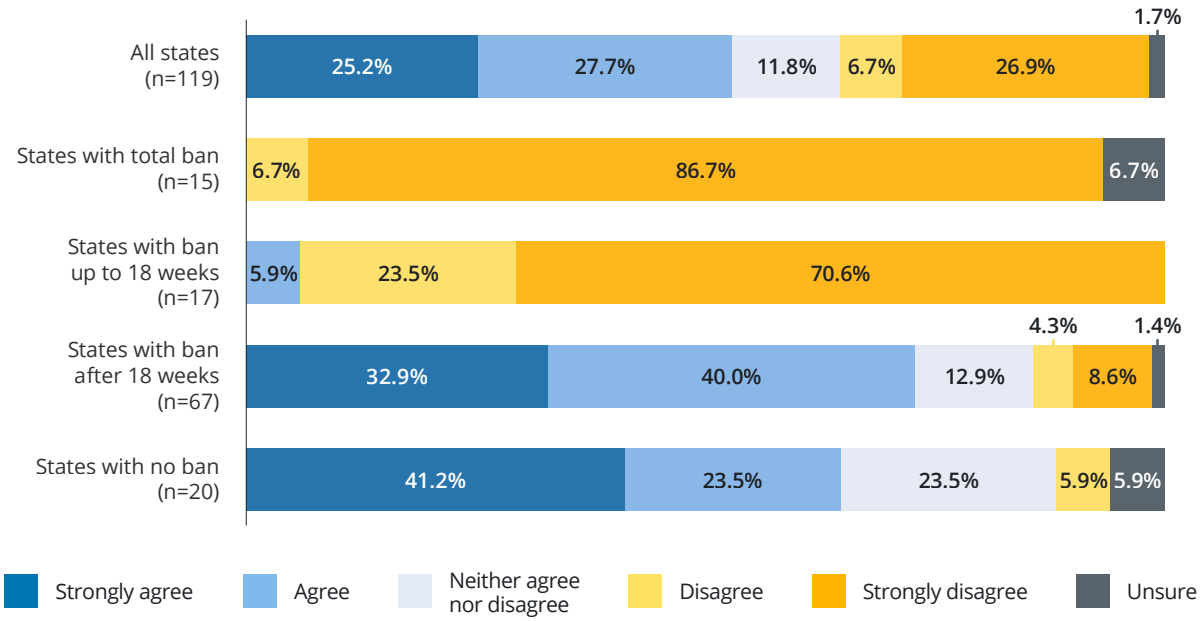
> *Yes, I am from a restricted state and trained in a restricted state for the first 2 years of residency. I plan to complete [a complex family planning] fellowship and then return to a restricted state to be an ally, advocate, and provider of services that I am able [to provide].*

Some respondents discussed other state policies, such as bans on gender-affirming care or policies impacting IVF, which also influenced where they would live post-residency.

PERCEIVED IMPACTS, FEARS, AND CONCERNS DUE TO ABORTION LAWS

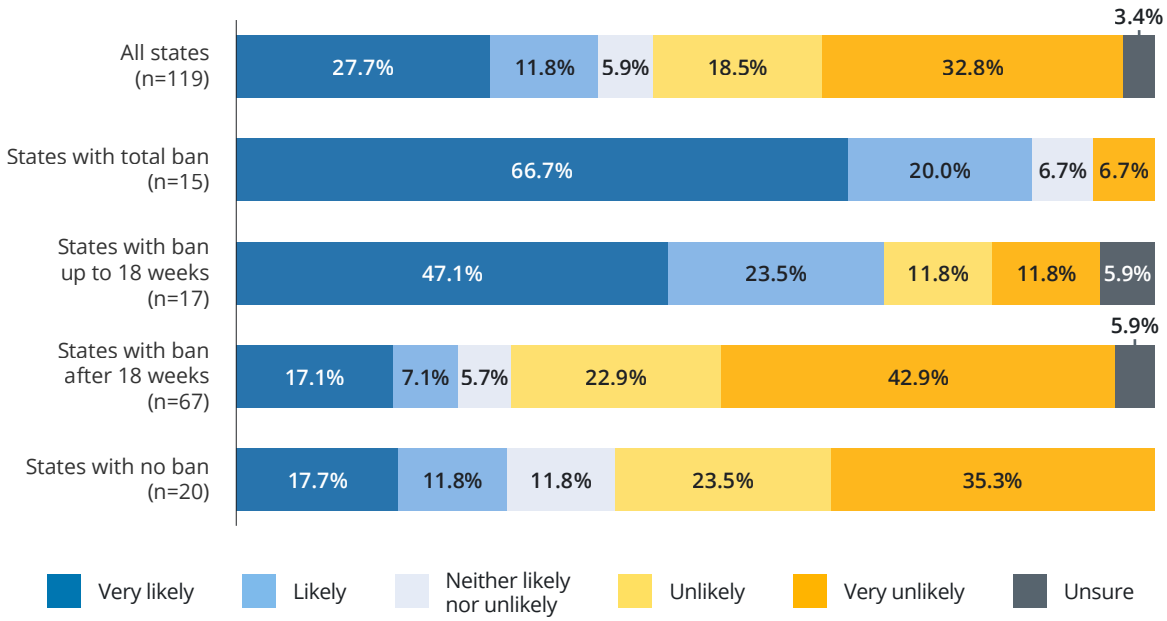
We asked respondents if they agreed or disagreed with the level of abortion restrictions in the state where they plan to practice after residency. Most respondents who will be living in states with total bans (86.7%) or states with bans up to 18 weeks (70.6%) strongly disagreed with the level of abortion restrictions in their state. For a complete breakdown of the level of agreement among respondents by state abortion policy, see Figure 3.

Figure 3. Do OB-GYN residents agree or disagree with the level of abortion restrictions in the state they plan to practice in? (n=119)



We also asked respondents how likely it is that state restrictions on abortion will impact their ability to provide care. 66.7% of respondents who will be living in states with total bans and 47.1% of respondents who will be living in states with bans up to 18 weeks indicated that state policies are very likely to impact their ability to provide care. See Figure 4 for a complete breakdown of responses by state policy environment.

Figure 4. How likely is it that state abortion restrictions will impact OB-GYN residents' ability to provide care? (n=119)



Respondents also discussed how abortion policies are currently limiting their ability to provide care that their patients need in open-text responses. Residents who were completing their training in states with abortion bans or gestational bans up to six weeks detailed how their ability was severely restricted. One resident in Texas stated, "The current legal environment in Texas has made it impossible to provide patient-centered abortion care." Another resident who will be moving to Florida after completing their residency said, "Florida has passed a 6-week abortion ban, which will significantly impact my ability to assist patients with unintended, unwanted pregnancies."

Respondents were also asked to rate their agreement with different statements regarding their fear of criminalization, professional discipline, and facing conflict between complying with state policy and medical and ethical obligations. Among participants who will be living in states with total bans or gestational bans up to 18 weeks, a higher proportion of respondents indicated fear of facing criminalization, professional discipline, or conflict while providing care. For instance, when asked to rate their agreement with the statement "I fear I will face conflicts between complying with state abortion laws and medical ethical obligations," respondents who will be living in states with a total ban or gestational bans up to 18 weeks strongly agreed (66.7% and 52.9% respectively). Meanwhile, 11.4%

of respondents who will be living in states with gestational bans after 18 weeks or viability bans, and 11.8% of respondents living in states with no gestational bans, strongly agreed with the statement. For further information on how participants fear criminalization, professional discipline, and facing conflict between state policy and their medical and ethical obligations, see Figures 5-7.

Figure 5. Level of agreement among respondents with "I fear I will face conflict between complying with state abortion laws and medical ethical obligations" (n=119)

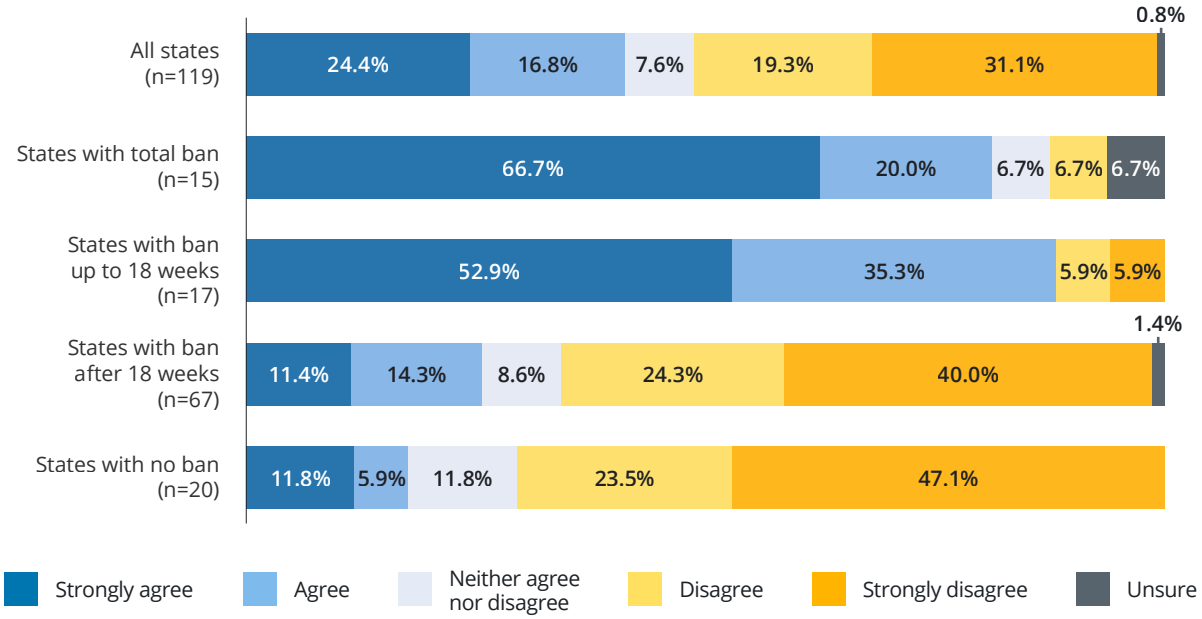


Figure 6. Level of agreement among respondents with "I fear state abortion laws will put me at risk of professional discipline (n=119)

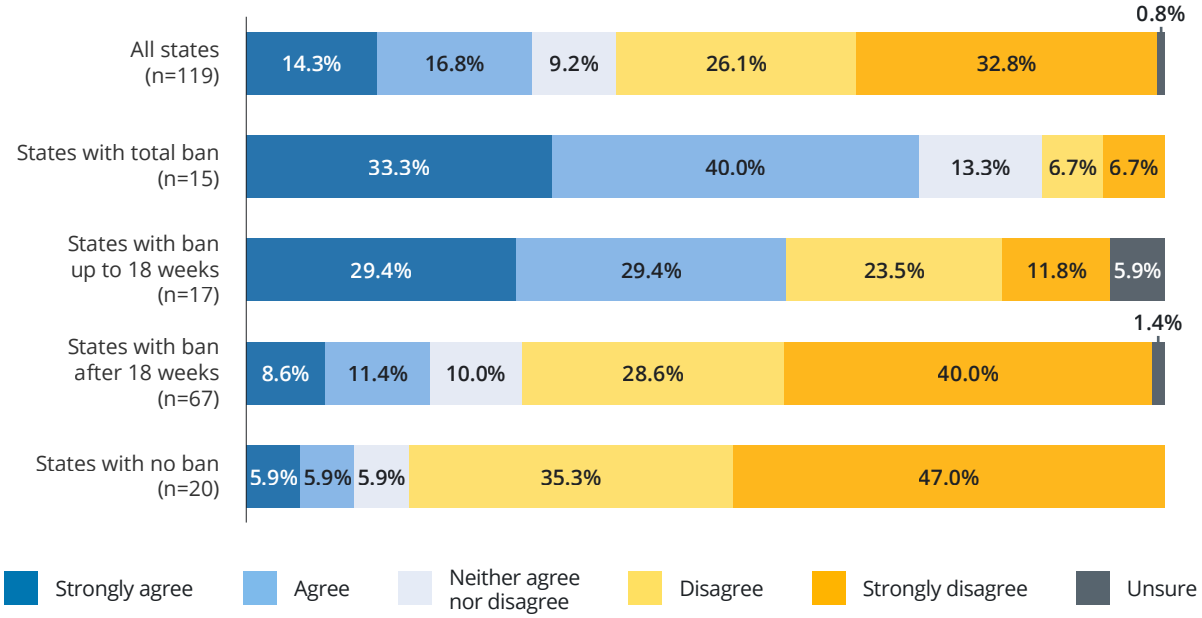
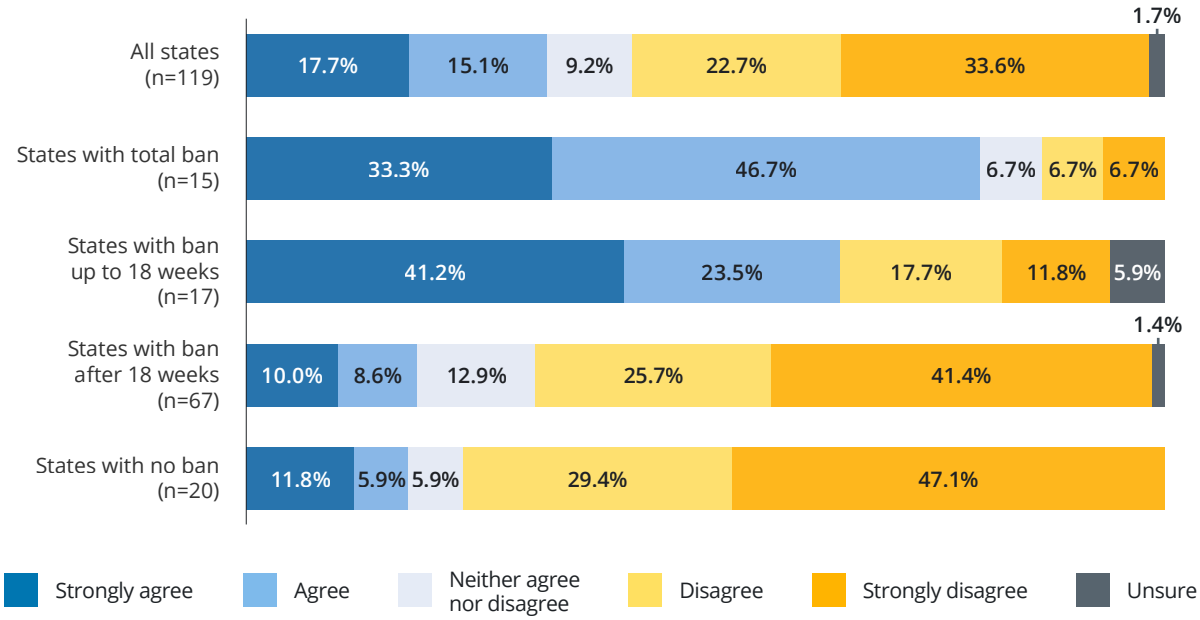


Figure 7. Level of agreement among respondents with "I fear state abortion laws will put me at risk of criminalization" (n=119)



Across five questions related to the level of concern residents have over the impact of state abortion policies, higher proportions of respondents in states with total bans or states with gestational bans up to 18 weeks indicated higher levels of concern compared to respondents in states with later bans or no bans. For example, when asked about their level of concern that state abortion policies may result in delays to patients' care, 86.7% of respondents who will be living in states with a total ban and 76.5% of respondents who will be living in states with bans up to 18 weeks responded that they are extremely concerned. Meanwhile, only 12.9% of respondents in states with bans after 18 weeks or viability bans, and 11.8% of respondents in states with no bans stated that they are extremely concerned (Figure 8). Respondents in total ban states and states with bans up to 18 weeks also expressed higher levels of concern over their ability to provide abortion care (Figure 9), maternal health care generally (Figure 10), being an abortion provider and facing legal ramifications (Figure 11), and that state abortion policies are unclear (Figure 12).

Figure 8. Respondents' level of concern that state abortion laws may result in delays to patient care (n=119)

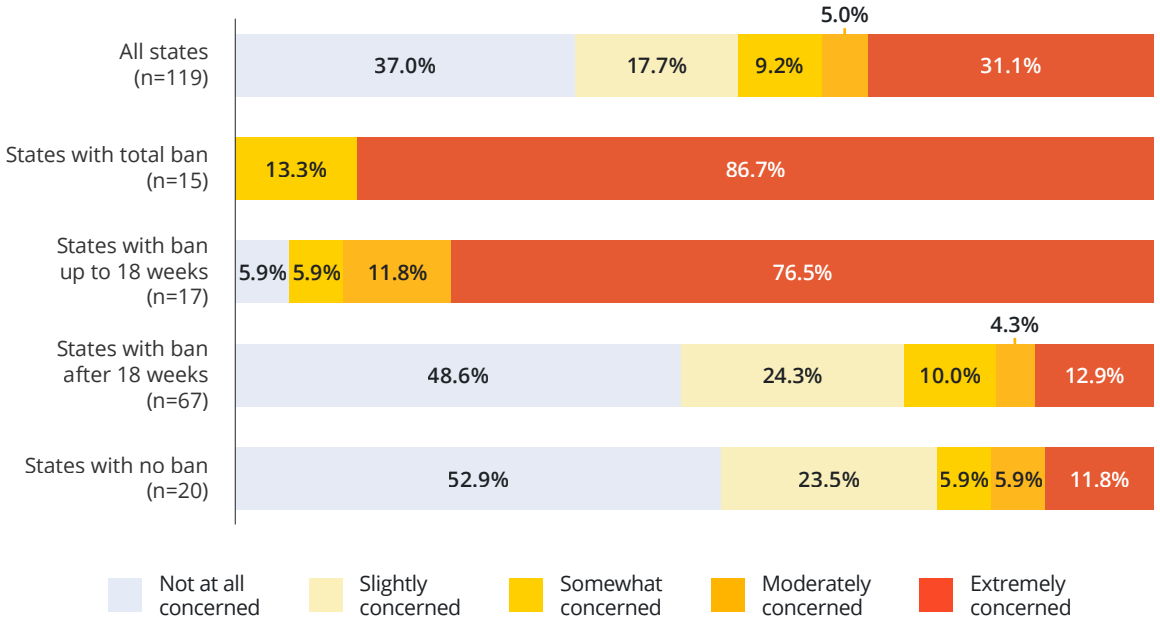


Figure 9. Respondents' level of concern that exceptions to abortion restrictions will impede their ability to provide care (n=119)

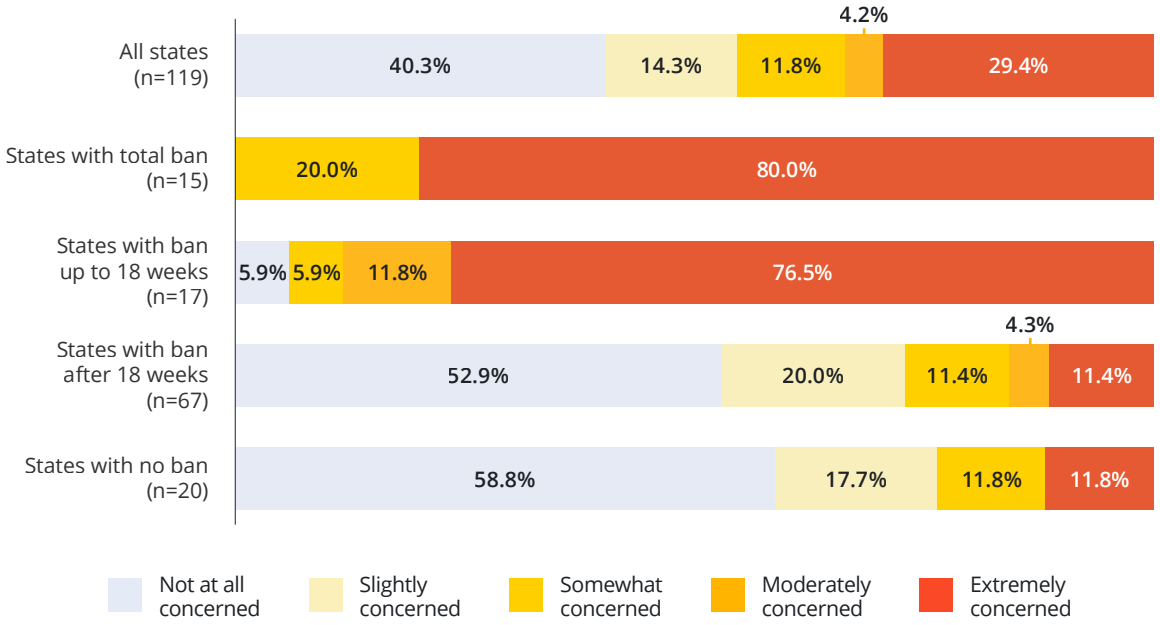


Figure 10. Respondents' level of concern that maternal health will be negatively affected due to state abortion restrictions (n=119)

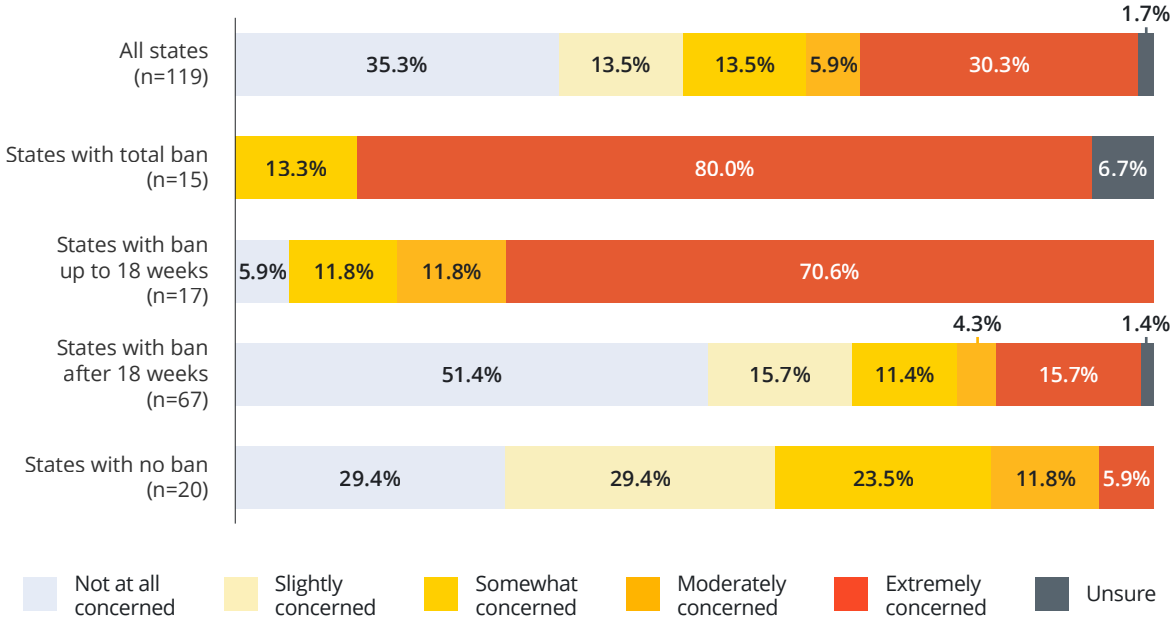


Figure 11. Respondents' level of concern about facing legal ramifications for being an abortion provider (n=119)

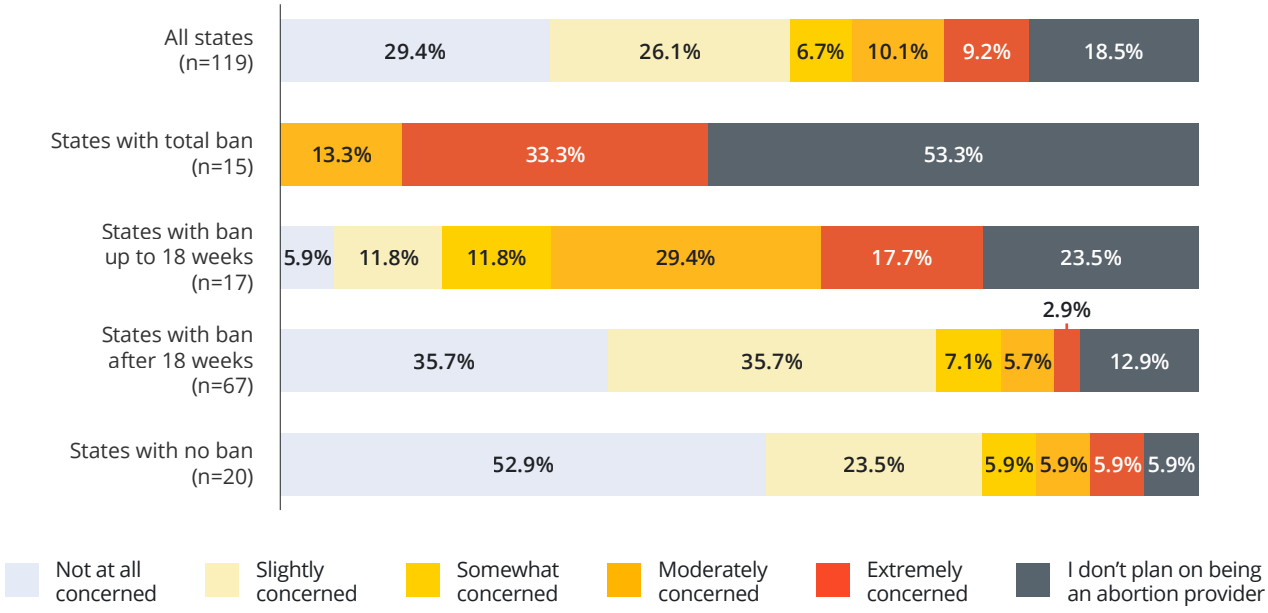
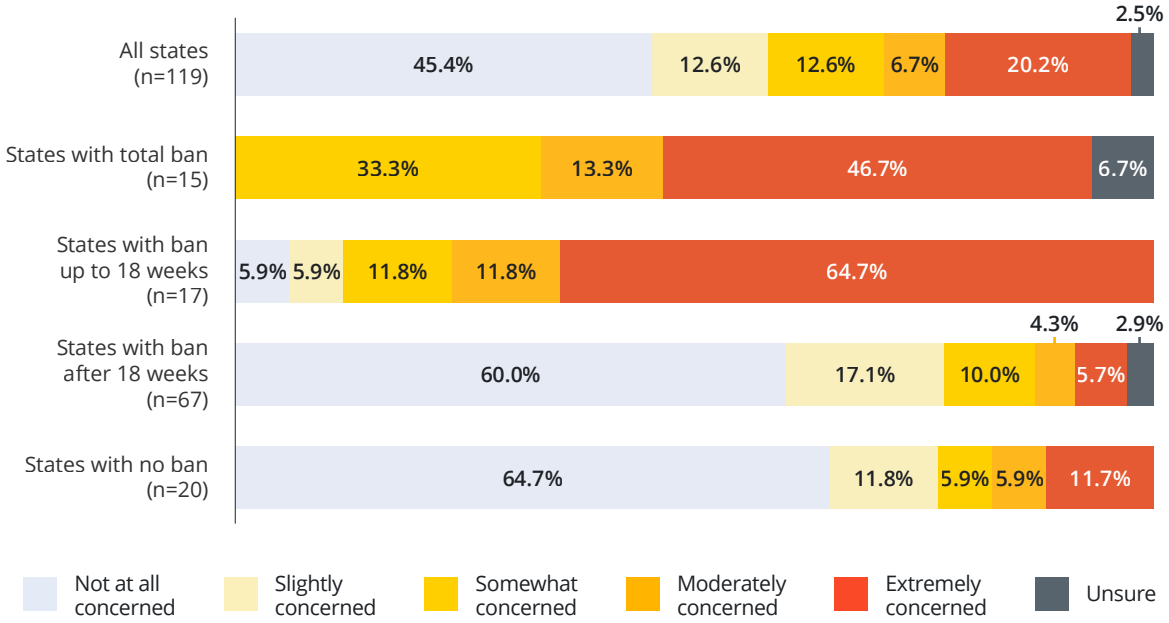


Figure 12. Respondents' level of concern that legal exceptions to state abortion restrictions are unclear (n=119)



In the open-response questions, residents also expressed concern that state abortion policies are or will negatively impact their patients' safety, health outcomes, and rights. Respondents expressed that restrictive state abortion policies create barriers to delivering safe, effective care, with patients facing increased risks as a result. 15% of respondents elaborated on these concerns, explaining concerns about negative health outcomes resulting from restrictive policies, including health complications, patient distress, worsening maternal health outcomes, and outcomes that could negatively impact future fertility. For instance, one resident training in Georgia observed,

> *We have also seen sicker and sicker moms with poor outcomes of their pregnancy who did not want to continue the pregnancy from the beginning, but did not have access to abortion now that you have to leave the state.*

Others described how restrictions limit their ability to safely provide care; as one resident put it: "I cannot take care of patients in a safe way if these [restrictions] always exist. If a patient came in with a miscarriage and needed treatment, I wouldn't be able to safely provide that."

Another respondent, training in Missouri, explained how barriers affect care options even for medically indicated situations:

> *It is currently illegal to provide termination for such scenarios to include pre-viable [Preterm Premature Rupture of Membranes] or augmentation for these patients unless there is imminent threatened harm to maternal life … This strips the pregnant patient's right to choose their own life as more valuable and places them at significant risk for severe medical adverse outcomes, lifelong morbidity, and threat to future fertility.*

Notably, respondents also self-reported that health system barriers, regardless of the state policy environment, significantly imposed on their ability to provide abortion care. Even in states with later or no gestational or viability bans, providers faced restrictions at the health-system level. Common health-system-specific barriers cited were hospital religious affiliation and internal institutional policies. However, issues with insurance coverage and fear of provider and hospital liability were also mentioned.

Hospital policies created a parallel set of burdens, further complicating respondents' ability to provide full-scope reproductive care. A resident who trained in Nevada said

> *Most states I am looking for jobs in have codified abortion protections and allow abortion care to approximately 24 weeks. Unfortunately, my ability to provide care will likely be more impacted by institutional policies, as many restrict providers' ability to appropriately provide this care outside of life-saving circumstances, even when it is protected by state law if we were to do so in said institutions.*

These challenges were particularly pronounced for those with protective state policies but working in religiously affiliated hospitals. A respondent from Washington alluded to this by saying, "Very protective laws around abortion [in Washington]. The biggest threat is catholic-owned hospitals."

Respondents also expressed concern over the impacts on their patients' autonomy. Concerns over patients' autonomy arose in 12 responses, with residents reporting that restrictive policies obstructed patients' ability to choose and access timely reproductive care. As one resident, who anticipates practicing in Ohio, noted, "developing legislation in Ohio may…impact [local clinics], making it harder to refer patients to receive the care they desire."

Some residents, however, spoke positively about practicing in states with protective abortion policy environments, where they observed the impact of supportive policies on patient autonomy. A resident from New York shared, "Practicing in New York versus training in Missouri has shown me the pivotal impact that abortion access and physician training have on patient safety and autonomy."

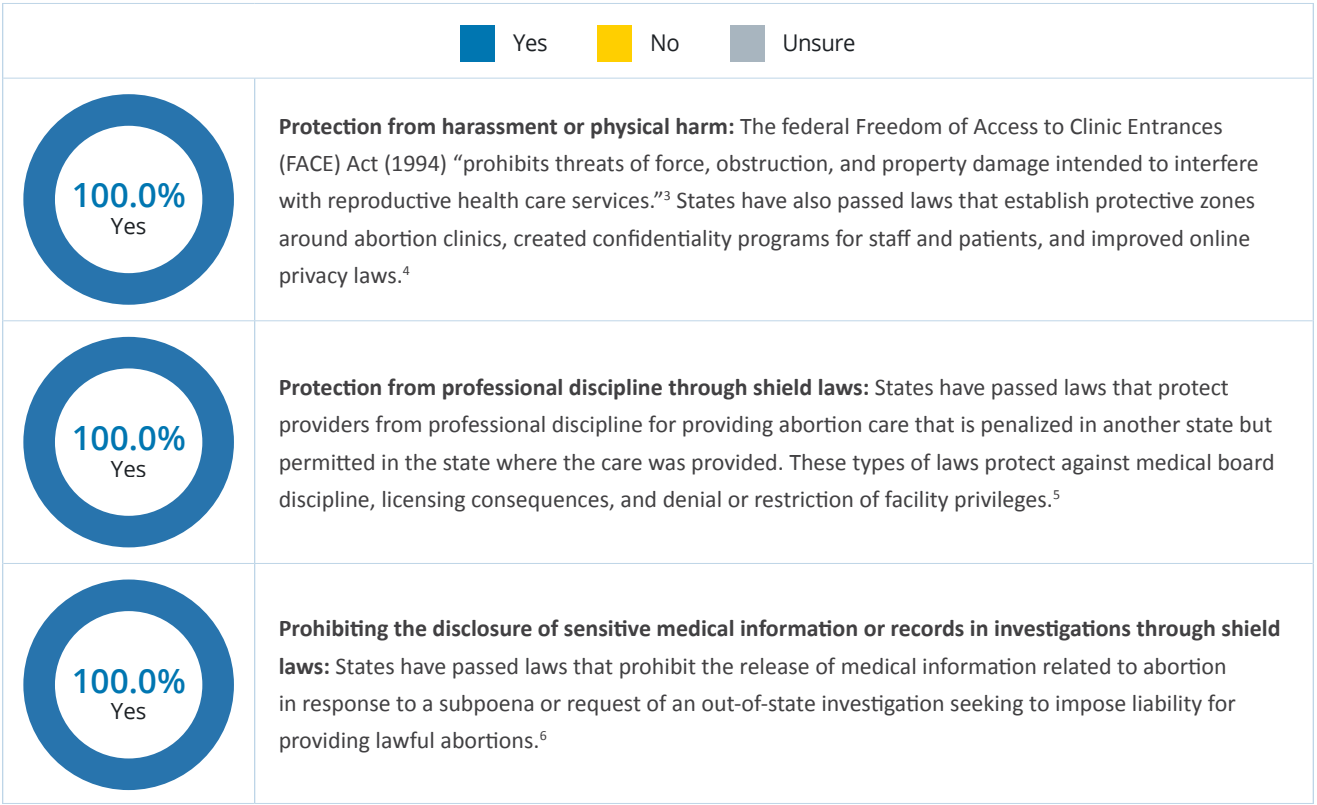
POLICIES THAT DO OR WOULD MAKE FUTURE ABORTION PROVIDERS FEEL SAFER WHILE PROVIDING CARE

As we wanted to explore what policies would make abortion providers feel safer while providing care, we filtered out participants who indicated that they would not provide abortions in their careers. Residents who may provide abortions in their future practice (n=124) were asked about their preferences for certain policies that may offer some level of legal protection. These policy options were developed in collaboration with our legal staff and presented to respondents who intended to provide at least some abortion care in their future practice. 100 percent of these respondents indicated that they would feel safer while providing abortion care with the following in place: 1)

policies that protect clinic staff from harassment or physical harm, 2) protections from professional discipline, especially when providing care to out-of-state patients, and 3) privacy protections of medical information related to abortion care would make them feel safer while providing abortion care. Almost all respondents (99.2%) indicated that the following would make them feel safer: 1) a state constitutional right to abortion, 2) policies that protect providers from out-of-state investigations and legal actions, or 3) policies that prohibit health insurers' disclosure to third parties without the express authorization of the individual receiving care. Most respondents (96%) indicated that a lack of hospital restrictions would make them feel safer while providing abortions. Similarly, 90% of respondents indicated that having no restrictions on abortion would make them feel safer while providing care.

Fewer respondents (70.2%) indicated that health exceptions would make them feel safe while providing abortion care. This type of policy is further discussed in the discussion section.

Figure 13. Would the following make you feel safer while providing abortion care? (n=124)

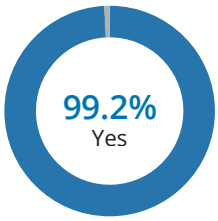
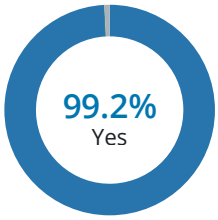
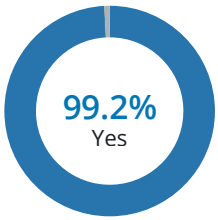
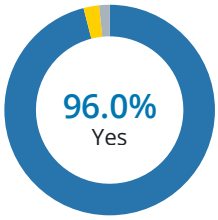
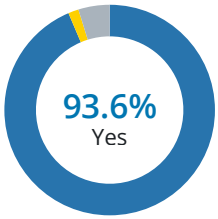
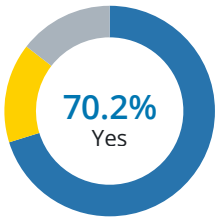


[3] 18 U.S.C. § 248 (1994), https://www.law.cornell.edu/uscode/text/18/248.

[4] Nash, E., & Guarnieri, I. (2023). *Eight Ways State Policymakers Can Protect and Expand Abortion Rights and Access in 2023 | Guttmacher Institute*. https://www.guttmacher.org/2023/01/eight-ways-state-policymakers-can-protect-and-expand-abortion-rights-and-access-2023.

[5] Center on Reproductive Health, Law, and Policy. (2025, February). *Shield Laws for Reproductive and Gender-Affirming Health Care: A State Law Guide | UCLA Law*. https://law.ucla.edu/academics/centers/center-reproductive-health-law-and-policy/shield-laws-reproductive-and-gender-affirming-health-care-state-law-guide

[6] *Id.*

	**HIPAA protection against disclosure of sensitive reproductive health information to third parties:** Policies, such as HIPAA's 2024 privacy rule to specifically protect the privacy of reproductive health information from disclosure to investigate or impose liability on someone seeking, obtaining, providing, or facilitating lawful abortion.[7]
	**Protection from out-of-state investigations and legal actions under shield laws:** Policies include protection for providers from extradition, arrest, and witness summons in out-of-state investigations, lawsuits, and prosecutions for providing lawful care.
	**Having a state constitutional right to abortion:** After the Supreme Court overturned a federal right to abortion, 11 states' high courts have recognized a state constitutional right to abortion.[8] As of November 2024, voters in 10 states have also enacted state constitutional amendments that affirm the right to abortion.[9]
	**Having no hospital restrictions:** Hospitals' policies may restrict a provider's practice via religious restrictions/directives that prohibit abortions, sedation policies, and non-compete clauses
	**Having no state policy restrictions:** State policies that restrict abortion include placing a gestational ban on abortion, enforcing waiting periods between the abortion counseling session and receiving the abortion, and limiting insurance coverage.
	**Having health exceptions to state policy gestational or viability bans:** Abortion bans include health exceptions to prevent the death of the pregnant person. Some states include health exceptions for when there is a risk to the health of the pregnant person and if there is a lethal fetal anomaly present. It is important to note that these health exceptions are often confusing and lead to delays in care.

[7] US Department of Health and Human Services. (2024, April 22). *HIPAA Privacy Rule Final Rule to Support Reproductive Health Care Privacy: Fact Sheet*. US Department of Health and Human Services. https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html

[8] Center for Reproductive Rights. (n.d.). *State Constitutions and Abortion Rights*. Center for Reproductive Rights. Retrieved April 22, 2025, from https://reproductiverights.org/maps/state-constitutions-and-abortion-rights/

[9] KFF. (2024, November 6). Ballot Tracker: Outcome of Abortion-Related State Constitutional Amendment Measures in the 2024 Election. *KFF*. https://www.kff.org/womens-health-policy/dashboard/ballot-tracker-status-of-abortion-related-state-constitutional-amendment-measures/

DISCUSSION

Most respondents received abortion education, but not at all gestational periods, and not all abortion methods.

State abortion laws have profound impacts on the medical education, training, and skills of future OB-GYNs. Comprehensive abortion education is a crucial part of health care education as it improves learners' competence and proficiency in critical skills needed for uterine evacuation, ultrasonography, evaluation, and options counseling, pregnancy complications, and infections,[10] and has also improved physician metrics for patient privacy and autonomy.[11] Banning or limiting abortion also restricts the health care education that residents can receive while in residency, which may potentially lead to future providers not having adequate clinical skills, knowledge, and experience to provide abortion care, but also miscarriage management, and other vital pregnancy care.[12]

Accordingly, the Accreditation Council for Graduate Medical Education's (ACGME) requires all accredited OB-GYN programs to provide their residents with clinical abortion training, even if that clinical rotation has to occur in a different state.[13] Programs like the Ryan Residency Program have matched residents in ban states with abortion rotation opportunities in access states, but not all OB-GYN residents in ban states have access to these opportunities due to limits of capacity, administrative challenges, legal obstacles, and other barriers.

In our sample, 93.4% of participants received some form of abortion training. This is unsurprising given our sample leans towards residents who are completing their training in states with access to abortion at least up to 18 weeks and because all respondents had at least one year of training before the *Dobbs* decision that allowed states to ban abortion. This high percentage may not hold true for resident classes who started training after *Dobbs.*

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[10] Steinauer, J. E., Turk, J. K., Fulton, M. C., Simonson, K. H., & Landy, U. (2013). The benefits of family planning training: a 10-year review of the Ryan Residency Training Program. *Contraception*, *88*(2), 275–280. https://doi.org/10.1016/j.contraception.2013.02.006;Steinauer, J. E., Turk, J. K., Zite, N., Ogburn, T., & Horvath, S. (2024). Routine abortion training correlates with obstetrics and gynecology program directors' assessment of graduating residents' skills. *American Journal of Obstetrics and Gynecology*, *231*(5), e186–e189. https://doi.org/10.1016/j.ajog.2024.07.020

[11] Merz, A. A., Janiak, E., Mokashi, M., Allen, R. H., Jackson, C., Berkowitz, L., Steinauer, J., & Bartz, D. (2022). "We're called upon to be nonjudgmental": A qualitative exploration of United States medical students' discussions of abortion as a reflection of their professionalism. *Contraception*, *106*, 57–63. https://doi.org/10.1016/j.contraception.2021.09.004

[12] Pasha, A. S., Breitkopf, D., & Glaser, G. (2023). The Impact of Dobbs on US Graduate Medical Education. *Journal of Law, Medicine & Ethics*, *51*(3), 497–503. https://doi.org/10.1017/jme.2023.89

[13] ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology Program Requirement IV.C.7.a).(4) at pg. 28. Accessed May 15, 2025. https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_2023.pdf (" Programs must provide clinical experience or access to clinical experience in the provision of abortions as part of the planned curriculum. If a program is in a jurisdiction where resident access to this clinical experience is unlawful, the program must provide access to this clinical experience in a different jurisdiction where it is lawful."): *id.* at IV.C.7.a).(4).(b) ("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.")

Importantly, although almost everyone received abortion training, among respondents who indicated receiving abortion training (n=142), over 90% of them learned dilation & curettage, dilation & evacuation, and/or medication abortion. Importantly, some respondents did not learn all three methods, resulting in varying knowledge and skills among residents. Additionally, there are differences among residents' knowledge and skills, as many did not learn to provide abortions later in pregnancy. While 70.4% of respondents learned how to provide an abortion after 21 weeks. 25.4% only learned how to provide an abortion from 14 to 21 weeks, and nearly 5% only learned how to provide an abortion up to 13 weeks.

In open-text responses, respondents discussed how even if they were not training in a total ban state, they experienced limitations in their training, especially in states with earlier gestational bans. One of our respondents, who is completing her residency in Georgia, a state with a six-week ban at the time of the survey, described how the state's policy has limited her learning:

> *I am in a Ryan Program, but the abortion training we have is mostly lectures. While I do have surgical experience with D+C due to miscarriages, etc., I do not have medical abortion training in person nor D+E training. We cannot even do D+E procedures at our hospital, even for a miscarriage.*

Notably, residents in states with total abortion bans must go out of state to receive any abortion training at all. Even in states where abortion is not banned, residents have to seek further abortion education opportunities. For instance, one respondent in our sample stated that while she received training in-state, she went out-of-state to learn dilation and evacuation. Out-of-state training opportunities may be challenging for some residents to access, as there are limited partnerships between programs.[14] Furthermore, some residents may face insurmountable hurdles imposed by the state or their program, or other barriers that make it difficult for residents, such as needing new state licenses, coordinating travel and housing, facing financial constraints, or family commitments.[15]

Residents are considering state abortion policy while deciding where to live post-residency, though other factors prevail. Most survey respondents who knew where they were moving after residency were moving to states where abortion is not banned.

Since the *Dobbs* decision, researchers have studied how state abortion policies may shape the nationwide geographic distribution of medical professionals as medical students apply for residency programs, residents and fellows of all specialties think about where to live after residency, and practicing physicians contemplate staying or moving out of states with total abortion bans or severe

[14] Turk, Jema K., et al. "Out-of-State Abortion Training Rotations for Residents in States with Limited Access." *O & G Open*, vol. 1, no. 2, June 2024, p. 017, https://doi.org/10.1097/og9.0000000000000017.

[15] Id.; Pasha, A. S., Breitkopf, D., & Glaser, G. (2023). The Impact of Dobbs on US Graduate Medical Education. *Journal of Law, Medicine & Ethics*, *51*(3), 497–503. https://doi.org/10.1017/jme.2023.89

restrictions.[16] Studies have documented that abortion bans are impacting residents wanting to train in particular states, as well as residents' general lack of desire to work in a state with an abortion ban or severe restrictions. A survey among medical students, residents, fellows, and practicing physicians found that most respondents (82.3%) preferred to apply to train or work in states that protected abortion access, and 76.4% of respondents indicated that they would not apply to states that had legal consequences for providing abortions.[17] Similarly, a survey conducted among Ryan Residency residents found that 17.6% of residents changed the location of where they planned to practice or complete their fellowship due to the *Dobbs* decision, with residents living in abortion-restrictive states being 8 times as likely to change their plans due to the *Dobbs* decision.[18] Many respondents also indicated that they would not live in states with abortion restrictions, and among respondents pursuing a fellowship after residency, many indicated that they did not rank or ranked programs lower if they were in restrictive states.[19]

Similarly, some early reports have shown that post-*Dobbs* abortion bans and restrictions are impacting practicing physicians, causing them to leave ban and restrictive states or making them want to leave, and a growing trend of hospitals closing hospital maternity wards given provider shortages. One study in Idaho, for example, found that in the 15 months after the total abortion ban went into effect, 22% of practicing obstetricians left the state, and two hospitals closed due to their inability to recruit obstetricians.[20] Texas, another state with a total ban, has also experienced attrition as physicians have left the state.[21]

However, there have also been empirical studies that have found no significant changes in where OB-GYNs are practicing and where residents are enrolling in programs after the *Dobbs* decision.[22]

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[16] Traub, A., Aaron, B., Kawwass, J., King, L., Mermin-Bunnell, K., & Wang, K. (2023). The Dobbs Decision and Its Geographical Effect on Future Physician Training [ID: 1380882]. *Obstetrics & Gynecology*, *141*(5S), 100S. https://doi.org/10.1097/01.AOG.0000931232.83495.32; Bernstein, S. A., Levy, M. S., McNeilly, S., Fishbach, S., Jain, S., Gold, J. A., & Arora, V. M. (2023). Practice Location Preferences in Response to State Abortion Restrictions Among Physicians and Trainees on Social Media. *Journal of General Internal Medicine*, *38*(10), 2419–2423. https://doi.org/10.1007/s11606-023-08096-5; Sabbath, E. L., McKetchnie, S. M., Arora, K. S., & Buchbinder, M. (2024). US Obstetrician-Gynecologists' Perceived Impacts of Post–Dobbs v Jackson State Abortion Bans. *JAMA Network Open*, *7*(1), e2352109. https://doi.org/10.1001/jamanetworkopen.2023.52109

[17] Bernstein, S. A., Levy, M. S., McNeilly, S., Fishbach, S., Jain, S., Gold, J. A., & Arora, V. M. (2023). Practice Location Preferences in Response to State Abortion Restrictions Among Physicians and Trainees on Social Media. *Journal of General Internal Medicine*, *38*(10), 2419–2423. https://doi.org/10.1007/s11606-023-08096-5

[18] Woodcock, A. L., Carter, G., Baayd, J., Turok, D. K., Turk, J., Sanders, J. N., Pangasa, M., Gawron, L. M., & Kaiser, J. E. (2023). Effects of the Dobbs v Jackson Women's Health Organization Decision on Obstetrics and Gynecology Graduating Residents' Practice Plans. *Obstetrics & Gynecology*, *142*(5), 1105. https://doi.org/10.1097/AOG.0000000000005383

[19] Id.

[20] Idaho Physician Well-Being Action Collaborative, & Idaho Coalition For Safe Healthcare. (2024). *A Post Roe Idaho.* https://issuu.com/idahocsh/docs/final_post_roe_idaho_data_report_feb._2024?fr=xKAE9_zU1NQ

[21] Tobin-Tyler, E., Gruppuso, P. A., & Adashi, E. Y. (2023). *A Year After* Dobbs*: Diminishing Access To Obstetric-Gynecologic And Maternal-Fetal Care*. https://doi.org/10.1377/forefront.20230803.340506

[22] Staiger, B., Bolotnyy, V., Borrero, S., Rossin-Slater, M., Van Parys, J., & Myers, C. (2025). Obstetrician and Gynecologist Physicians' Practice Locations Before and After the Dobbs Decision. *JAMA Network Open*, *8*(4), e251608. https://doi.org/10.1001/

This may not be a reflection of the impact of state abortion policy but rather the reality that for many providers, relocation is a difficult and time-consuming process, and there are factors that stop them from moving, including job availability, state licensing, commitment to their community, and family obligations.[23] While the studies[24] observed no disproportionate changes in the OB-GYN practice locations and number of enrollments into new states, both study teams call for the continued monitoring of workforce movement and impacts.[25]

Our study suggests that some residents are not choosing or prefer not to work in states with total bans or severe gestational restrictions. We observed that 81.8% of respondents who knew they were moving post-residency are moving to states where abortion is not banned, with most of them moving to states that have bans after 18 weeks, viability bans, or no bans. Respondents who completed their residency training in states with bans after 18 weeks, viability bans, or no bans are primarily moving to states with similar policies, rarely moving to states that have bans before 18 weeks. More residents practicing in total ban environments indicated they are leaving the state after residency than residents working in any other policy environment.

While respondents are considering various factors while choosing where to live, such as professional opportunities like fellowship location, or being closer to family members, many respondents in our sample made it clear that abortion policy is an important factor in their decision-making process, and for 13%, it was the most important factor. For one resident moving out of Indiana, the state's total ban on abortion further solidified her choice to move out of state after completing her residency.

> *When I started residency in Indiana, I wasn't necessarily planning to stay for personal/family reasons. Now, with the abortion restrictions, I definitely will not be staying.*

Our study and other studies suggest the need to continue to monitor the geographic distribution of future and current OB-GYNs as the ramifications of restrictive abortion policies continue to unfold. Further research is needed to explore whether residents leave or refuse to move to states with abortion bans. Additionally, a recently published commentary on studies assessing workforce impacts

jamanetworkopen.2025.1608; Strasser, J., Schenk, E., Luo, Q., & Chen, C. (2024). Lower obstetrician and gynecologist (OBGYN) supply in abortion-ban states, despite minimal state-level changes in the 2 years post-Dobbs. *Health Affairs Scholar*, *2*(12), qxae162. https://doi.org/10.1093/haschl/qxae162

[23] Phillips, R. L., Dodoo, M. S., Petterson, S., Xierali, I., Bazemore, A., Teevan, B., Bennett, K., Legagneur, C., Rudd, J., & Phillips, J. (2009). *Specialty and Geographic Distribution of Physician Workforce: What Influences Medical Student & Resident Choices*. Robert Graham Center. https://www.graham-center.org/dam/rgc/documents/publications-reports/monographs-books/Specialty-geography-compressed.pdf

[24] Staiger, B., Bolotnyy, V., Borrero, S., Rossin-Slater, M., Van Parys, J., & Myers, C. (2025). Obstetrician and Gynecologist Physicians' Practice Locations Before and After the Dobbs Decision. *JAMA Network Open*, *8*(4), e251608. https://doi.org/10.1001/jamanetworkopen.2025.1608; Strasser, J., Schenk, E., Luo, Q., & Chen, C. (2024). Lower obstetrician and gynecologist (OBGYN) supply in abortion-ban states, despite minimal state-level changes in the 2 years post-Dobbs. *Health Affairs Scholar*, *2*(12), qxae162. https://doi.org/10.1093/haschl/qxae162

[25] Id.

calls for further research on residency training location and people earlier in their medical career. These are crucial points in their professional and personal careers, as many residents will stay in the state where they completed their residency.[26] Regardless, examining the future OB-GYN workforce is crucial as a loss of doctors leads to decreased access to all reproductive health care needs and options. When providers leave a state due to abortion bans or severe restrictions, it not only reduces the number of abortion providers but can also result in fewer maternity care providers. This can exacerbate already deeply harmful maternity care deserts.[27] Increased attrition of OB-GYNs may, thus, also exacerbate maternal and infant mortality.[28]

Residents expressed fear and concern over the potential impact of abortion policies on their careers and future patients.

Many residents are concerned about the impacts of abortion policies on their careers.

OB-GYN residents, especially those who will be practicing in states with total bans or gestational bans up to 18 weeks, indicated that they fear facing criminalization, professional discipline, legal ramifications, and conflict between complying with state laws and their medical ethical obligations due to their states' abortion policies. One respondent in our sample further described this tension providers are feeling this way: "We take an oath to do no harm, and the state governments in other states are forcing physicians to forgo that oath to not get prosecuted."

Our findings are consistent with studies since *Dobbs* that have found residents and practicing physicians fear criminalization, incarceration, or loss of medical licenses due to state laws.[29] These fears often cause moral distress among residents as they must weigh between providing care to their patients and worrying about what could happen to themselves and their families if they violate state laws.[30]

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[26] Liberty, A., Colwill, A., & Darney, B. G. (2025). How Should We Study and Interpret Workforce Impacts of Abortion Restrictions? *JAMA Network Open*, *8*(4), e256136. https://doi.org/10.1001/jamanetworkopen.2025.6136

[27] Kolb, K. (2024, October 22). *Maternity Care Providers and Trainees Are Leaving States with Abortion Restrictions, Further Widening Gaps in Care*. The Commonwealth Fund. https://doi.org/10.26099/pds5-qf29; Stoneburner, A., Lucas, R., Fontenot, J., Brigance, C., Jones, E., & DeMaria, A. L. (2024). *Nowhere to Go: Maternity Care Deserts Across the US* (No. 4). March of Dimes. https://www.marchofdimes.org/peristats/assets/s3/reports/2024-Maternity-Care-Report.pdf

[28] Tobin-Tyler, E., Gruppuso, P. A., & Adashi, E. Y. (2023). *A Year After* Dobbs*: Diminishing Access To Obstetric-Gynecologic And Maternal-Fetal Care*. https://doi.org/10.1377/forefront.20230803.340506; Kolb, K. (2024, October 22). *Maternity Care Providers and Trainees Are Leaving States with Abortion Restrictions, Further Widening Gaps in Care*. The Commonwealth Fund. https://doi.org/10.26099/pds5-qf29

[29] Turk, J. K., Claymore, E., Dawoodbhoy, N., & Steinauer, J. E. (2024). "I Went Into This Field to Empower Other People, and I Feel Like I Failed": Residents Experience Moral Distress Post-Dobbs. *Journal of Graduate Medical Education*, *16*(3), 271–279. https://doi.org/10.4300/JGME-D-23-00582.1; Sabbath, E. L., McKetchnie, S. M., Arora, K. S., & Buchbinder, M. (2024). US Obstetrician-Gynecologists' Perceived Impacts of Post–Dobbs v Jackson State Abortion Bans. *JAMA Network Open*, *7*(1), e2352109. https://doi.org/10.1001/jamanetworkopen.2023.52109; Frederiksen, B., Ranji, U., Gomez, I., & Published, A. S. (2023, June 21). A National Survey of OBGYNs' Experiences After Dobbs. *KFF*. https://www.kff.org/womens-health-policy/report/a-national-survey-of-obgyns-experiences-after-dobbs/

[30] IBID.

Residents are concerned about the impacts of abortion policies on their ability to provide care to patients and their patients' reproductive autonomy.

Respondents intending to practice in states with total bans or bans up to 18 weeks are more concerned that abortion policies will impede their ability to provide care and that they will face conflict while trying to comply with state policies and medical ethical standards, compared to respondents living in states with no abortion restrictions, viability bans or bans after 18 weeks. Many respondents also described their concern over abortion restrictions as they can impede their ability to provide care, result in delays, and negatively impact maternal health. For example, a resident who will be living in Virginia said, "Abortion restrictions create unnecessary logistical barriers that delay and harm patient care for important medical conditions." These concerns are well-founded. Studies that have assessed the impacts of post-Dobbs state abortion bans have found that practicing OB-GYNs report clinical impacts such as delays in patient care, restrictions on how they counsel patients on pregnancy options, and inability to provide appropriate care or referrals.[31] Researchers at Advancing New Standards in Reproductive Health (ANSIRH) at UCSF have noted extreme delays in pregnancy termination care, delays to other health issues such as chemotherapy, IUD removal, and elective gynecological surgeries, and incidents where abortion bans required providers to deviate from the standard of care.[32]

In open-text responses, some residents (n=12) also discussed feeling concern for their patients' rights and expressed wanting to live in states that protect their patients' rights. One respondent who will be practicing as a urogynecologist said: "As a urogyn, I won't be performing abortions or providing general GYN care to younger patients. However, I think reproductive autonomy is majorly important and would want to practice in a state that safely supports patients in making these decisions." Stripping away reproductive autonomy is harmful not only because it denies people of rights, dignity, and health care to which they should be able to access, but because it also erodes trust in the health care system, especially among communities that have historically faced coercion and mistreatment by the medical field.[33]

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[31] Sabbath, E. L., McKetchnie, S. M., Arora, K. S., & Buchbinder, M. (2024). US Obstetrician-Gynecologists' Perceived Impacts of Post–Dobbs v Jackson State Abortion Bans. *JAMA Network Open*, *7*(1), e2352109. https://doi.org/10.1001/jamanetworkopen.2023.52109; Cutler, A. S., Hale, C. M., Bennett, E., Jacques, L., & Higgins, J. (2025). Experiences of Obstetrician-Gynecologists Providing Pregnancy Care After Dobbs. *JAMA Network Open*, *8*(3), e252498. https://doi.org/10.1001/jamanetworkopen.2025.2498

[32] Grossman, D., Joffe, C., Kaller, S., Kimport, K., Kinsley, E. T., Morris, N., & White, K. (2024). *Care Post-Roe: Documenting cases of poor-quality care since the Dobbs Decision*. Advancing New Standards in Reproductive Health (ANSIRH), University of California, San Francisco (UCSF). https://www.ansirh.org/sites/default/files/2024-09/ANSIRH%20Care%20Post-Roe%20Report%209.04.24_FINAL%20EMBARGOED_0.pdf

[33] Heisler, M., Cox-Touré, T., & Kaufman, R. (2023). US abortion bans violate patients' right to information and to health. *The Lancet*, *401*(10387), 1480–1482. https://doi.org/10.1016/S0140-6736(23)00808-5; Center for Reproductive Rights, Lift Louisiana, Physicians for Human Rights, & Reproductive Health Impact. (2024). *Criminalized Care: How Louisiana's Abortion Bans Endanger Patients and Clinicians*. https://reproductiverights.org/wp-content/uploads/2024/03/Criminalized-Care-Report-Updated-as-of-3-15-24.pdf

Residents support multiple avenues for increased policy protections.

While some states have passed laws that have enacted bans and restrictions on abortions, many states have enacted constitutional amendments to enshrine the freedom to give and get care into law and have passed other specific types of laws and policies meant to protect providers' ability to provide abortion care. To our knowledge, no other study has surveyed 3rd and 4th year residents nationwide on their views on whether any array of positive policies would make them feel safer in their practice, and no empirical studies have asked about newer protective policies like shield laws.

Every survey respondent indicated that laws that specifically protect providers from harassment and physical harm would make them feel safer in their practice. State law in this area is increasingly important now that the federal government has announced its intention to severely curtail enforcement of the federal law that protects abortion providers from violence, harassment, and property damage,[34] coupled with the chilling recent pardons of dozens of people who had been convicted under the federal law for blocking access to and temporarily shutting down abortion clinics under federal law.[35]

Every survey respondent also indicated that certain aspects of state shield laws made them feel safer while providing abortion care. Shield laws are meant to protect people accessing and providing abortion care that is legal in that state from the reach of states that have civil, criminal, and professional consequences for abortion care. As of June 2025, through legislation or executive order, 22 states and Washington, D.C., have shield law protections.[36] Eight of these states' shield laws explicitly protect the provision of care regardless of patient location, which includes telehealth provision.[37] The shield laws are now being tested in the courts for the first time as legal battles unfold in New York, where New York is using its shield laws to protect a New York-based doctor from both a Texas civil action and a Louisiana criminal indictment related to abortion care legal in New York.[38] Every single survey respondent indicated that particular shield law protections, such as protections from professional discipline and prohibitions on the disclosure of sensitive medical information or records in out-of-state investigations, would make them feel safer in their practice. As many as 99.2% indicated that other types of state shield laws and federal data privacy provisions would make them feel safer in their practice.

[34] U.S. Department of Justice. (2025, January 25). Memorandum for Kathleen Wolfe, Supervisory Official of the Civil Rights Division. https://www.justice.gov/media/1386461/dl?inline

[35] Stengle, J. (2025, February 14). *New York doctor is fined in Texas, charged in Louisiana over abortion pills in tests of shield laws*. AP News. https://apnews.com/article/abortion-doctor-maggie-carpenter-pills-847112cde026e29333c3481310593582

[36] Center on Reproductive Health, Law, and Policy. (2025, June). *Shield Laws for Reproductive and Gender-Affirming Health Care: A State Law Guide | UCLA Law*. https://law.ucla.edu/academics/centers/center-reproductive-health-law-and-policy/shield-laws-reproductive-and-gender-affirming-health-care-state-law-guide

[37] Id.

[38] Stengle, J. (2025, February 14). New York doctor is fined in Texas, charged in Louisiana over abortion pills in tests of shield laws. *AP News*. https://apnews.com/article/abortion-doctor-maggie-carpenter-pills-847112cde026e29333c3481310593582; Belluck, P. (2025, March 27). New York County Clerk Blocks Texas Court Filing Against Doctor Over Abortion Pills. *The New York Times*. https://www.nytimes.com/2025/03/27/health/new-york-texas-abortion-shield-law.html

Almost all respondents (99.2%) indicated that a state having a protected constitutional right to abortion would make them feel safer while providing abortion care. According to the Center on Reproductive Rights, at the time of the *Dobbs* decision, there were 11 states whose high courts held that their state constitution protected the right to abortion.[39] Additionally, since the *Dobbs* decision, there has been a rise in efforts to pass state constitutional amendments, either legislatively referred or citizen-initiated, meant to protect or expand the right to abortion. As of November 6, 2024, 10 states have enacted constitutional amendment measures that affirm the right to abortion.[40] Additionally, all 10 of these amendments were passed via ballot initiative by the majority of voters.

The vast majority of respondents indicated that having "no state restrictions on abortion" would improve their sense of safety while providing care. States restrict abortion through numerous approaches: gestational bans, building requirements, waiting periods, and mandatory counseling sessions, by way of just a few examples. As of September 2024, only nine states and Washington, D.C. do not impose any gestational bans on abortion.

Similarly, the vast majority of respondents indicated that a lack of hospital restrictions would make them feel safer while providing care. Hospital restrictions can impose limits on care that go beyond state law. Catholic hospitals typically have the most restrictive abortion policies since they typically operate under the Ethical and Religious Directives for Catholic Health Care Services, which severely restrict or prohibit contraception, all abortions, and other reproductive health services.[41] These directives often result in providers denying or delaying care even when doing so conflicts with state protections.[42] Like providers practicing in total ban states, providers working at Catholic hospitals will not provide emergency abortion services if there is a fetal heartbeat detected and will wait until the pregnant person's life is in danger to act, or will refer them to other hospitals.[43] However, non-religious hospitals can and sometimes do impose restrictions on care as well, such as extra procedural hurdles before care can be provided, stricter gestational limits than state law permits, or non-compete clauses that restrict providers' ability to moonlight as abortion providers elsewhere.[44]

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[39] Center for Reproductive Rights. (2022). *State Constitutions and Abortion Rights: Building protections for reproductive autonomy*. https://reproductiverights.org/wp-content/uploads/2022/07/State-Constitutions-Report-July-2022.pdf

[40] KFF. (2024, November 6). Ballot Tracker: Outcome of Abortion-Related State Constitutional Amendment Measures in the 2024 Election. *KFF*. https://www.kff.org/womens-health-policy/dashboard/ballot-tracker-status-of-abortion-related-state-constitutional-amendment-measures/; Felix, M., Sobel, L., & Published, A. S. (2024, February 9). Addressing Abortion Access through State Ballot Initiatives. *KFF*. https://www.kff.org/womens-health-policy/issue-brief/addressing-abortion-access-through-state-ballot-initiatives/

[41] United States Conference of Catholic Bishops (USCCB).(2018). Ethical and Religious Directives for Catholic Health Care Services, Sixth Edition. Washington, DC: USCCB; *See also* Martin, N. (2024, April 24). Emergency abortion care is before the Supreme Court—and blue states should be very worried. *Mother Jones*. https://www.motherjones.com/politics/2024/04/emergency-abortion-care-is-before-the-supreme-court-and-blue-states-should-be-very-worried/

[42] Id.

[43] Hasselbacher, L. A., Hebert, L. E., Liu, Y., & Stulberg, D. B. (2020). "My Hands Are Tied": Abortion Restrictions and Providers' Experiences in Religious and Nonreligious Health Care Systems. *Perspectives on Sexual and Reproductive Health*, *52*(2), 107–115. https://doi.org/10.1363/psrh.12148; Martin, N. (2024, April 24). Emergency abortion care is before the Supreme Court—and blue states should be very worried. *Mother Jones*. https://www.motherjones.com/politics/2024/04/emergency-abortion-care-is-before-the-supreme-court-and-blue-states-should-be-very-worried/

[44] Rollison, J., Miner, S. A., & Predmore, Z. (2025). Barriers to providing procedural abortion care among trained clinicians: An evaluation

Notably, 30% fewer respondents indicated that health exceptions would make them feel safer while providing care compared to other policies we asked about. This was unsurprising considering health exceptions to abortion bans are written by legislators, not health care providers, so they often do not map onto the realities of medical practice. Abortion ban exceptions—whether for health, emergency, rape, or incest scenarios—typically contain vague, non-medical language that does not provide clarity or certainty for medical professionals.[45] Thus, it's unsurprising that residents surveyed found less comfort in state policy that enshrines health exceptions into an abortion ban—which still comes with penalties if they interpret the exception incorrectly[46]—than other forms of state policy protections we asked about. Indeed, many understand abortion ban exceptions—written by anti-abortion politicians—to be intentionally unhelpful and unworkable.[47]

LIMITATIONS

There are limitations to this analysis. Of our 152 respondents, 77.6% of them are from states that have abortion bans after 18 weeks, at viability, or have no bans. Therefore, the opinions of residents living in more restrictive environments (total ban or ban before 18 weeks) are underrepresented. While the survey was anonymous, residents living in states with total bans or bans before 18 weeks may still have had concerns over participating in a survey that studies criminalized care. Additionally, there are also sampling bias concerns, as respondents who chose to participate in this study may have felt more strongly about abortion restrictions compared to those who did not participate.

The sample size is also a limitation of this study. We approximate that there were approximately 2939 third- and fourth-year residents at the time of the survey.[48] Our sample, therefore, consists of 5.1% of our target population. Thus, these findings may not encompass all OB-GYN residents' experiences, concerns, and fears due to state abortion restrictions.

Our study was conducted at a single point of data collection. Feelings may have shifted since the current presidential administration went into power, or other events such as the passage of additional state constitutional amendments codifying abortion rights in 2024.

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of an abortion training program. *Contraception*, 110901. https://doi.org/10.1016/j.contraception.2025.110901;Hasselbacher, L. A., Hebert, L. E., Liu, Y., & Stulberg, D. B. (2020). "My Hands Are Tied": Abortion Restrictions and Providers' Experiences in Religious and Nonreligious Health Care Systems. *Perspectives on Sexual and Reproductive Health*, *52*(2), 107–115. https://doi.org/10.1363/psrh.12148

[45] Felix, M., Sobel, L., & Salganicoff, A. (2024, June 6). *A Review of Exceptions in State Abortion Bans: Implications for the provision of abortion services | KFF*. KFF. https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/

[46] Reporter, G. S. (2024, June 7). US state abortion ban exemptions aren't vague by accident. Uncertainty is the point. *The Guardian*. https://www.theguardian.com/commentisfree/article/2024/jun/07/state-abortion-ban-exemptions-uncertainty

[47] Nash, E. (2022, December 13). *Focusing on "Exceptions" misses the true harm of abortion bans - Ms. magazine*. Ms. Magazine. https://msmagazine.com/2022/12/13/abortion-ban-exceptions-rape-incest-health-life/; Felix, M., Sobel, L., & Salganicoff, A. (2024, June 6). *A Review of Exceptions in State Abortion Bans: Implications for the provision of abortion services | KFF*. KFF. https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/

[48] Obstetrics and gynecology Residency Programs. (2025). Residencyprogramslist.com. https://www.residencyprogramslist.com/obstetrics-and-gynecology

This study also attempted to collect data via a mixed methods design using a limited number of open-text response questions. If we could ask more qualitative questions or interview participants after the survey, we may have gotten further qualitative reasons for why we observed the trends we did.

CONCLUSION

This study adds to the growing literature on the impacts of state abortion policies on providers, while focusing on the population whose personal and professional actions will define the obstetric care options for generations to come. More evidence would be needed to confirm that total abortion bans and very restrictive gestational policies drive OB-GYN residents out of state. However, this study supports the notion that residents consider state and environmental restrictions in defining their professional path, which includes future places of residence. State policies are also contributing to residents' concerns over their patients' health and rights, and their risk tolerance for professional discipline and criminalization. While there are policies that are harming providers, many states have passed policies intended to protect them, though restrictions from hospital systems and non-governmental institutions continue to obstruct the standard of care.

SOME RECOMMENDATIONS FOR FUTURE RESEARCH AND POLICY

Further Research Needed

- Further study of OB-GYN location decisions over time.
    - Continue to monitor and research where OB-GYN residents live and practice after residency, with a larger sample and over time. The effects on the workforce will continue to develop as time passes. It is necessary to continue to monitor where providers move and do not move, as access to health care may become further fragmented as time passes. Continue to monitor the supply of providers in abortion-restrictive states and whether negative health impacts and/or growing care deserts are occurring. Potential questions to consider are 1) what is providers' willingness to move and practice in ban states; 2) what health impacts are occurring within these states?
        - Track new providers entering the states' workforce or leaving the workforce (whether it be because they are moving out of state, retiring, or changing their profession)
        - Understand what other areas of care, besides abortion, are being affected by abortion bans and provider shortages, care deserts, or legal restrictions on which types of providers can provide full-spectrum pregnancy care.
- Study whether an increase in state enforcement of abortion and other laws to criminalize and punish doctors is impacting or altering provider location decisions and workforce impacts. Texas and Louisiana, two total ban states, have tried to punish a New York state provider for providing legal care within New York. Such actions may become more common or bring additional concerns and challenges for providers and may also impact providers' decision-making on where and what to practice and their level of concern while providing care.
- Study impacts of state abortion policy on a wider array of health professionals who provide and support abortion, pregnancy health, birth, and reproductive care. OB-GYNS are a vital part

of the workforce supporting pregnancy and reproductive health care, but they are not the only professionals who provide that care. From fetal medicine specialists to family practitioners, to emergency medicine practitioners, to midwives, nurse practitioners, and doulas—a wide array of health professionals are potentially negatively impacted directly in their practice by abortion bans and restrictions, and those impacts should be studied as well. Moreover, all medical professionals who can get pregnant are impacted by state abortion policies, regardless of whether they provide pregnancy-related care, and thus, wider impacts on the health professions should be studied.

- Conduct further studies on specific policy interventions that providers find most protective and helpful.

SOME RECOMMENDATIONS FOR POLICY MAKERS AND ENFORCEMENT BODIES

Education

- Ensure every medical student and resident receives abortion training, and ideally, ensure all students and residents going into health professions receive that training.
    - This includes using all statutory, regulatory, licensing, credentialing, and accrediting powers available to require institutions and programs to provide expanded abortion care education to undergraduate medical students, OB-GYN residents, and other medical residents.
    - This study focuses on OB-GYN residents, but residents in many other practice areas outside of OB-GYN need or wish to have training in abortion as well. These include aspiring clinicians in family medicine, emergency medicine, anesthesiology, pediatrics, and advanced practice medicine. The same abortion bans and restrictions that impact OB-GYN residents also affect these residents, whose training needs include abortion care, obstetric care, miscarriage management, and ectopic pregnancy care.
    - Undergraduate medical education is an underutilized opportunity to expand exposure to a range of pregnancy management skills, including abortion. Research has found that exposure to abortion education for undergraduate medical students is associated with an increased desire to provide clinical abortion care in the future.[49]
- Expand training opportunities and address barriers to training for OB-GYN residents in states with abortion bans and restrictions.
    - Encourage ACGME to enforce its abortion training mandate for accredited OB-GYN programs. At the same time, determine how best to "thread the needle" between the importance

[49] Farmer LE, Clare CA, Liberatos P, Kim H, Shi Q. Exploring barriers to abortion access: medical students' intentions, attitudes and exposure to abortion. Sex Reprod Healthc 2022;34:100790. doi: 10.1016/j.srhc.2022.100790

of enforcing important training requirements with the risk that sanctioning or defunding programs in ban states would exacerbate pre-existing maternity care deserts.

- Explore opportunities to host greater numbers of traveling OB-GYN residents in access states.
- Explore new opportunities to launch out-of-state training for non-OB-GYN residents in ban states to travel to access states.
- Ensure that ban states or institutions in ban states (and not residents themselves) bear the costs of traveling and living out-of-state for residency training.
- Ensure that ban states or institutions in ban states fund the increased teaching, legal, and administrative costs of hosting traveling residents currently borne by host institutions.
- Eliminate restrictions on out-of-state travel for abortion training rotations imposed on state school residents in certain states, which restrict travel even during residents' personal time, using their own funds.
- Use strategies, including litigation, that would force states to allow travel for abortion training while keeping programs open.

Health Policy

- States should end all abortion bans and restrictions.
  - Bans and restrictions on abortion of all kinds—not just total bans—impact a health professional's practice and, if they are a person who can get pregnant while living and working in a state, their personal or family's health and well-being as well.
  - Moreover, health exceptions do not work to sufficiently protect patient safety or a provider's ability to provide care consistent with standards of care and ethical obligations. These health exceptions are often unclear and unworkable. OB-GYN residents in our survey have indicated that these types of policies do not necessarily make them feel safer while providing care.
- States should continue to enact policies that make residents feel safer while providing care.
  - Policies that would make residents feel safer are policies that would provide protections from harassment or physical harm, professional discipline for providing legal care, disclosure of sensitive medical information, disclosure of sensitive reproductive health information to third parties, out-of-state investigations or legal actions, and a constitutional right to abortion.
  - 100% of our respondents who may provide abortions in their career indicated that shield law protections from professional discipline and protections against disclosure of medical information in response to out-of-state investigations would make them feel safer while providing care. While 18 states and Washington, D.C., have protections against professional discipline, only 12 states have specific shield law protections against disclosure of medical information by providers, plans, or insurers.[50] States seeking to adopt policies that would

[50] Center on Reproductive Health, Law, and Policy. (2025, February). *Shield Laws for Reproductive and Gender-Affirming Health Care:*

make residents feel safer while providing care should enact shield law protections for the privacy of medical information. States should further consider laws that specifically protect against the sharing of medical information related to sensitive services such as reproductive and gender-affirming care through health information exchanges or electronic health networks across state lines. Laws in California and Maryland offer examples of these specific protections.[51] These state law protections may become increasingly important as the future of federal privacy protections related to medical information, including HIPAA's privacy rules, grows more uncertain.

- 99.2% of respondents indicated that shield law protections against extradition, arrest, and witness summons in out-of-state investigations, lawsuits, and prosecutions for providing lawful care would make them feel safer providing care. All states with shield laws have some form of protection against out-of-state investigations and prosecutions, but these protections vary in breadth and strength. For example, only eight states explicitly protect the provision of care regardless of patient location, which includes telehealth provision. States lacking such explicit protection could expand their shield law protections to provide further assurance to residents.

- Ensure strong strategic defenses for protective policies via Attorneys General, and legal resources such as Abortion Defense Network and SoCal LARJ.

  - To be effective, protective policies require enforcement. As seen in New York—with the New York Governor's and Attorney General's refusal of Louisiana's extradition request and notice to New York state courts not to enforce the Texas civil judgment—state officials' commitment to enforcing the shield laws shapes the efficacy of these laws. States should ensure that state and other affected actors are aware of their obligations under their protective policies and shield laws, including through bulletins and trainings.[52]

  - Providers may need additional legal support to understand and avail themselves of protective laws. Supporting existing national and local legal resources designed to protect reproductive rights, including the Abortion Defense Network and the Southern California Legal Alliance for Reproductive Justice (SoCal LARJ),[53] allows providers to access legal advice and representation while navigating an increasingly complex national landscape with growing risks.

A State Law Guide | UCLA Law. https://law.ucla.edu/academics/centers/center-reproductive-health-law-and-policy/shield-laws-reproductive-and-gender-affirming-health-care-state-law-guide

[51] Cal. Civ. Code § 56.101; Md. Code Health-Gen. § 4-302.5.

[52] For example, California's Attorney General has issued letters to pharmacies and health data companies reminding them of their obligations not to disclose individuals' medical information to law enforcement without a warrant in most circumstances under the state's shield laws. *Attorney General Bonta Reminds Pharmacies and Health Data Companies of Their Obligations Under New California Law Governing Protected Health Information* (June 26, 2024), https://oag.ca.gov/news/press-releases/attorney-general-bonta-reminds-pharmacies-and-health-data-companies-their.

[53] Center on Reproductive Health, Law, and Policy. (n.d.). *Southern California Legal Alliance for Reproductive Justice: UCLA law*. UCLA School of Law. https://law.ucla.edu/academics/centers/center-reproductive-health-law-and-policy/southern-california-legal-alliance-reproductive-justice

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ABOUT THE CENTER ON REPRODUCTIVE HEALTH, LAW, AND POLICY (CRHLP)

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APPENDICES

METHODS

Between March 18, 2024, and June 8, 2024, the study team surveyed third- and fourth-year OB-GYN residents via Microsoft Forms via convenience sampling. The survey instrument was distributed via email to OB-GYN residency program directors, managers, and coordinators of 222 ACGME-accredited OB-GYN programs listed on ACOG's website. Emails for program directors, managers, and coordinators were obtained via each program's website. For 79 programs, a program director and coordinator/manager were emailed, for 121 programs, a program manager or coordinator was emailed, and for 22 programs, the program email was emailed as no other contact information was provided. 22 program personnel confirmed that they sent out the survey, and two programs were unable to send out the survey due to being newer programs and not having third- or fourth-year residents. Based on the number of residency personnel who confirmed sending out the survey to their residents, we estimate that at least 279 residents received the email. Researchers disabled the options allowing respondents to submit multiple responses and for sharing personally identifiable information.

The survey collected demographic information, abortion training, post-residency plans, and influences on decisions made for post-training. Respondents were also asked to respond to a series of Likert scale questions concerning current levels of concern and fear, and potential policy protections for abortion and abortion providers. Respondents could provide more insights into their responses via open-ended questions. IRB exemption was provided by the University of California, Los Angeles Institutional Review Board.

Before analysis, the team categorized states into four categories based on the states' abortion policies as of June 2024: (1) total abortion ban, (2) up to 18 weeks of pregnancy, (3) after 18 weeks of pregnancy or at viability, and (4) no ban. For the categorization of individual states, see Table 2. While multiple options for categorization were considered, the final four categories used in this report were chosen based on Guttmacher Institute's categorization of states on their *State Bans on Abortion Throughout Pregnancy* webpage to maintain consistency with the categorization of previous studies with a similar research topic.[54] The team also considered the final respondent sample compared to the estimated population of total third- and fourth-year residents to discern representativeness.

Univariate and Bivariate analyses were conducted using Stata 18. Some analysis was limited to respondents who knew where they would be living after residency (n=119) or respondents who did not choose the option "I do not plan on being an abortion provider" (n=124). Open-ended questions were analyzed using an inductive approach. Three team members thematically coded qualitative responses. The mixed methods survey design reflects a triangulation approach where both qualitative and quantitative questions were asked in the same phase.

[54] Guttmacher Institute. (2024, May 1). *State Bans on Abortion Throughout Pregnancy | Guttmacher Institute*. Guttmacher. https://www.guttmacher.org/state-policy/explore/state-policies-abortion-bans

TABLES

Table 1a. Demographic characteristics of third and fourth OB-GYN residents who completed the survey (n=152)

DEMOGRAPHICS	N (%)
YEAR OF RESIDENCY	
PGY-3	86 (56.6)
PGY-4	66 (43.4)
AGE, YEARS	
26-30	64 (42.1)
31-35	78 (51.32)
36-40	6 (3.95)
>40	4 (2.63)
GENDER	
Cis-gender female	139 (91.4)
Cis-gender male	13 (8.6)
SEXUAL ORIENTATION	
Straight/Heterosexual	129 (83.6)
Bisexual/pansexual	19 (12.5)
Gay/lesbian/queer	5 (3.3)
Prefer not to say	1 (0.7)
RACE/ETHNICITY	
White	93 (61.2)
Black or African American	9 (5.9)
Asian	18 (11.8)
Hispanic	12 (7.9)
Mixed race	18 (11.8)
Other	2 (1.32)
PARTICIPATION IN RYAN RESIDENCY PROGRAM	
Yes	107 (70.4)
No	45 (29.6)
PROFESSIONAL PLANS FOR AFTER RESIDENCY	
Academic generalist	43 (28.3)
Private practice generalist	49 (32.2)
Community hospital generalist	2 (1.3)
Complex Family Planning Fellowship	9 (5.9)
Other	49 (32.2)

Table 1b: Abortion training during residency and residents' anticipated provision of abortion and miscarriage management in their practice (n=152)

ABORTION TRAINING DURING RESIDENCY	N (%)
RECEIVED ABORTION TRAINING DURING RESIDENCY	
Yes	142 (93.4)
No	10 (6.6)
ABORTION TRAINING LOCATION (n=142)	
In-state	137 (96.5)
Out-of-state	5 (3.5)
ABORTION TRAINING BY GESTATIONAL PERIOD (n=142)	
Up to 13 weeks	6 (4.2)
14 to 20 weeks	36 (25.4)
Over 21 weeks	100 (70.4)
ABORTION TRAINING BY METHOD LEARNED (n=142)	
Dilation & curettage (D&C)	140 (98.6)
Dilation & evacuation (D&E)	134 (94.4)
Induction	6 (4.2)
Manual Vacuum Aspiration (MVA)	122 (85.9)
Medication Abortion	139 (97.9)
ANTICIPATED ABORTION PROVISION	
PROCEDURAL ABORTION	
Yes	102 (67.1)
No	26 (17.1)
Unsure	24 (15.8)
MEDICATION ABORTION	
Yes	105 (69.1)
No	24 (15.8)
Unsure	23 (15.1)
ANTICIPATED MISCARRIAGE MANAGEMENT	
PROCEDURAL MISCARRIAGE MANAGEMENT	
Yes	133 (87.5)
No	9 (5.9)
Unsure	10 (6.6)
MEDICATION MISCARRIAGE MANAGEMENT	
Yes	133 (87.5)
No	9 (5.9)
Unsure	10 (6.6)

Table 2. Abortion Bans and Restrictions Based on Gestation*

ABORTION POLICY	STATES
Total ban	Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, South Dakota, Tennessee, Texas, West Virginia
Up to 18 weeks of pregnancy	Arizona, Florida, Georgia, Nebraska, North Carolina, South Carolina, Utah
After 18 weeks of pregnancy or at viability	California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kansas, Maine, Massachusetts, Montana, Nevada, New Hampshire, New York, North Dakota, Ohio, Puerto Rico, Pennsylvania, Rhode Island, Virginia, Washington, Wisconsin, Wyoming
No ban	Alaska, Colorado, District of Columbia, Maryland, Michigan, Minnesota, New Jersey, New Mexico, Oregon, Vermont

Note: *Since June 2024, multiple states have had changes in their abortion policies, with some becoming more restrictive and others becoming more expansive.

Table 3. States where residents are deciding to stay and where residents are moving to after residency

STATES WHERE RESIDENTS ARE COMPLETING THEIR RESIDENCY (N=152)	N (%)
Total ban	19 (12.5)
Up to 18 weeks of pregnancy	15 (9.9)
After 18 weeks of pregnancy or viability	97 (63.8)
No ban	21 (13.8)
STATES WHERE RESIDENTS ARE STAYING AFTER RESIDENCY (n=64)	
Total ban	5 (7.8)
Up to 18 weeks of pregnancy	4 (6.3)
After 18 weeks of pregnancy or at viability	47 (73.4)
No ban	8 (12.5)
STATES WHERE RESIDENTS ARE MOVING TO AFTER RESIDENCY (n=60)	
Total ban	10 (16.7)
Up to 18 weeks of pregnancy	14 (23.3)
After 18 weeks of pregnancy or at viability	22 (36.7)
No ban	9 (15.0)
Unsure	5 (8.3)