Reworking Emergency Medicine Resident Education Post-Dobbs v Jackson Women's Health Organization

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Overview of Dobbs' Impact on Emergency Medicine Practice

On June 24, 2022, the US Supreme Court in *Dobbs v Jackson Women's Health Organization* reversed a 50-year precedent, a constitutional right to an abortion, and returned this decisions to each state.[1] Following the *Dobbs* decision, more than 24 states have some form of an abortion ban, although 11 of these bans face court challenges.[2] As a result of these abortion bans, emergency medicine (EM) physicians are encountering new and increasingly complex clinical challenges.

First, many of the state abortion bans leave EM physicians vulnerable to criminal liability.[3] Some states criminalize aiding or assisting in the provision of an abortion. Even when there is an exception for medical care to save the life of the mother, the laws may not delineate what is a life-threatening emergency, although some specifically exclude mental health considerations.[4] Conditions that seem unequivocal from a medical perspective, such as an ectopic pregnancy,[5] for which the standard of care is to end the pregnancy, are not clearly protected from prosecution. Laws often leave room for interpretation or create specifications that can delay definitive treatment and cause harmful consequences. For example, many laws leave open whether methotrexate can be used to induce abortion for ectopic pregnancy if there is still a fetal heartbeat.[6] With this ambiguity, EM physicians in states with bans may find themselves caught between risking criminal charges, on the one hand, or clinical negligence, on the other.[7]

Moreover, the EM ethos of "anyone, anything, anytime"[8] is threatened by legal challenges to the Emergency Medical Treatment and Labor Act (EMTALA), which requires emergency departments (EDs) to provide stabilizing treatment to patients under their care. Following the *Dobbs* decision, the US Department of Health and Human Services (HHS) issued explicit guidance that "if a physician believes that a pregnant patient presenting at an ED, including certain labor and delivery departments, is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment."[9] EMTALA, per HHS, should preempt any state law. However, courts have differed on whether it does.[7,10,11]

Implications for Residents and Fellows

The state-to-state variability in abortion access means starker differences in choices for incoming residents. Geographic location is consistently a leading driver of rank list decisions.[12] Considering that residents tend to stay and practice where they trained,[13] applicants may rightfully feel the need to ensure that a potential training site has long-term potential for their lives; access to a full range of reproductive services may be an important component of these decisions for residency applicants, their partners, and other loved ones.

Information on the extent to which states' positions on reproductive health services informs choice of training location is emerging. In one recent online survey, nearly 90% of medical student respondents indicated they would not apply to residency in a state where there was an early or late ban on abortion or where there could be legal consequences for providing abortion care.[14] Greater than 90% said they would preferentially apply for residency in states where access to abortion was preserved.[14] The Association of American Medical Colleges' Match data from the most recent application cycle suggests that such intentions are being realized.[15] This year the number of unique applicants to abortion restricted states appears to have declined disproportionately in states with abortion bans, and while unique applicants to obstetrics and gynecology decreased overall, the decrease was highest in states with complete bans (-10.5%) and lowest (-5.3%) in states without restrictions. If these patterns persist, shifts in where trainees apply, interview, rank, and practice will

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worsen the number and size of reproductive care deserts and exacerbate health inequities.

EM trainees may be concerned about the completeness of their education in abortion-restricted states. Abortion restrictions are likely to impact the context of care in myriad ways, including the routineness of pregnancy testing, discussions after an incidental finding of pregnancy (eg, obtained during trauma evaluation or prior to cross-sectional imaging), as well as management of patients who are having spontaneous abortions or seeking care for complications after medical or procedural abortions. Abortion restrictions can compromise clinical care and patient-physician relationships. For example, a history of a previous abortion may be relevant to patient care, but patients may not wish to divulge such histories in states where there are legal consequences for doing so.

Programs in all states that wish to attract diverse, competitive candidates need to consider how they will address the concerns of prospective applicants. Saying nothing may be the worst course of action: it may amplify the perception that discussing abortion care is off limits and will be neglected during training, even when relevant. As they are able, program leaders may wish to address the impact of reproductive health care restrictions directly during the inquiry and interview process, acknowledge any limitations on practice or training, and consider discussing with applicants accommodations (eg, elective away rotations) or curricular adaptations under consideration to make up for training gaps.

One of the appeals of EM is its practice breadth and autonomy (ie, the ability to jump in and do what is necessary for sick and unstable patients). Post-*Dobbs*, it is important for programs to vouch they are preserving the essence of EM practice, even as laws attempt to encroach on evidence-based, high-quality care. This is particularly necessary in a time when students' interest in entering EM is plummeting.[16]

Recommended Changes to EM Training

The Accreditation Council for Graduate Medical Education (ACGME) states that EM residency programs prepare physicians by teaching fundamental skills, knowledge, and humanistic qualities that constitute the foundations of EM practice and enable effective management of clinical problems.[17] However, this core content likely needs an update. The first official EM residency was started in 1971[18] and *Roe v Wade* was decided in 1972; thus, EM training has been based on reproductive care standards that have evolved greatly over the past 50 years. For example, since 2020 the 2-pill medication abortion has become the dominant form of first trimester abortion in the United States, and self-managed abortions—those performed outside a formal clinical setting, such as telehealth dispersal of medication—are on the rise following the *Dobbs* decision.[19]

The *Dobbs* decision will exacerbate existing disparities in maternal health,[20] and likely drive related pregnancy and miscarriage care to the perennial health system safety net, the ED. As a result, EM education will necessarily expand to include contraception screening and provision, manual uterine evacuation, and the provision of medication abortions in the ED. There is precedent for EM physicians performing these functions, but they need to be further developed and more widely incorporated into residency training.[21-23]

For obstetrics and gynecology residency programs, the ACGME requirement for abortion training remains unchanged post-*Dobbs*, with a recent update stating that "if a program is in a jurisdiction where resident access to this clinical experience [provision of abortions] is unlawful, the program must provide access to this clinical experience in a different jurisdiction where it is lawful."[24] Following this lead, EM residency programs could offer experiences in various practice environments, for example, through a network of interstate reproductive health electives, so that residents in abortion-restrictive states can travel to learn related procedures and be better able to discuss options with patients who may have to travel out of state to receive reproductive health care. Such experiences will allow residents to gain competencies and be fully prepared to practice independently no matter where they work after training. To provide these training opportunities, some residency programs, in less restricted reproductive health states, must step forward and establish themselves as centers of excellence for interstate education. Issues regarding training medical licenses, lost resident time, salary, and travel will require national discussions and perhaps outside funding.

Online resources related to reproductive care can also be incorporated into residency curricula. Examples include Innovating Education in Reproductive Health,[25] Training in Early Abortion for Comprehensive Healthcare,[26] and Training, Education, & Advocacy in Miscarriage Management.[27] Simulations may be employed to expand training available to residents for problem recognition, resuscitation, stabilization, and procedural skills. The COVID-19 pandemic showed the utility of using virtual learning and was generally well received among residents.[28] Residency programs could leverage the virtual environment and organize shared grand rounds or other

conferences, where lecturers from different practice environments could interact.

In addition, EM training should be expanded to incorporate liability and legal resources that physicians will need to practice safely, particularly in states with laws that restrict provision of standard of care practices. This will require routine engagement with medicolegal experts and legal departments within institutions. Some legal education will be needed, regardless of residency location. As patients travel to nonrestricted states for care and develop emergent conditions, EM physicians practicing in abortion-legal states will need to understand the legal implications of caring for "abortion refugees" across state lines as well as know available resources—including travel, lodging, and financial support—to fully care for these patients.

Conclusions

Abortion-restricted states are heading into a perpetual cycle of skills drain, trainee avoidance, and physician loss that will harm patients who need reproductive services of all kinds—not just abortion. This is already demonstrated by maternity wards closure in states with restrictive laws.[29] Where there are gaps in care, people will turn to the ED, which must be prepared to receive them with clinicians competent to provide high-quality care.

While training institutions face tremendous challenges in providing reproductive health-related care, EM is a specialty that is defined by nimbleness, adaptation, and innovation. A fundamental aspect of our practice is to work in challenging, complex, and rapidly shifting environments. Across all states, EM trainees will most certainly continue to learn this meta-skill.

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