

**Where have all the OBGYNs gone? An investigation into the effect of abortion restrictions  
on availability of women's health providers**

By

Carlie Famiglietti

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Faculty Advisor: Mary Lou Ciolfi, JD, MS

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### ***Abstract***

In 2022, the Supreme Court overturned its previous ruling in *Roe v. Wade*, effectively ending federal protections for abortion. Quickly after, many states enacted abortion restrictions or outright bans. Abortion bans are harmful public policies that are impacting the availability of OB-GYNs for many reasons, including the threat of criminal prosecution. This has led to a dearth of healthcare access for millions of women in 21 abortion-restricted states, as OB-GYNs move out of state and new medical residents choose to practice elsewhere. A literature review and interviews with three key informants were conducted to explore this issue. Key informant interviews focused on the post-*Dobbs* landscape for women's healthcare, the impact of reproductive care restrictions on healthcare providers and patients, and future prospects. Findings show that both practicing and resident OB-GYNs are choosing not to work or train in abortion-restricted states. Qualitative results revealed the psychological toll of abortion bans on all healthcare providers and widening socioeconomic disparities. Barriers to keeping OB-GYNs in state also include restrictions on their autonomy and threat of criminal liability. No agency or governmental organization has proposed a policy solution to this problem. Primary solutions have come from physician-led organizations. These groups are building coalitions to lobby state policymakers against abortion bans and campaign for ballot measures in favor of abortion rights. These findings have implications for the future of women's healthcare. If policymakers are unwilling to propose solutions and physician-led organizations are unsuccessful in their efforts, millions of women will lose access to routine gynecological care, not only access to abortion.

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## ***Introduction***

Since the 2022 Supreme Court ruling in *Dobbs v. Jackson Women's Health Organization*,<sup>1</sup> more than 20 states have enacted total abortion bans and restrictions based on gestational age. This paper describes the impact that state-level abortion bans have on the movement of OB-GYNs and women's health providers. News reporting and organizational reports have suggested that these policies have the unintended consequence of pushing women's health providers out of abortion-restricted states. A literature review and interviews with key informants demonstrate the direct influence of *Dobbs*<sup>1</sup> on OB-GYNs and other healthcare providers. Informants confirm that state-level abortion bans enacted after the *Dobbs*<sup>1</sup> decision have both driven providers out of state and made it difficult to recruit new OB-GYNs and high-risk OB-GYNs. Informants also characterize women's health providers as overstrained from non-evidence-based restrictions on reproductive care enacted before the *Dobbs*<sup>1</sup> decision, including physician-only laws, targeted regulation of abortion providers (TRAP), and Risk Evaluation and Mitigation Strategy (REMS) requirements for mifepristone, which is used for medication abortion. There is vast literature documenting socioeconomic disparities in healthcare, and key informants strengthen that evidence by describing how abortion bans widen those disparities. Additionally, key informants stress that providers are unable to provide adequate care for their patients and that this has had a negative psychological impact.

Key informants, the literature, and recent data and reporting show that no agency or governmental organization has proposed an effective policy solution to the problem caused by a lack of women's health providers. However, advocacy organizations are litigating abortion restrictions on several different fronts, and providers and patients are challenging abortion bans on the grounds that they have experienced harm at the hands of the state. In the absence of action

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by state lawmakers, physician-led organizations are lobbying policymakers and campaigning for ballot measures protecting abortion.

This is a critical issue as more conservative state policymakers push to pass strict abortion bans without considering the implications. In the words of one state lawmaker, “We never looked that close, and what exactly that bill said and how it was written and language that was in it.”<sup>2</sup> Policymakers have not been quick to react when this problem is brought to their attention. Consequently, OB-GYNs are leaving abortion-restricted states due to restrictions on their autonomy as healthcare providers and the threat of criminal liability. As women’s health providers leave, there are no healthcare providers to fill gaps in obstetrics and gynecological care, leaving women in these states to either travel for healthcare or not access it at all.

### ***Background***

State-level abortion bans and restrictions are driving OB-GYN providers out of state, creating a dearth of access to women’s healthcare services. In the United States, 21 states have banned abortion or significantly restricted access to the procedure based on gestational age.<sup>3</sup> An abortion is not performed solely to terminate an unwanted pregnancy, it is also part of comprehensive pregnancy, miscarriage, and gynecological care.<sup>4</sup> Penalties for obtaining an abortion in these states range from civil lawsuits to large monetary fines, while penalties for providing an abortion can include permanent suspension of a medical license and a threat of felony charges with prison time.<sup>3,5,6</sup> OB-GYNs are leaving these states because of the restrictions on their autonomy as physicians and the very real risk of criminal prosecution. Adding to this problem, new OB-GYN residents are choosing not to practice in states with abortion restrictions due to licensure threats and risk of prosecution.<sup>7</sup>

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### **OB-GYN Practice Trends**

While OB-GYN movement between states is not new, movement has significantly increased within the last year leading to new maternal care deserts. Each year from 2005 to 2015, approximately 6.5% of practicing OB-GYN providers moved their practice, with 58% remaining within the same state.<sup>8</sup> While data on OB-GYN movement from 2022 to 2023 is not yet available, the Association of American Medical Colleges (AAMC) has reported a 10.5% decrease in OB-GYN applicants in states with complete abortion bans.<sup>7</sup> This movement is evidenced in three states with strict abortion bans. Testimony in *Sistersong Women of Color Reproductive Justice Collective v. State of Georgia*<sup>9</sup> revealed that Georgia's strict abortion ban has resulted in the inability of Emory University to recruit OB-GYN residents for its fellowship program. Furthermore, 75% of OB-GYN providers in Oklahoma reported that they were planning or considering a move out of state, or would leave if they could.<sup>2</sup> In Idaho, 12 labor and delivery physicians have moved out of state in 2023, including 5 of only 9 maternal-fetal experts, who specialize in high-risk pregnancy care.<sup>2</sup> Across the United States, at least 61 women's health clinics have closed within the last year.<sup>10</sup> Women of all ages seek out healthcare services at women's health clinics, and as women age they are more likely to need healthcare interventions that require a gynecologist.<sup>11</sup> Closing clinics will affect all women who need gynecological care, not solely those who require pregnancy care.

### **Abortion Legal History**

Abortion rights have a long legal history in the United States. Before the Supreme Court ruling in *Dobbs v. Jackson Women's Health*,<sup>1</sup> an individual's right to abortion was protected in the 1973 Supreme Court decision in *Roe v. Wade*.<sup>12</sup> The Court's ruling in *Roe v. Wade*<sup>12</sup> held that an individual's decision to terminate their pregnancy was contained within the right to privacy,

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enshrined in the 14<sup>th</sup> Amendment's concept of personal liberty and the 9<sup>th</sup> Amendment's reservation of rights to the people. This landmark ruling created federal legal protections for individuals who needed abortion care by protecting it within the constitutional right to privacy.<sup>12</sup> In 1992 the Supreme Court pivoted slightly from this decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.<sup>13</sup> In this decision, the Court upheld restrictions in a Pennsylvania abortion law.<sup>13</sup> While reaffirming the decision in *Roe v. Wade*<sup>12</sup> that abortion care falls under an individual's right to privacy, it also upheld state requirements as not being an undue burden on the exercise of that right.<sup>13</sup> This ruling introduced the undue burden standard to state-level abortion policies, meaning that justices would deem a new abortion law unconstitutional if it intended to construct a significant barrier for individuals seeking an abortion.<sup>13</sup> The ruling in *Planned Parenthood v. Casey*<sup>13</sup> also allowed states to enact abortion restrictions based on viability of the fetus, rather than relying on trimester. Importantly, *Planned Parenthood v. Casey*<sup>13</sup> upheld an individual's right to an abortion before their fetus is deemed viable. With these two Supreme Court rulings, abortion rights were protected in the U.S. for nearly 50 years.

### ***Dobbs* Decision Impact**

In 2022, the Supreme Court ruled in *Dobbs v. Jackson Women's Health Organization*<sup>1</sup> that the U.S. Constitution does not protect an individual's right to abortion care. Overruling both *Roe v. Wade*<sup>12</sup> and *Planned Parenthood v. Casey*,<sup>13</sup> the Supreme Court held that abortion rights were not covered by the constitutional concepts of liberty nor privacy.<sup>1</sup> This ruling gave power to individual states to enact abortion policies because abortion care was no longer protected at the federal level. Many states already had trigger laws for abortion, which were laws that would ban abortion if federal legal protections were overturned. Thirteen states immediately banned

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abortion after the *Dobbs*<sup>1</sup> ruling using these trigger laws.<sup>3</sup> Currently, fifteen states ban abortion, with eleven others restricting abortions based on gestational age, sometimes as soon as six weeks into pregnancy, which is often before an individual knows they are pregnant.<sup>3</sup> Many of these abortion bans include extremely limited exceptions in cases to protect the life or health of the mother, or in the case of rape or incest.<sup>6</sup> Ten states allow for health exceptions to their abortion bans, but only Arizona uses explicit language to define which major bodily functions must be at risk in order to qualify for a legal abortion.<sup>6</sup> Other states use language such as “impairment of a life-sustaining organ”<sup>6</sup> or “impairment of a major bodily function,”<sup>6</sup> but do not explicitly define these criteria. Because legal exceptions are written in vague language, many providers are unsure of when they apply, leading to patients being turned away when they are experiencing medical emergencies.<sup>6,14</sup> Three states have an affirmative defense clause built into their abortion bans, meaning the healthcare provider must prove in court that the abortion they provided met the legal criteria for an exception.<sup>3</sup> In reality, the exceptions in these laws are so vague that physicians do not know when or how to apply them, leading to delayed care, refusal of care, and serious health complications.<sup>6,15</sup>

The *Dobbs*<sup>1</sup> ruling changed the way OB-GYNs and other women’s health providers are able to practice medicine. Providers are reluctant to offer the full range of interventions for patients with pregnancy-related health conditions, complications, or those who may be experiencing a miscarriage, due to the fear of legal retribution.<sup>6,15</sup> Criminal penalties for providers who are found guilty of violating state abortion bans range from hefty fines and suspension of their medical license to prison time.<sup>5,6,16</sup> One year after the ruling, 68% of practicing OB-GYNs reported their ability to manage pregnancy-related emergencies has worsened.<sup>17,18</sup> The threat of criminal prosecution is not only driving women’s health providers



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out of state, but it is also making OB-GYN medical students think twice about where they apply for residency. The AAMC has reported a 10.5% decrease in OB-GYN residency applicants in states with abortion bans compared to a 5.3% decrease in states without abortion restrictions.<sup>7</sup> Additionally, a survey of OB-GYN residents found that almost 18% reported that the *Dobbs*<sup>1</sup> ruling was the reason they changed the location of their future practice and fellowship plans.<sup>19</sup> OB-GYN residents who planned to practice in abortion-restricted states before the *Dobbs*<sup>1</sup> ruling were 8.5 times more likely to change their future practice plans than those who planned to practice in abortion-protected states.<sup>19</sup> Approximately 25% of OB-GYN residents surveyed indicated they did not want to live in a state with abortion restrictions.<sup>19</sup> Alarming, a survey of U.S. medical students, residents, and physicians across all specialties indicated that the vast majority of physicians (82%) preferred to work or train in states with protections for abortion access, and 76% reported that they would not apply to work in states with legal consequences for providing abortion care.<sup>20</sup>

### **Access to Care**

With current providers moving out of state and new residents choosing to practice elsewhere, women who live in abortion-restricted states will be unable to access healthcare. They will not only lose access to abortion care, but will be unable to access miscarriage care, family planning programs, STI treatment and preventive health services such as yearly cancer screenings, among others.<sup>17</sup> A 2022 report found that approximately 2.2 million women of childbearing age live in a maternity care desert, which is a county where there are no OB-GYN providers or clinics and hospitals offering obstetric care.<sup>21</sup> Abortion bans are only exacerbating this problem. Furthermore, abortion bans disproportionately affect minority populations, including communities of color, those with low socioeconomic status, and those who live in rural

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regions.<sup>22</sup> Patients seeking abortion care are disproportionately Black, Latina, and have incomes below the federal poverty level.<sup>22</sup> This is especially concerning when put into context of the national maternal mortality rate. According to the most recent data, the total U.S. maternal mortality rate is 32.9 per 100,000 live births.<sup>23</sup> However, for non-Hispanic Black individuals that rate is more than double at 69.9, compared to non-Hispanic White individuals at 26.6 per 100,000 live births.<sup>23</sup> In rural regions, individuals have a 9% greater likelihood of increased maternal morbidity and mortality than those who live in urban areas.<sup>24,25</sup> Yet, women of color have a 33% greater chance of maternal morbidity and mortality than white women, regardless of where they live.<sup>24</sup> Not only do abortion bans disproportionately affect communities of color, but they force pregnancy in a community with a maternal mortality rate more than double the national rate.

### **Health Outcomes**

State-level abortion restrictions are linked to negative physical and mental health impacts, as well as worse financial outcomes. States with restrictive abortion policies have higher maternal mortality rates than those that are protective of abortion.<sup>26</sup> Furthermore, the risk of death associated with childbirth is fourteen times that associated with abortion,<sup>27</sup> and legal abortion has a 0.4% rate of serious complications.<sup>28</sup> A majority of women receiving abortion care have household incomes of less than 200% the federal poverty level.<sup>27</sup> This is important because for at least five years after being denied an abortion, women are more likely to not have enough money for living expenses such as food and housing, and are more likely to have an increased amount of debt.<sup>29</sup> Additionally, denying a patient an abortion is linked to negative developmental and socioeconomic consequences on their existing children.<sup>30</sup> Low birth weight is also higher among women living in abortion-restricted states, potentially indicating a lack of maternal care.<sup>31</sup>

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Pregnant individuals who lack access to obstetrics care are much more likely to have pregnancy complications and negative birth outcomes such as a higher risk of preterm birth, asthma, and intellectual disabilities.<sup>24,32</sup> Alarmingly, pregnant individuals are three times more likely to die from pregnancy-related complications in states with abortion restrictions.<sup>31,33</sup> Fifteen states ban abortion with very limited exceptions, affecting over 19 million women of childbearing age.<sup>3</sup> Without appropriate healthcare, these women face an increasing health burden.

Abortion bans also impact OB-GYN training. The Accreditation Council for Graduate Medical Education (ACGME) requires that OB-GYN residents receive both surgical and non-surgical abortion training.<sup>34</sup> Approximately 30,000 medical students are currently training in states with abortion bans.<sup>33</sup> In addition, 1,400 OB-GYN residents are enrolled in programs in states where abortion is either banned completely or severely restricted.<sup>33</sup> If residents are not able to travel out of state to receive abortion training, they will not be trained in this vital skill. The procedure used in a surgical abortion is evidence-based care that is not only necessary for those who wish to terminate their pregnancy, but is also used to treat incomplete miscarriages or remove endometrial polyps, which can be cancerous.<sup>33,34</sup> Without training, OB-GYNs will not be able to provide this care no matter where they choose to practice.

The health access problem caused by a lack of available OB-GYNs is severe.<sup>2,17,24</sup> There are currently no state-level initiatives to address the dearth of OB-GYNs in abortion-restricted states. State governments are slow to recognize this as a problem and have yet to introduce any policy solutions to address it. Abortion-restricted states are closing entire labor and delivery wards because there are no physicians to staff them. In Idaho, 5 out of 9 maternal-fetal specialists have moved out of state.<sup>5</sup> At the same time, the Idaho state legislature disbanded the state's Maternal Mortality Review Committee.<sup>35,36</sup> The Idaho Maternal Mortality Review Committee

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was a federally funded program that reviewed the records of women who died during pregnancy, childbirth, or within one year after pregnancy, for the purpose of determining the root cause of death.<sup>36</sup> This data was then used to draw actionable recommendations to prevent future deaths. Without it, maternal deaths in the state are not being reported and no action is being taken to prevent them.<sup>35,36</sup> Two OB-GYN units in Alabama hospitals have also closed, citing staff shortages and low patient numbers.<sup>37</sup> OB-GYNs and high-risk OB-GYNs are leaving Idaho, Texas, Oklahoma, and Tennessee, among others.<sup>2</sup> In Oklahoma more than half and in Tennessee one-third of the state's counties are maternity care deserts.<sup>2</sup>

Without OB-GYNs, women and pregnant individuals are forced to either travel out of state for care or forgo healthcare services altogether. Time and financial costs of traveling are prohibitive for some, leading to the potential for a large population of women without access to healthcare. Individuals who do not receive prenatal care are between three and four times more likely to have a pregnancy-related death, and babies born in maternity care deserts are more likely to be born prematurely or underweight.<sup>32,33</sup> In December 2022, 39% of counties in abortion-restricted states were maternity care deserts compared to 25% in counties where abortion is accessible.<sup>38</sup>

## **Proposed Solutions**

The main strategies to address this dearth of OB-GYN providers have come from advocacy and physician-led organizations, yet there are some federal proposals. At the federal level, the leading strategy is to organize political support for federally codified abortion rights. This would preempt any state ban or restriction on the procedure, thereby eliminating the main driving factor behind OB-GYNs moving out of abortion-restricted states. Alternatively, the federal government's Department of Health and Human Services (HHS) has re-issued guidelines

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for the Emergency Medical Treatment and Labor Act (EMTALA), reaffirming the necessity for emergency departments to provide abortion care in medical emergencies.<sup>39</sup> HHS holds that EMTALA preempts any state-level abortion ban, but states with strict abortion bans have pushed back.<sup>40,41</sup> In Idaho, a U.S. District judge blocked the state from enforcing the ban in cases where the patient's health was in "serious jeopardy,"<sup>42</sup> holding that the state policy conflicted with federal legislation. However, a U.S. Circuit judge reversed the ruling, saying that EMTALA does not set standards of care and therefore does not conflict with the state abortion ban.<sup>42</sup> In Texas, the federal government brought a similar case against the state, with the same outcome.<sup>41</sup> In both states, HHS is appealing the rulings on the basis of federal preemption.<sup>42</sup>

In addition to this, legal experts suggest that legal counsel representing healthcare systems must educate physicians to combat the confusion surrounding vague language in abortion bans.<sup>14</sup> Ideally, this would help physicians know which situations constitute a medical emergency.<sup>14</sup> However, the reality of medical emergencies is rarely so straightforward. EMTALA could potentially provide legal protections for physicians who provide abortion care in emergency situations. This could help assuage fear of criminal prosecution for OB-GYNs who work in hospitals, potentially keeping them in-state. However, federal preemption with EMTALA is an imperfect solution because not all OB-GYNs work in a hospital setting and abortion care is not only needed in medical emergencies.

State-level interventions addressing this issue are mixed. Some states have passed legislation protecting abortion rights, with shield laws in place to protect women's health providers who provide abortions.<sup>3</sup> These laws protect providers, patients, and abortion support organizations from criminal investigation from law enforcement in abortion-restricted states.<sup>3</sup> In states with abortion restrictions, there has not been much progress. State legislatures that have

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enacted abortion bans are doing nothing to keep women's health providers in state and are not reversing their policies without political change. In fact, many abortion-restricted states are allocating money for pregnancy resource centers, also known as Crisis Pregnancy Centers.<sup>10,43</sup> Crisis Pregnancy Centers (CPCs) are often religiously affiliated, anti-abortion organizations that typically offer pregnancy testing, baby supplies, parenting classes, and "heartbeat" ultrasounds, which are meant only to show a pregnant individual that their fetus has a heartbeat.<sup>10,36,43</sup> CPCs are not licensed medical centers and do not staff any medical professionals.<sup>10,43</sup> Louisiana and Mississippi both have a state tax credit program that funds CPCs, and Texas has recently earmarked \$100 million towards an Alternative to Abortion program, which directly funds pregnancy resource centers.<sup>10,43</sup> Although legislators in abortion-restricted states tout these organizations as solutions, CPCs are not evidence-based and do not employ medical professionals. Therefore, they are an inadequate solution to a dearth of women's healthcare and will not keep OB-GYNs in state.

Telehealth services can help increase access to OB-GYNs when few or none are available in abortion-restricted states. Telehealth has shown promise in abortion-protected states, increasing access to medication abortion and facilitating abortion care.<sup>44,45</sup> Telehealth services help increase access to care for those in rural areas, or those who live far from healthcare providers.<sup>46</sup> Translating this success to help individuals in maternity care deserts access OB-GYN care would be feasible. In New Mexico, the Human Services Department and Hospital Association have drafted a proposal to allow rural Medicaid recipients to access Telehealth prenatal and postpartum OB-GYN visits while under the care of a local nurse at a nearby hospital.<sup>47</sup> This way patients would have access to prenatal and postpartum care where there are no OB-GYNs, while still getting vital signs and other physical measurements taken by a nurse.<sup>47</sup>

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This combination of virtual and physical medical care could be the best way forward with an increasing number of counties becoming OB-GYN deserts. The Interstate Medical Licensure Compact makes this proposal more feasible.<sup>48</sup> This agreement allows for easier licensing among participating states, allowing physicians to practice in multiple states more readily.<sup>48</sup> Combined with the use of effective Telehealth, this Interstate Compact can help women in abortion-restricted states access healthcare when OB-GYNs leave.

Meaningful solutions are also coming from physician-led organizations. Physicians in some abortion-restricted states have formed Political Action Committees (PACs) to lobby policymakers and campaign for policies that protect reproductive rights.<sup>49</sup> This solution shows promise in the long term. In the shorter term, experts have suggested training other types of physicians to provide women's healthcare services.<sup>28,50</sup> The American Journal of Obstetrics & Gynecology (AJOG) has recommended training family medicine and internal medicine physicians, as well as advanced practice clinicians to provide women's healthcare.<sup>50</sup> Some family medicine physicians intend to provide obstetrics care, but it is unclear whether the majority of advanced practice clinicians intend to follow this recommendation.<sup>51</sup> Even before the *Dobbs*<sup>1</sup> ruling, family and internal medicine physicians were increasingly performing pap smears, STI screening, and other preventive women's healthcare.<sup>52,53</sup> With specialized training, these providers can also expand access to women's healthcare, including pregnancy care. Recently, physicians in leadership at a family medicine residency program in Mississippi have created a new fellowship designed to train two to three family physicians in obstetrics care each year to address the OB-GYN shortage.<sup>54</sup> Experts have also suggested that acute care surgeons should expand their training, so they are able to treat complications arising from self-managed abortions, which are more likely in states with abortion-restrictions.<sup>28</sup> Complications from self-

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managed abortions can include infection, incomplete abortion, hemorrhage, and/or ingestion of substances or medications that are not the standard of care for medication abortion.<sup>28</sup> Providers other than OB-GYNs will need to care for and treat these patients when OB-GYNs leave abortion-restricted states.

### **Unintended Consequences**

Without a cohesive strategy or solution to the problem, physicians in abortion-restricted states are left to refer patients out of state for care. Not only do physicians refer patients out of state if they require an abortion, but some family medicine physicians must also refer pregnant patients out of state for specialized care.<sup>2</sup> On top of this, many abortion bans are written in vague language that leaves physicians unsure of how to refer patients out of state for an abortion without violating the law.<sup>55</sup> Referring patients out of state can cause unnecessary stresses in the form of logistics, transportation, and other costs. State-level abortion bans also have the unintended consequence of increasing abortion incidence in abortion-protected states that surround those with restrictions.<sup>56</sup> From 2022 to 2023, the incidence of abortions performed in a clinical setting increased by 69% in Illinois, 89% in Colorado, 124% in South Carolina, and a startling 220% in New Mexico, which borders Texas, the state with the strictest abortion ban.<sup>56</sup> This has implications for existing OB-GYNs and medical staff in abortion-protected states who may become overstrained, taxing an already fragile system.

### **Multiple Streams Framework**

OB-GYNs moving out of abortion-restricted states is a serious societal problem. Kingdon's<sup>57</sup> Multiple Streams Framework explains how problems, policies, and politics intertwine. In the problem stream, the definition of a problem determines whether it reaches the attention of policymakers and the general public.<sup>57</sup> Using the Multiple Streams Framework, a



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problem can be defined by the change of an indicator, a focusing event, and feedback on an existing policy.<sup>57</sup> The reversal of nearly 50 years of legal precedent with the *Dobbs*<sup>1</sup> ruling was a focusing event bringing public attention to the issue of reproductive rights. Yet attention to the issue is unfocused without an indicator to help define the problem. In this case, the availability of OB-GYNs is an indicator of health that can elevate this issue to the level of policy agendas. State-level abortion bans have caused a change in the availability of OB-GYNs, helping to describe the magnitude of the problem. Kingdon<sup>57</sup> also describes the personal experiences of lawmakers as focusing events that can illuminate policy problems, meaning that only when decisionmakers or their families are unable to access OB-GYN care will they define it as a problem. Feedback from physicians, patients, and advocacy groups depict abortion bans as medical crises, yet policymakers are hesitant to act. Indicator change, focusing events, and feedback are all being ignored by lawmakers, both at the federal and state level. Defining the problem in these ways should make it impossible to ignore.

## ***Methods***

### **Literature Review**

From May 2023 to December 2023, reputable news reporting was reviewed daily using Google alerts for the terms “abortion,” “reproductive rights,” and “OBGYN.” News reporting revealed relevant organizational reports from the Guttmacher Institute, Kaiser Family Foundation (KFF) and the Association of American Medical Colleges (AAMC). Google Scholar was used to search academic journals for peer-reviewed articles using the same search terms listed above and others such as, “abortion,” “OBGYN brain drain,” “OBGYN movement between states,” “lack of OBGYN,” “decrease OBGYN,” “traveling for abortion,” “abortion bans,” “financial harms unwanted pregnancy,” “missed abortion care,” and “family medicine

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women's health." The results were narrowed to include articles published since 2013, written in English, and using one or more of the above search terms.

### **Key Informant Interviews**

Key informants were recruited from stakeholder groups, including physician and advocacy organizations. Twelve outreach emails were sent in October 2023, with follow up emails sent one week later. Six stakeholders responded to outreach emails, with one declining to participate and two lost in the follow up process. Three interviews were conducted between October and November 2023. Key informants were labeled as Key Informant 1 (KI1), Key Informant 2 (KI2), and Key Informant 3 (KI3). Interviews focused on three main subject areas, including the post-*Dobbs*<sup>1</sup> landscape for women's healthcare, the impact of reproductive care restrictions on healthcare providers and patients, and future prospects. Interviews were semi-structured and conducted via telephone and Zoom. Interviews were recorded with participant consent and transcribed using Otter.ai. Qualitative interview transcripts were analyzed using ATLAS.ti software. Codes were categorized into two main groups, those that related to the problem of OB-GYN access and those that related to any proposed solution. Codes and code groups were synthesized into four overarching themes. The principal themes identified were about OB-GYNs leaving abortion-restricted states, the landscape of women's healthcare changing after *Dobbs*,<sup>1</sup> litigation as a strategy to lessen the burden on providers, and the emergence of physician-led advocacy.

### **Policy Analysis Framework**

Literature review and informant interviews were analyzed using Kingdon's Multiple Streams Framework.<sup>57</sup> Analysis focused on the problem stream of the framework, which states

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that focusing events, indicator change, and feedback on an existing policy are necessary to raise a problem to the level of state policy agenda.<sup>57</sup>

### ***Discussion***

Literature and key informant interviews reveal that the landscape of women's healthcare in the United States has changed dramatically since the *Dobbs*<sup>1</sup> decision. The ruling has created unprecedented constraints that affect all healthcare providers, not solely OB-GYNs. As one key informant stated, "all sorts of different providers are affected by these barriers, not just abortion providers" (Key Informant 3 interview, [Nov. 15, 2023]). Another key informant spoke about the many state-level restrictions on reproductive care, including procedural and medication abortion, already in place before the *Dobbs*<sup>1</sup> decision. Many of these restrictions are not evidence-based and restrict the autonomy of providers.<sup>58</sup> Although any restrictions on reproductive care are harmful, these individual state regulations did not reach national attention until the *Dobbs*<sup>1</sup> decision was made public. When *Roe v. Wade*<sup>12</sup> was overturned, many states had trigger bans immediately making abortion illegal.<sup>3</sup> The majority of these state abortion bans included criminal penalties for providers who performed an abortion, immediately changing the scope of practice for many, if not all, women's health providers.<sup>3,6</sup> The Supreme Court ruling in *Dobbs v. Jackson Women's Health*<sup>1</sup> served as a focusing event for the issue of abortion care at the national level. Both providers and patients experienced the negative impacts of reproductive care restrictions well before *Dobbs*,<sup>1</sup> yet the new lack of federal protection brought the issue to the national stage. Interviews with key informants described the landscape after *Dobbs*<sup>1</sup> as a "nightmare," (Key Informant 3 interview, [Nov. 15, 2023]) likening it to a breaking point.

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### **Restrictions on Reproductive Care**

Key Informant 2 highlighted both national and state-level restrictions on reproductive care that limit the practice of many women's health providers, including OB-GYNs. These include physician-only laws,<sup>58</sup> targeted regulation on abortion providers (TRAP) laws,<sup>59</sup> and the Food and Drug Administration's Risk Evaluation and Mitigation Strategy (REMS) requirements for mifepristone use, which is prescribed for medication abortion.<sup>60</sup> Physician-only laws, KI2 noted, exclude providers such as nurse practitioners, midwives, and physician assistants from legally providing abortion care even if abortion is legal in the state.<sup>58</sup> The same key informant stressed that these laws contradict years of evidence that healthcare providers other than physicians can safely and effectively provide both procedural and medication abortion care, which is supported in the literature.<sup>58</sup> In fact, states that have moved to protect abortion care after the *Dobbs*<sup>1</sup> decision have expanded access by allowing additional types of providers to perform abortions.<sup>61</sup> Additionally, TRAP laws impose burdensome restrictions on clinics and physician offices where abortions may be performed, beyond what is necessary for patient safety.<sup>59</sup> These laws make it difficult and often too costly for these sites to operate, essentially reducing the number of abortion providers without banning the procedure outright, as KI2 noted.

Lastly, REMS requirements are meant to prevent and/or manage risks associated with some drugs but have the unintended effect of restricting provider autonomy.<sup>62</sup> KI2 reported speaking with providers who are frustrated that they cannot simply write a prescription for mifepristone in the same way they would for any other comparably safe medication. Instead, they must involve the chief medical officer, the pharmacy, the therapeutics committee, and the operations team. Physician-only laws, TRAP laws, and REMS requirements for mifepristone all prevent healthcare providers from providing care to the best of their ability. These laws often

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contradict scientific evidence and create an extra burden for providers practicing reproductive care. These types of restrictions all existed before *Dobbs*<sup>1</sup> and contribute to women's health provider shortages by preventing qualified healthcare providers from operating. *Dobbs*<sup>1</sup> introduced the threat of criminal prosecution to healthcare providers who were already navigating many burdensome restrictions on their practice.

After *Dobbs*,<sup>1</sup> fifteen states banned abortion or restricted it based on gestational age of 6 weeks, which is so early in pregnancy that many individuals do not even know they are pregnant.<sup>3</sup> Three of these states have an affirmative defense clause written into their abortion ban, meaning a provider must prove in court that the abortion they provided met the state's criteria for a legal exception to the ban.<sup>3</sup> This is especially concerning for providers because the majority of states do not list medical criteria for exceptions to their abortion bans, but instead say abortion is legal in situations to prevent the mother's death, or if the pregnancy is a result of rape or incest.<sup>6,14</sup> At least two states allow for a legal exception to their abortion ban based on "reasonable medical judgment."<sup>14</sup> Providers are left the task of proving their patient would have died without an abortion. Patients are left the onerous task of reporting their rape to police officers to qualify for a legal exception. This has forced providers in abortion-restricted states to turn patients away if they are experiencing pregnancy complications that are not immediately threatening their life. In fact, twenty patients and two OB-GYNs are suing the state of Texas for this reason.<sup>63</sup> Patients listed as plaintiffs in this case include one diagnosed with end-stage renal disease who was denied an abortion after developing a deep vein thrombosis, eclampsia, and an embolism, and another patient whose water broke too early and developed sepsis while waiting for an abortion.<sup>63</sup> These patients presented to a hospital with medical emergencies where abortion would be considered necessary treatment and EMTALA would require physicians to

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provide that treatment.<sup>39,63,64</sup> Yet due to the state's abortion ban and possibility of criminal liability, physicians were unsure if they would be able to provide a legal abortion.<sup>63,64</sup> The uncertainty of how to provide medical care in pregnancy emergencies was emphasized by evidence from Key Informant 1. KI1 spoke about new hospital rapid response teams in his state created for the purpose of determining how best to provide legal care to patients presenting to emergency rooms with pregnancy and miscarriage complications. These rapid response teams consist of lawyers and healthcare providers in order to help alleviate concerns about the legality of the healthcare they provide. With such vague language, even lawyers are sometimes unsure of the best way forward, leading to the delay in care evidenced in the literature.<sup>63</sup>

The legal exceptions to abortion bans are impossible for physicians to navigate alone. This is supported by news reporting and evidence provided by key informants. KI2 reported knowledge of patients who were denied emergency medical care for miscarriages and pregnancy complications due to abortion bans, while KI1 highlighted the emergence of hospital rapid response teams that include physicians and lawyers. Even with this type of support, physicians may still be held liable. For example, KI1 reported that their state had sued and ultimately fined a physician for talking to the news media about an abortion she provided to a 10-year-old rape victim. The state argued that the physician had violated the Health Insurance Portability and Accountability Act (HIPAA) by talking to a news reporter, even though the physician did not include any identifying information about the patient other than her age. In this case, a physician was legally reprimanded for providing an abortion that met the criteria for a legal exception to the state's abortion ban.

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## **Psychological Impact**

Key informants stressed the psychological toll of the *Dobbs*<sup>1</sup> decision on providers. One key informant described their state government as “attacking” women’s health providers (Key Informant 1 interview, [Oct. 6, 2023]). According to this key informant, their state legislature enacted an abortion ban with extremely limited exceptions, the judiciary upheld the ban, and their state attorney general tried to remove the medical license of a physician who provided an abortion to a rape victim. In the words of this informant, “if I were an OBGYN provider looking for a place to practice, this would be the last place that I would look” (Key Informant 1 interview, [Oct. 6, 2023]). In addition, Key Informant 3 described the situation on her first day of work after the *Dobbs*<sup>1</sup> decision as a “medical crisis” (Key Informant 3 interview, [Nov. 15, 2023]). Their state abortion ban had gone into effect, and she spoke about the environment as a time when physicians didn’t know if the care they provided would result in being charged with a felony or loss of their medical license. KI3 described this situation as a “disaster for patients” (Key Informant 3 interview, [Nov. 15, 2023]) and as having an immense psychological toll on providers.

This informant, a physician, reported multiple instances of patient visits in the wake of the state trigger ban that left her extremely disheartened. For example, one provider in their clinic had an initial meeting for abortion counseling with a patient where they discovered that the patient was recently diagnosed with stage 3 melanoma and needed an abortion to start chemotherapy. Because their state required a 24-hour waiting period, the patient had to come back the next day to receive her abortion medication. Within that 24-hour period, the state’s trigger ban had gone into effect and the provider had to call their patient to tell her they could no longer help her get the care she needed. Eventually, providers helped this patient find abortion

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care out of state. However, KI3 emphasized the impact these situations have on providers. She described having these types of conversations with multiple patients as “heart wrenching” and “emotionally taxing” (Key Informant 3 interview, [Nov. 15, 2023]).

### **Provider Shortages**

The psychological toll on providers and future uncertainty are driving factors behind the provider shortage emerging in abortion-restricted states. Two informants from abortion-restricted states spoke about difficulty in recruiting OB-GYNs and other women’s health providers to their states. In one state, KI1 had knowledge of OB-GYNs and perinatologists, who specialize in high-risk pregnancy care, who left the state due to its abortion ban. Although this informant could not be certain about the number of providers who have left the state, he predicted a problematic shortage of OB-GYNs within the next five to ten years.

A second key informant spoke about the difficulty of recruiting medical residents to Ohio after the *Dobbs*<sup>1</sup> decision. In Ohio, a trigger ban immediately made all abortion illegal for 82 days until it was challenged in state court.<sup>65</sup> The court suspended the ban until it could be determined that it did not violate the state constitution.<sup>65</sup> Because of this, for the majority of the past year, physicians in the state have been operating on a practical level as if the *Dobbs*<sup>1</sup> decision never happened. However, this uncertainty and threat of a near-total abortion ban being enacted still contributed to recruiting issues. According to KI3, the threat of an abortion ban being legalized made it much more difficult to recruit OB-GYNs and specifically high-risk OB-GYNs. She elaborated, saying that physicians did not want to move to a state where there might be criminal penalties and possible jail time for practicing medicine in a patient’s best interest.

KI2 provided court transcripts in an ongoing lawsuit against Georgia’s abortion ban where testimony from a professor of Obstetrics and Gynecology at Emory University revealed



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that the program had received half as many resident applications as it had in each of the previous ten years.<sup>9</sup> The program also had a few resident applicants cancel their interviews after the state abortion ban took effect.<sup>9</sup> This evidence provided by key informants strengthens news reporting and literature findings that medical students are choosing not to apply to residency programs in states with abortion bans.<sup>7,20</sup>

According to the Multiple Streams Framework, an indicator change combined with a focusing event can raise an issue to the level of a problem worth addressing.<sup>57</sup> An indicator change refers to a change in the state of system and is a useful way of defining a problem in a way that garners attention.<sup>57</sup> Providers choosing not to practice in abortion-restricted states is an indicator change that should bring this issue to the attention of policymakers. If this trend continues, millions of women in abortion-restricted states will lose access to gynecological and pregnancy care. Kingdon<sup>57</sup> also writes that the American government often works as a function of crisis. Physicians have described the aftermath of *Dobbs*<sup>1</sup> as a medical crisis, meaning this issue has the potential to reach the state and national policy agenda. Yet when faced with both an indicator change and the awareness of a crisis, state and federal policymakers are not proposing new policies to address the issues caused by abortion bans. Physicians, who are raising concerns about a crisis in abortion-restricted states, are instead campaigning and writing policy in opposition to state lawmakers.

### **Socioeconomic Disparities**

While data suggests that abortion bans disproportionately affect marginalized communities,<sup>22</sup> key informant interviews illuminated health equity issues that were not explicit in the literature review. Key Informant 2 reported that the harms caused by abortion restrictions disproportionately affect “low-income communities, communities of color, young people,

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immigrants, and LGBT people” (Key Informant 2 interview, [Nov. 11, 2023]). Studies suggest this is true across the country.<sup>22</sup> Key Informant 3 further characterized this issue by illustrating two encounters she had during the time of her state’s trigger ban. In one instance, KI3 received a call from a 13-year-old patient’s mother asking if she should put her daughter on birth control pills even though she wasn’t sexually active. The mother was concerned about the possibility that her young daughter may be raped, become pregnant, and then be forced into childbirth because the state’s abortion ban had almost no exceptions. KI3 reported feeling shocked at the phone call, not knowing how to advise the patient’s mother. Later, KI3 reported feeling devastated when she discovered this exact situation happened in a different state. In Mississippi, a 12-year-old rape victim was forced into childbirth because her family could not afford the nine-hour drive to the nearest legal abortion provider.<sup>66</sup>

On another occasion, KI3 recalled counseling a 16-year-old African American patient who was pregnant and wanted to visit an OB-GYN before deciding whether to terminate her pregnancy. Because of the state’s trigger ban, when the *Dobbs*<sup>1</sup> ruling was announced KI3 had to call the patient to tell her that if she was considering having an abortion, she could not wait for her OB-GYN visit, she had to return to the abortion clinic that day, and even then, it may be too late. Notably, the informant described the patient as being from a very socially supportive but low-income community, explaining how it would be extremely difficult for her family to help her travel out of state for an abortion if she needed. This young patient was memorable to KI3 because she represented how socioeconomic disparities in healthcare can widen when patients cannot access the care they need. Evidence from the Turnaway Study suggests that women who want to terminate their pregnancy yet are turned away due to state-level restrictions or lack of access to abortion care have worse financial outcomes than those who have an abortion.<sup>67</sup> In this

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respect, evidence from key informants is consistent with the literature. Abortion restrictions disproportionately affect marginalized communities, rendering physicians unable to offer help. Not only do these restrictions threaten healthcare providers with criminal charges, fines, and the possible revocation of their medical licenses, but they also impose emotional harm on physicians who know they can help patients but are unable to do so because of state law.

### **Policy Response**

Responses to state policy changes after *Dobbs*<sup>1</sup> are varied. Key informants were not aware of any agency that had a proposed solution to the evolving OB-GYN shortage. The leading response to state-level abortion bans has been driven by physician-led organizations.<sup>49</sup> This finding was confirmed by evidence from key informants. KI1 spoke about helping to create a statewide organization of healthcare providers in order to build a coalition to lobby policymakers in all aspects of health policy. The organization was formed in opposition to the *Dobbs*<sup>1</sup> decision. Their first action was to publish a full-page advertisement signed by 1,300 physicians and nurses in eight newspapers around the state urging policymakers not to pass the state abortion ban. KI3 spoke about posting a letter urging their state policymakers to revoke the state trigger ban to a Facebook group for physicians in the state. Eventually, they had over one thousand physicians in the state join their group. KI3 then helped create a political action committee (PAC) comprised of physicians who focused their efforts on campaigning for a ballot measure protecting abortion access in the state constitution. This campaign ultimately proved successful, and, as KI2 pointed out, similar campaign initiatives have been successful in other states, including those where the state government is hostile towards abortion access. The importance of physician-led coalitions cannot be understated. In the absence of any proposed

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policy solutions to address the shortage of women's health providers, physicians in abortion-restricted states are taking action.

Aside from physician-led campaign initiatives, advocacy groups are responding to policy changes in the aftermath of *Dobbs*<sup>1</sup> by bringing lawsuits in several states. KI2 detailed the different ways in which the American Civil Liberties Union (ACLU) is litigating state abortion bans and restrictions on other aspects of reproductive care. The organization has ongoing litigation challenging state abortion bans in numerous states including Georgia, Alabama, and in Ohio before voters elected to protect abortion access in the state constitution in November 2023. KI2 also spoke about the ACLU's ongoing litigation challenging the FDA's REMS restrictions on mifepristone as well as TRAP laws in Alabama. According to this informant, the main strategy to address provider shortages brought on by the *Dobbs*<sup>1</sup> decision is to litigate the restrictions on reproductive care that put an increased burden on women's health providers.

At the federal level, a literature review suggested the use of EMTALA could protect providers who provide an abortion in the case of a medical emergency.<sup>39</sup> Practically, this has not been true. There are numerous documented cases of patients experiencing pregnancy or miscarriage emergencies being turned away from hospital emergency rooms.<sup>63,64</sup> In fact, KI3 explicitly bemoaned the fact that there are no federal protections for abortion care. She expressed feeling that the decision to allow states to legislate reproductive care has been a disaster. Additionally, providers and patients are suing states with abortion bans on the grounds that they've experienced harm because of these laws.<sup>63</sup> According to KI2, providers are suing states in Georgia, Ohio, Utah, Idaho, and Texas, as mentioned earlier. Many of these lawsuits are still ongoing. While this would be an adequate solution in the long term, these lawsuits will not help patients access care nor will they keep women's health providers in state in the short term.

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### **Alternate Providers**

Literature has suggested that alternate types of providers, such as family and internal medicine physicians and advance practice clinicians, should be trained to provide women's healthcare services in OB-GYN deserts.<sup>54,68</sup> However, this may have unintended consequences. OB-GYNs and other women's health providers spend years training in specialized residency programs and fellowships. Replicating this type of apprenticeship training would be difficult, and other provider types may still be unprepared to care for patients with complex conditions or high-risk pregnancies. Mississippi has addressed this problem by introducing a family medicine obstetrics fellowship in order to more adequately train physicians.<sup>54</sup> A handful of other abortion-restricted states have similar fellowship programs for family medicine physicians,<sup>69</sup> but this will only help fill gaps in OB-GYN care if family medicine physicians choose to practice obstetrics and gynecology. Idaho, an abortion-restricted state experiencing a "dire" (Key Informant 1 interview, [Oct. 6, 2023]) lack of OB-GYN care, only has one such fellowship program.<sup>69</sup> Additionally, these providers will be taking on obstetrics care, meaning they will need extended malpractice insurance, which can be prohibitively expensive.<sup>70</sup> OB-GYNs typically have high malpractice insurance, which means that other physicians practicing obstetrics and gynecological care will be subject to high malpractice costs.<sup>70</sup> Some family physicians train with the intent to practice obstetrics care, yet still report difficulty in finding hospitals that will allow them delivery privileges and a lack of support from practicing OB-GYNs.<sup>71</sup>

Additionally, evidence from key informants suggests that this is not a viable solution. Key Informant 1 spoke about a family medicine physician in Idaho who was also practicing obstetric care. This informant reported that many physicians had left Idaho and represented the situation as "dire" (Key Informant 1 interview, [Oct. 6, 2023]). This is consistent with news

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reporting about OB-GYNs and maternal-fetal-medicine specialists moving out of the state.<sup>2,5</sup>

Key Informant 2 reported that Alabama has restricted midwife practice by imposing medically unnecessary restrictions on midwife-led birthing centers. These restrictions are burdensome and costly, effectively making it impossible for the birthing centers to operate. While KI1 suggested their state policymakers may loosen restrictions for midwives in the future when they acknowledge the OB-GYN shortage as a problem, KI2 reported that abortion-restricted states are often hostile towards midwives and other women's health providers, labeling them solely as abortion providers.

According to the Multiple Streams Framework, a focusing event isn't always enough to define an issue as a problem worthy of a policy solution.<sup>57</sup> In this case, feedback on the impact of a state policy should help bring lawmaker attention to the problem. State government officials are receiving feedback from physicians about the unanticipated consequences of the abortion policies they've enacted. This feedback, along with information about providers choosing not to practice under abortion bans, is enough to define this as a policy problem. Personal experiences of policymakers are a variation of a focusing event, as described by Kingdon.<sup>57</sup> As one informant pointed out, policymakers may not be willing to address this provider shortage until they experience it in their own lives. Focusing events, indicator change, and feedback on a policy are all needed to define a problem. OB-GYN shortages created by abortion bans meet all three criteria. OB-GYNs and other providers are moving out of abortion-restricted states with no proposed solutions to fill gaps in the healthcare desert they leave behind.

### ***Policy Implications***

State-level abortion bans have far-reaching implications for the future of women's healthcare. In lieu of change within state governments, advocacy groups are joining forces with

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providers and patients to challenge abortion restrictions in court. The Center for Reproductive Rights filed a lawsuit in March 2023 on behalf of two OB-GYNs and twenty women who were denied abortion care over unclear medical exceptions to the Texas state abortion ban.<sup>72</sup> The lawsuit aims to force the Texas Supreme Court to create a binding interpretation of the ban's exception in the case of a medical emergency.<sup>72</sup> In November 2023, the Court heard oral arguments in the case.<sup>72</sup> Physicians in North Dakota are also suing the state. North Dakota's abortion ban allows for an exception if the pregnant patient faces death or a serious health risk.<sup>3,73</sup> Physicians are asking the District Court to stop the state from enforcing the ban against providers who perform an abortion to treat pregnancy complications using their medical judgement.<sup>73</sup> In both Texas and North Dakota, state abortion bans contain vague language surrounding exceptions, seemingly allowing physicians to decide when an abortion is medically necessary.<sup>72,73</sup> However, providers face being charged with a felony if the state decides the abortion they provided violates the ban,<sup>6</sup> and they are unwilling to take that risk.

In September 2023, the Texas state legislature passed a bill that outlines some medical criteria for exceptions to the state abortion ban.<sup>74</sup> The bill protects providers who perform an abortion to treat a previable premature membrane rupture or terminate an ectopic pregnancy.<sup>74</sup> While this was a much-needed clarification to the state abortion ban, ectopic pregnancies are never viable, and patients who experience a previable premature membrane rupture are at a high risk for perinatal mortality.<sup>75</sup> Both of these health conditions can be considered an emergency that physicians would treat with abortion care. Without these legal clarifications, OB-GYNs were not able to treat these patients without the risk of criminal prosecution. Still, in all other medical emergencies, physicians are unable to use their own judgement and expertise.

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If states continue to define legal exceptions, providers may be more willing to stay in abortion-restricted states. This would help providers by outlining clear criteria for legal exceptions, thus eliminating the risk of criminal and civil liability. Ideally, this would also lead to fewer patients being turned away from clinics and hospitals when they need emergency abortion care. Providers will be less fearful of criminal penalties if medical exceptions to state abortion bans are legally binding. This would be beneficial progress in relieving the burden and threat of criminal prosecution on OBGYNs.

Without meaningful political change, state governments that have enacted abortion bans will work to further restrict access to reproductive care. In Kansas, state lawmakers passed a law that would require healthcare providers to tell patients that medication abortion can be reversed, and that abortion is associated with an increased risk of breast cancer.<sup>76</sup> Neither claim has any scientific basis.<sup>76,77</sup> If enforced, the law would force physicians to provide incorrect medical advice to their patients which is unethical and would have lasting implications. A state District Court blocked the law, holding that it violated a provider's free speech and a patient's right to an abortion, which is protected in the Kansas state constitution.<sup>76</sup> In Texas, four counties have begun targeting women who leave the state for abortion care.<sup>78,79</sup> These counties have passed ordinances that prohibit any travel on state roads within their district for the purpose of traveling for abortion care.<sup>78,79</sup> No violations of these ordinances have been reported yet,<sup>79</sup> but enforcement is problematic since it would be difficult to prove an individual is traveling for abortion care without an invasion of privacy.

Lastly, a pregnant individual in Texas filed a lawsuit in December 2023 asking a District Court to assert that she has the right to terminate her pregnancy because her fetus was diagnosed with Trisomy 18, a deadly condition.<sup>80</sup> A District Court ruled that she could legally terminate her



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pregnancy, but the Texas Attorney General petitioned the state Supreme Court to intervene.<sup>80</sup>

The Texas Supreme Court reversed the lower court's ruling, blocking the patient from receiving an abortion.<sup>80</sup> The Court held that the patient's physician did not adequately establish the patient's symptoms were life-threatening even though the patient had visited three emergency rooms within the last month due to complications of the pregnancy.<sup>80</sup> While legal exceptions to state abortion bans are meant to protect the pregnant patient's life and health, their vague language has the opposite effect. Physicians cannot prove their patients are facing risk of major bodily impairment if that standard is not defined.<sup>6</sup> This vague legal language is being used to deny medically necessary abortion care to patients in states that are hostile towards abortion rights.

States that have enacted abortion restrictions and total abortion bans are hostile towards reproductive care in numerous ways. Although physicians and constituents are alerting state policymakers to the problem with their abortion bans, policymakers continue to restrict OB-GYN practice and reproductive care. Without any meaningful changes, state governments that have enacted abortion bans will continue to further restrict reproductive healthcare, leading to worse health outcomes for all women.

### ***Conclusion***

The Supreme Court's ruling in *Dobbs v. Jackson Women's Health*<sup>1</sup> served as a breaking point for healthcare providers. Before *Dobbs*,<sup>1</sup> many states already had restrictions on reproductive care, such as physician-only laws,<sup>58</sup> TRAP laws,<sup>59</sup> and REMS restrictions on mifepristone.<sup>60</sup> These restrictions are burdensome for providers, but violations do not carry criminal penalties. After *Dobbs*,<sup>1</sup> providers in states with abortion bans could no longer perform an abortion for any reason other than to save a pregnant individual's life, or in some cases of

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rape or incest.<sup>3</sup> However, these exceptions are not clearly defined, leaving providers unwilling to test their boundaries.<sup>6,14</sup> These policies restrict provider autonomy and threaten providers with criminal liability. Procedural or medication abortion is part of comprehensive gynecological care, not used solely to terminate an unwanted pregnancy.<sup>4</sup> States with abortion bans are not only hostile towards reproductive health but are also hostile towards women's health providers.

Because of this, OB-GYNs are choosing not to practice or train in abortion-restricted states. The AAMC reported a 10.5% decrease in OB-GYN applicants in states with complete abortion bans during the 2022-2023 cycle,<sup>7</sup> and 82% of physicians and medical residents across all specialties prefer to work or train in states that have protected abortion access.<sup>20</sup> Abortion bans have a negative psychological impact on providers who must routinely refuse abortion care to patients, and disproportionately affect marginalized communities who already have lower than average access to healthcare services.<sup>22</sup> Burgeoning physician-led organizations are petitioning state governments in opposition to abortion restrictions, yet state policymakers are not acting.<sup>49</sup> Instead, physician-led organizations are fundraising, campaigning, and building coalitions in favor of ballot measures that protect abortion access. This has been successful in some abortion-restricted states, but others still lack any initiative to keep OB-GYNs in state. Without incentives to stay, OBGYNs will continue to leave abortion-restricted states and their populations will be unable to access comprehensive gynecological and pregnancy care, endangering the life, health, and wellbeing of millions of women of all ages and their families.

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