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Viewpoint

The Implications of the Supreme Court's Dobbs Judgment on Medical Training in the US

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Abstract

The recent US Supreme Court judgement restricting abortion represents an assault upon all women, especially less privileged women. This judgement will result in a rise in maternal mortality, a figure that for the US is already a very public outlier and tragedy. This commentary focusses on the impact of the Dobbs judgement on medical training. The ripple effects of this judgement and subsequent legislation enacted in abortion restrictive States are far wider than many will have assumed.

Keywords: Medical Training; Abortion; Law; Gender Equity; Maternal Care.

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The recent US Supreme Court judgement restricting abortion represents an assault upon all women [1], especially younger, poorer, minority women [2]. The high maternal death rate in the US has long been a damning international outlier, indicative of a broken health care system. This form of legislation inherently undermines gender equity and adversely impacts reproductive autonomy, reproductive justice and health equity [3]. The Dobbs judgement impacts not only all women, but all taxpayers. Medicaid births constitute 41% of all births ranging from a low of 21% in Utah, to a high of 61% in Louisiana. To know that tax dollars are being spent on inequitable and sub-optimal maternal care that will lead to further increases in maternal mortality rates is an issue that should energise all federal tax payers. Trite suggestions that foster care is an answer to the abortion issue fails to grasp critical weaknesses and shortcomings patently evident in that sector.

Much has been written about the impact of the abortion ban, an issue which is probably best described as a "magnet for political controversy" [4]. However, less has been written about the implications for training medical personnel, particularly when looking wider and beyond the stipulations of the bans themselves. This discussion aims to address these issues.

At the most basic level abortion practical training will effectively largely cease in restricted States. The newly enacted restrictions have already led many physicians working in the maternity health field in these States to relocate [5,6]. This will undoubtedly serve to increase what are termed maternity care deserts, impacting both patients and training. Physician competency in these States will be critically compromised [7]. Even in States with only partial restrictions medical personnel may not perform enough medically required abortions to achieve or maintain competence [8]. If trainees cannot learn non-lifesaving abortion techniques then within a short time there may cease to be anybody left to perform lifesaving abortions, as well as to teach others these invaluable skills [9,10]. Skill atrophy has implications not only for abortion care, but also for abortion adjacent care, such as miscarriage management [8,13]. One of the best predictors of a physician providing the full spectrum of pregnancy and miscarriage management options is training in abortion care as a resident [9,10,11].

More than 20 States have now enacted partial or complete bans on access to abortion that go beyond that previously protected by the Roe vs Wade judgement [12]. Crucially from an accreditation perspective this means that approximately 45% of medical education programs are in states that have or are likely to ban abortion [11]. The abortion ban will impact not only where students may opt to study [13], but also their choice of residency and career [10]. Average medical school graduate debt in 2022 was $205,037 [14]. This is a considerable debt to take on, particularly if one anticipates not having the full range and depth of training options available. However, career options and opportunities are not the only reason why potential students and residents may opt to choose less restrictive States. Medical training is usually undertaken by relatively young adults, coinciding with their most reproductive years. Evidence suggests that as many as one in six

medical students or their partners had an abortion [10,15]. Trainees therefore may opt to avoid states where abortion care is restricted to safeguard for their own and/or their family's health [10]. This is a real issue as further evidence suggests that physicians who become pregnant have higher rates of pregnancy related complications than the women generally [7].

The Accreditation Council for Graduate Medical Education (ACGME) have clarified that all programs must offer the opportunity for direct procedural training in terminations of pregnancy for those residents who desire it. The ACGME has provided updated guidance stating that programs in locations where access to such care is unlawful must support clinical experiences in a different jurisdiction [10,16]. However, achieving this level of provision given that almost half of programs are in restrictive States seems unfeasible [8,11]. Arranging such interstate rotations would require an enormous allocation of financial, legal, and administrative resources [8,10]. Concerns about this suggestion include not only the viability of such an option in terms of logistics and scheduling [8[, but the impact such an intense focus on attempts to achieve this requirement would have on other training rotations which might become the opportunity cost of such arrangements [10].

It must be acknowledged that medical students can impact productivity negatively and therefore there can be a lack of doctors willing to supervise them. The economic realities of contemporary medicine in the US should not be underplayed in evaluating plans for dramatic increases in training opportunities in less restrictive States. From the year 2000 onwards an ever-increasing number of doctors not free agents, but work under the umbrella of health systems with associated targets and metrics. The US hospital system is still critically weakened from the financial onslaught caused by the COVID-19 pandemic, and hundreds of rural hospitals/health centres/ clinics are under threat of closure [17-19].

The potential solution of out of State rotations to provide abortion training is also uncertain from a legal perspective. The question has been raised if residents can legally participate in out of State rotations in abortion techniques [8]. Additionally, could a university or program administrator involved in organizing or approving such a rotation be deemed culpable of aiding or abetting abortions? It is important to note that a decade ago the politics of abortion access were described in the US as "near fever-pitch" [20]. The divisiveness of this issue has only increased over time. Therefore, as well as the possibility of the real or threatened legal action against arranging or facilitating such out-of- state rotations there is also the real possibility that some State Governments may use financial pressure on universities to prevent this type of rotation. State Governments hold significant purse-strings as university funders, a tool that zealots in the current environment may choose to exploit.

The ripple effects of the abortion ban are considerable [7]. Significantly more than half of the medical workforce are women. This means that inevitably human resources will be impacted, including those who provide training [9]. Current training and supervision systems will be further stretched when a larger proportion of the workforce are pregnant, or on parental leave, or traveling across State lines themselves for abortion care [9]. Training and education opportunities may also be skewed geographically into the future as medical associations may be pressured to not hold conferences in States with restrictive bans as some clinicians in early pregnancy may be reluctant to attend [7]. Although these conferences are often arranged many years in advance, future bookings may swing towards more liberal States. In the meantime enhanced online access may be required at such training and educational events [7].

The abortion bans will also severely curtail research in abortion restrictive States across a range of issues related to maternal health. This may include not only abortion care, but miscarriage management, as well as contraceptive oriented research [8]. This may have a knock-on impact on research income and associated institutional overheads, international prestige, and global rankings. Several of the top ten best medical schools in the US two are located in states with abortion bans. Research, research income and publications are vital to maintaining such rankings. An effective ban on such an important aspect of maternal care may threaten the ranking of premier universities in abortion restrictive States. Abortion training restrictions and any drop in global university rankings may also impact foreign student applications and enrolment at universities in abortion restrictive States. Every year hundreds of foreign students are admitted to MD programs in the US. The training and skill loss in abortion restrictive states may act as a deterrent. Foreign student numbers are a factor in various university ranking systems. The loss of high levels of tuition fees, particularly from high paying foreign students may negatively impact College income and hence training and research.

It has also been noted that top tier applicants may avoid abortion restrictive States in order to access comprehensive training [10]. It is possible therefore that some educators in these States may find themselves having to adjust their training style to assist slightly less able students. This may come as a shock to some educators requiring a significant adjustment in teaching styles.

The new abortion restrictions may result in delayed treatment, medical mismanagement, and increased risk to mothers as physicians seek to protect themselves from legal action [8]. This in turn may result in both moral distress and the potential for moral injury, resulting a decline in both trainee and physician mental health and wellbeing [10,21]. Additional training in resilience and self-care as well as additional supports in training programs may be required to protect medical students. On this issue it should be noted that several States, such as Missouri and Texas, have even banned medical treatment in instances of ectopic pregnancy [7].

Evidence suggests that in States where abortions are limited more women will give birth. This means that labour and delivery wards will have to work over capacity. This is unsafe and not only impacts all births [9], but will inevitably reduce training opportunities and supports. Similarly maternity healthcare providers in less restrictive States within easy travel from more restrictive States may find themselves over-burdened. This may impact not only the standard of care provided, but also the ability of these facilities to provide adequate training.

A number of additional training requirements in the post Dobbs scenario have also been identified. For example as maternity care deserts grow, especially in restricted States, and for those operating across State lines from the security of more liberal legislation, increased skills in telehealth and remote prescribing will be required [7]. It has also been suggested that clinician educators may need to explore the provision of robust formalised miscarriage training, simulation, or remote learning [11]. However, it must be acknowledged that high fidelity simulation requires significant lead-in time, development and financial investment, which may not be available [8].

Working within abortion restrictive States clinicians may also have to receive additional training in working with patients in an environment of diminished patient trust [7]. With an increasingly punitive and litigious environment emerging in the maternal health care arena some patients in abortion restrictive States may be increasingly reticent to provide detailed and accurate pregnancy related information.

There is currently a considerable lack of clarity around abortion legislation in restrictive States, particularly given the contested and dynamic nature of evolving legislation. For example, what exactly constitutes a life-saving situation? Where does ending pregnancy for the purpose of immediate potentially lifesaving surgery or chemotherapy stand? [9,22] The training implications of operating in this scenario are significant. Medical curriculums are already over-burdened. Yet with the spectre of litigation and prosecution looming increased time and resources will have to be spent on legal topics [13]. Given the unfolding legislative environment this may not be a simple once off commitment, but an ongoing requirement. In addition, the medical workforce will need to become more familiar with dealing with both self-managed abortion and its complications, as well as the potentially lethal complications of the use of unsafe methods [8,9]. Additional training opportunities will also have to be developed to increase staff numbers trained in paediatrics and working in neo-natal ICUs as there will undoubtedly be more infants born with significant medical needs whose parents might otherwise have terminated their pregnancy after adverse foetal anatomical or genetic diagnosis [9]. Additional training opportunities may also be required in mental health disciplines. The US Mental health care system is already stretched beyond capacity and will undoubtedly be challenged further responding to both the needs of women carrying unwanted pregnancies, particularly after instances of rape and incest, and those attempting to care

for infants and neonates with profound needs [9]. Medical and social safety nets are unlikely to expand as need does, particularly within a short time frame [9].

The restrictions on abortion and abortion training will have significant negative impacts on maternal care across the US. Training in abortion and abortion adjacent skills will disappear or at least be critically hampered in many States. It is highly unlikely that less restrictive States will be able to facilitate a fraction of the required training required nationally, even if such rotations could be arranged. It is probable that we will witness an evolving decline in maternity care training and services as relevant educators relocate, retire, or find their skills suffering atrophy. Maternity care deserts and associated full-spectrum maternity care training deserts will spread. The bans will also impact the medical workforce as rates of births inevitably rise. This will impact educators directly, as well as via stretched and overloaded systems that will have less opportunity to take on and supervise trainees. These events are occurring at a time when there is a global shortage of healthcare personnel, impacting the US as it does many other countries. The pipeline of students into maternity care disciplines will be critically weakened in abortion restrictive States, hastening both a downward spiral in maternity care, and a concomitant increase in maternal mortality.

References

1. Hill M, Houghton F, Keogh Hoss MA. An Assault Upon Women: Reproductive rights in the US in the shadow of the 2022 US Supreme Court Ruling (the Dobbs ruling). Journal of the Royal Society of Medicine. 2023. doi: 10.1177/01410768231193308
2. Redd SK, Mosley EA, Narasimhan S, Newton-Levinson A, AbiSamra R, Cwiak C, Stidham Hall K, Hartwig SA, Pringle J, Rice WS. Estimation of Multiyear Consequences for Abortion Access in Georgia Under a Law Limiting Abortion to Early Pregnancy, JAMA Network Open. 2023;6(3):e231598. Doi:10.1001/jamanetworkopen.2023.1598
3. Liddell JL, McKinley CE. (2022). The Development of the Framework of Integrated Reproductive and Sexual Health Theories (FIRSHT) to Contextualize Indigenous Women's Health Experiences. Sexuality Research and Social Policy. 2022;19:1020-1033. https://doi.org/10.1007/s13178-022-00693-z
4. Wolf JH, Broecker JD. Placing abortion in historical, legal, and clinical context in American medical school classrooms. World Medical & Health Policy. 2022;14:178-194.
5. Abrams A. 'It's demoralizing': Idaho abortion ban takes toll on medical providers. The Guardian, 16/07/2023. https://www.theguardian.com/us-news/2023/jul/16/idaho-abortion-ban-ob-gyn-doctors
6. McLoughlin K. No OB-GYNs left in town: what came after Idaho's assault on abortion. The Guardian, 22/08.2023 https://www.theguardian.com/us-news/2023/aug/22/abortion-idaho-women-rights-

healthcare#:~:text=But%20she's%20also%20angry%20that,dictate%20how%20they%20practice%20medicine.
7. Samuels-Kalow ME, Agrawal P, Rodriguez G, Zeidan A, Love JS, Monette D, Lin M, Cooper RJ, Madsen TE, Dobiesz V. Academic Emergency Medicine. 2022;29:1414-1421.
8. Beasley AD, Olatunde A, Cahill EP, Shaw KA. New Gaps and Urgent Needs in Graduate Medical Education and Training in Abortion. Academic Medicine. 2023;98(4):436-439.
9. Harris LH. Navigating Loss of Abortion Services – A Large Academic Medical Centre Prepares for the Overturn of Roe v. Wade. New England Journal of Medicine. 2022;386(22):2061-2064.
10. Lambert SJ, Horvath SK, Casas RS. Impact of the Dobbs Decision on Medical Education and Training in Abortion Care. Women's Health Issues. 2023;33(4):337-340.
11. Vinekar K, Karlapundi A, Nathan L, Turk JK, Rible R, Steinauer J. Projected Implications of Overturning Roe v Wade on Abortion Training in U.S. Obstetrics and Gynecology Residency Programs. Obstetrics & Gynecology. 2022;140(2):146-149.
12. New York Times. Tracking Abortion Bans Across the Country. The New York Times, 23/08/2023. https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html
13. Gyuras HJ, Field MP, Thornton O, Bessett D, McGowan ML. The double-edged sword of abortion regulations: Decreasing training opportunities while increasing knowledge requirements. Medical Education Online. 2023;28(1):2145104. DOI: 10.1080/10872981.2022.2145104
14. Association of American Medical Colleges. Medical Student Education: Debt, Costs, and Loan Repayment Fact Card for the Class of 2022. AAMC; 2023. https://store.aamc.org/downloadable/download/sample/sample_id/575/
15. Levy MS, Arora VM, Talib H, Jeelani R, Duke CMP, Salles A. Abortion among physicians. Obstetrics and Gynecology. 2022;139(5):910-2.
16. Accreditation Council for Graduate Medical Education (ACGME). ACGME Program Requirements for Graduate Education in Obstetrics and Gynecology (2022) Accreditation Council for Graduate Medical Education; 2022. https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_9-17-2022.pdf
17. American College of Health Care Executives (ACHE). Survey: Workforce Challenges Cited by CEOs as Top Issue Confronting Hospitals in 2022. ACHE; 2023. Press Release Feb 13 2023.
18. Rhodes JH, Santos T, Young G. The Early Impact of the COVID-19 Pandemic on Hospital Finances. Journal of Healthcare Management. 2023;68(1):38-55. DOI: 10.1097/JHM-D-22-00037
19. Cordes C. Outsourcing the Revenue Cycle Management for Maintaining Viability for Small and Critical Access Hospitals. Presentation to the American College of Healthcare Executives August 2 2023.
20. Aksel S, Fein L, Ketterer E, Young E, Backus L. Unintended Consequences: Abortion Training in the Years After Roe v Wade. American Journal of Public Health. 2013;103(3):404-407.

21. Farrell CM, Hayward BJ. Ethical dilemmas, moral distress, and the risk of moral injury: experiences of residents and fellows during the COVID-19 pandemic in the United States. Academic Medicine. 2022;97(35):S55.
22. Giglio ME, Magalski GR, Doan YP, Bowman S. Abortion Training in Medical Education – Implications of the Supreme Court's Upcoming Decision. New England Journal of Medicine. 2022;386(8):707-709.