

***Dobbs'* Erosion of the Health Care Workforce: Harms to Providers and Patients**

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The Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, and extreme abortion bans and restrictions passed by states even prior to then, have had far reaching impacts on health care providers and the communities they care for.

Providers have been forced to shift the care or services they provide, relocate, or cease offering care altogether in response to restrictive state laws, the increasing threats of criminalization, and threats to medical licensures. Training opportunities in sexual and reproductive health care for those in restrictive states have severely diminished and become even more difficult to access. And existing provider shortages have been exacerbated by these public policy decisions, as well as by multiple ongoing public health crises. These challenges both undermine the health care workforce and hurt patients, whose ability to access evidence-based, high-quality, and equitable health care is further limited. Moreover, these harms are not limited to the reproductive health care context; there have been far-reaching consequences for maternal health and health care writ large.

Dobbs has directly harmed providers in several ways. The inability to provide care that they know to be routine and necessary for patients — and the climate of fear, confusion, and increased legal risk — have had both tangible and intangible negative effects on them. These include the economic costs of being forced to relocate to a new state in order to continue practicing medicine, the mental health toll of moral injury and seeing patients denied access to care, the financial and emotional cost of taking on legal risk, the threats to their physical safety from providing abortion care in increasingly hostile environments, among others. While we are already beginning to see these widespread impacts on the health care provider workforce in the short time since the *Dobbs* decision was rendered, we expect these consequences to intensify as providers continue to try

and meet demand for critical health care services amidst a constantly changing and adverse legal environment.

This issue brief documents these various harms to both patients and providers, and includes real-life stories from providers that illustrate the very difficult and complex questions they are facing. It also offers policy solutions to help address these harms and invest in a health care system that better meets the needs of both patients and providers.

***Dobbs* has intensified the health care provider shortage**

The *Dobbs* decision accelerated a growing health care workforce shortage. This crisis is fueled by several interrelated drivers, including burnout, a global COVID-19 pandemic, lack of worker-supportive policies, and stagnation in health system reforms such as inadequate provider reimbursements, misaligned incentives, and limited investment in multidisciplinary care teams at the state and federal levels.

The American Association of Medical Colleges (AAMC) currently projects a national physician shortfall across all primary care and specialties of at least 37,000, and potentially over 100,000, over the next decade.¹ The shortage of obstetrician-gynecologists (OB-GYNs), family medicine physicians, adolescent medicine doctors, and internal medicine providers is particularly concerning. For example, the American College of Obstetricians and Gynecologists (ACOG) estimated that in 2020, there was a shortage of 8,800 practicing OB-GYNs nationwide, with more than half of all U.S. counties lacking *any* practicing OB-GYN at all.² And, already, 30% of patients do not have a primary care doctor due to a shortage of family medicine providers.³ These provider shortages are not limited to physicians; the same factors are also driving a shortage of nurses. As one example, one study predicts a national deficit of nearly one million registered nurse jobs by 2030.⁴ Provider shortages extend to advanced practice clinicians, including midwives. In addition to the aforementioned factors, midwives and other community health providers in particular have also been forced to grapple with a history of racial, gender, and economic discrimination within their workplaces, alongside unnecessary, burdensome restrictions, including physician supervision requirements and scope of practice limitations.⁵

Unfortunately, in addition to shortages in the *overall* number of providers, the persistent lack of diversity among existing providers is especially troubling considering ongoing, intractable racial and ethnic health inequities. Only about 5.7% of physicians are Black or

African American and 6% are Hispanic,* even though they make up 14% and 19% of the U.S. population respectively.⁶ This lack of diversity matters because evidence shows that racial concordance between patients and providers has a direct impact not only on trust, which has been shown to be the cornerstone of patient-provider relationships, but on health outcomes as well.⁷ People of color continue to grapple with a health care system that routinely fails to treat them with respect, operates in untrustworthy ways, and is rife with medical racism and bias.⁸ Inequities in outcomes are well-documented, and evidence shows that patients of color are more likely to be misdiagnosed than white patients.⁹ For example, when Black people receive care from a provider of a different race, they are routinely offered fewer effective interventions or treatments.¹⁰ Another study found that Black men treated by Black physicians had better patient interactions and were more likely to agree to preventative services like cardiovascular screenings and immunizations that help combat rates of chronic disease, compared to Black men who were treated by providers who were not Black.¹¹ The study also estimates that if more Black people were seen by Black physicians, the Black-white heart disease mortality gap could be reduced by 19%.¹²

Looking specifically at reproductive health care, one study found that about one in four patients who identified as Black and roughly one in six who identified as Latinx reported race or ethnicity-based discrimination when seeking abortion care.¹³ That discrimination translated to negative experiences of care and poorer care quality, including less time with the physician, less patient care involvement, and lower quality physician communication.¹⁴

Increasing diversity in the health care workforce, especially among reproductive health care providers, will enable more patients of color to receive care from providers with the same racial or ethnic background, leading to more favorable care interactions and improved health outcomes.¹⁵ Unfortunately, another recent pair of Supreme Court decisions, *Students for Fair Admissions, Inc. (SFFA) v. President & Fellows of Harvard College* and *SFFA v. University of North Carolina*, roll back protections for affirmative action in higher education and will likely make it even harder to bring qualified and talented people of color into the health care professions pipeline.¹⁶ Studies show that affirmative action bans at the state level have led to about a 17% decline in the matriculation of medical school students who are underrepresented students of color;¹⁷ this trend will likely only spread nationwide and worsen in the coming years.

* We use the term “Hispanic” here because that is the language used in the studies referenced. Where possible, we use terminology like “Latine/x,” which encompasses shared culture, ethnicity, and identity and not racial categories, and which also challenges the gender binary in the Spanish language and embraces the diversity of genders that often are actively erased from spaces.

As more abortion bans and restrictions are implemented, the existing shortage of sexual and reproductive health care providers will continue to grow. It is no surprise that the states with the most restrictive reproductive health policies are among the states that already have the fewest physicians per capita, including, for example, Idaho, Mississippi, Oklahoma, Wyoming, and Arkansas.¹⁸ Currently millions of Black and Latinx people of reproductive age live in states with the most restrictive abortion bans,¹⁹ and while health care providers are more likely to continue living and practicing where they complete their training, abortion bans and restrictions mean that there are fewer opportunities for providers of color to train in and continue working to care for their communities.

***Dobbs* is harming reproductive health care providers' well-being and economic security**

The *Dobbs* ruling – on top of decades of increasing abortion restrictions – have further undermined both institutional and individual reproductive health care providers' financial security, health, and general well-being. In just the first hundred days post-*Dobbs*, at least sixty-six clinics, Planned Parenthood facilities, and doctors' offices stopped offering abortion care.²⁰ In addition, approximately half of clinics that were previously providing abortions in restrictive locations pivoted to providing only other services such as contraception and prenatal and maternal care.²¹ Other practices left the state entirely, relocating to less restrictive places. Reasons for closure or elimination of health care services include outright bans prohibiting provision of care, threat of criminal penalties including prison time, and other personal and legal risks associated with providing care in hostile states, including harassment and threats of violence. When clinics close or relocate, staff across the organization are impacted in many ways, including loss of employment.

On an individual provider level, the hostile legal landscape is forcing many to consider either leaving the health care industry entirely or moving to places with more legal protections and less legal risk. According to a recent survey of approximately one thousand health care workers, 11% said they "have considered leaving the health care industry due to states' implementation of abortion restrictions."²² Similar shares of workers said they would consider moving to states where abortion access is protected and that they are concerned about their job security. Already many providers have made the decision to relocate to less restrictive states, have ceased providing abortion care and pivoted instead to providing other types of essential sexual and reproductive health care, or have left the health care workforce entirely because of restrictive state laws.

"I chose to move to a state that would allow me to provide abortions to patients in a primary care setting. This was extremely difficult for me to find, especially since I am motivated to provide care for underserved patients (specifically at federally qualified health centers). Most FQHCs do not provide abortion care due to the Hyde Amendment. Fortunately, my job does allow this, but it required a move across the country."

— **Anonymous, MD, New York and Kansas**

The decision about whether or not to relocate undoubtedly impacts the availability of care in particular areas, but it is also a deeply personal question that has significant impacts on providers themselves. For providers who choose to move to a new state, there are the financial costs of securing housing, packing, transportation, obtaining new medical licensure, and more. The process of relocating takes time away from providing care and likely causes disruptions in income, which can be especially challenging for providers carrying student loan debt. There is also the emotional upheaval of uprooting oneself and one's family, moving away from communities and networks of support, children changing schools, and starting a life over again in a new and often unfamiliar area.

"I would say [the decision to move because of abortion restrictions has cost] over \$150,000 per year in lost job opportunities since 2021, as well as the cost of around \$20,000 to move, new medical licenses and DEA [registration fees] and in general to re-establish myself personally and professionally."

— **Mariana Montes, MD MPH, Illinois**

“There's a great amount of moral distress. I now work at an academic center, and there continues to be a lot of confusion about what is “legal,” and what can prompt a civil suit. Added to that, our [Attorney General] threatens anyone who helps someone get a legal abortion — including hospital support staff, so that many are afraid of taking care of pregnant people who have medical reasons to end their pregnancies — it is frustrating and maddening to not do right by patients because people from hospital administration down are scared about what “might” happen. My sense of self as a provider is compromised — I never realized until Dobbs just how much of my personal identity was tied to being an abortion provider. My income has been significantly impacted — I make approximately 30% less than when I was providing abortion care. While I'm fortunate to have a spouse that does well financially, it still has caused a lot of anxiety, and we've had to make decisions based on finances that we never had to make before.”

— Anonymous, MD, Texas

It is also essential to name that these shifts, from both institutions and individual providers, in response to abortion restrictions take a significant toll on the providers who wish to remain in their communities. While providers, abortion funds, support networks, and advocates continue to undertake herculean efforts to meet demands for care, it is not possible for individual providers who remain in restrictive states to meet the needs of entire communities alone. These providers also carry the tremendous emotional weight of being forced to limit access to essential patient care, or of risking their licensure or being criminalized.²³ In addition, providers who stay in restrictive states may incur added expenses such as higher malpractice insurance fees, increased security costs to counter harassment and threats of violence, and the expense of legal consultation or representation to address increased liability.

"I have strongly considered leaving for some time. It is increasingly difficult to be a practicing OB-GYN in Florida, let alone an abortion provider. I have family in Florida and have stayed for this reason. What this means is that I cannot practice to my highest ability. I have a specific skillset that I cannot use to provide care for patients. My ethics have also been compromised. I am forced to turn away patients I otherwise am able to care for and for whom I know this care is what is needed...It doesn't make sense and completely goes against medical ethics. What has felt important in staying in Florida is that I can still provide care to Floridians who need the care. I know that just because there are restrictions doesn't mean that people don't need their abortions."

— Robyn Schickler, MD, Florida

"I honestly would like to leave the state, however I have remained here due to family/work obligations. I know that patients in the state of Louisiana need access to health care more than ever, so at least I am helping to provide that for some of them. However, it has been challenging to not have somewhere to refer them to for abortion care in the state, knowing most can't travel out of state due to funding/transportation issues. I feel that the restrictive abortion laws are compromising patients' individual bodily autonomy, but also timely access to abortion care."

— Neelima Sukhavasi, MD MPH, Louisiana

"I have stayed in a restrictive state because I know the people of Ohio need and want excellent reproductive health care. Although we have many burdensome restrictions in place, at least we are able to provide abortion care to the people of Ohio and the surrounding states that have bans in place. Ohio already had a limited number of clinics for the size of its population, and now, with patients coming from surrounding states, there is even more need for trained, passionate abortion providers. Staying in a restrictive state is not without risks, and the fear of access to abortion being further restricted is still present even after a political win with the reproductive freedom amendment. Our clinics are heavily scrutinized, both from the state department of health and the protesters outside every day. The recent case of Brittany Watts facing charges for a miscarriage demonstrates the hostility of prosecutors in the state towards reproductive health care, even with a constitutional amendment in place."

— Courtney Kerestes, MD, Ohio

Lastly, providers who make the difficult decision to leave the health care workforce entirely are often sacrificing their income and economic stability, years of education and training, as well as a sense of mission and purpose from a profession that they are now having to leave behind.

These economic and emotional consequences may be felt most acutely by providers of color, who may have added layers of complexity as they consider whether to stay or relocate and the costs of either choice. For example, providers of color more frequently provide care in communities of color and may feel particularly compelled to stay in their communities because they recognize the importance of racial concordance between patients and providers and its role in improving health outcomes. In addition, providers of color may be at increased risk of being surveilled and criminalized in places where abortion bans and restrictions specifically target providers, so staying in a restrictive state means taking on that increased risk.²⁴ Providers of color also carry disproportionate debt from student loans, and so may be less likely to have resources to move to another state or less able to absorb the economic impacts of these shifts in the provider workforce.²⁵

Bans and restrictions on abortion care that continue to drive providers away and threaten the health and well-being of providers and their families are setting up impossible circumstances and perpetuating immense harm.

***Dobbs* is undermining medical education and training, diminishing the future health care workforce**

In addition to undermining the ability of current providers to practice medicine, the *Dobbs* decision has also fundamentally altered the landscape of education and training in medical schools and residencies. Importantly, education and training in abortion care, particularly opportunities for hands-on learning, have been limited in medical schools for decades prior to *Dobbs*. While U.S. medical schools require students to complete a rotation in obstetrics and gynecology, there is no requirement that the rotation include education or training related to abortion care. In 2020, researchers at Stanford University found that half of medical schools included no formal abortion training and, in some instances, provided only a single lecture on the procedure.²⁶ Not surprisingly, *Dobbs* has further exacerbated barriers to abortion training as states have moved rapidly to restrict or ban access to abortion entirely. In the face of heightened legal risk and increased uncertainty, it is likely that more medical schools located in restrictive states will cease to provide information or training in abortion care, if they did prior to *Dobbs* at all. Medical societies including ACOG and the American Medical Association (AMA) strongly support

comprehensive abortion education and training in medical school; but learners are increasingly missing out on this core competency as a result of abortion bans and restrictions, as well as heightened institutional anxiety as more states impose severe criminal and civil penalties on abortion provision.²⁷

Furthermore, it is estimated that 94% of abortions in the U.S. are provided in facilities outside of the traditional learning environment, such as hospitals and academic health centers.²⁸ Consequently, students who wish to obtain additional education and training in abortion care must seek out such training on their own. Even prior to *Dobbs*, this presented challenges to medical students, who must carry the burden of finding and obtaining this essential education and training. In the post-*Dobbs* environment, with many medical schools located in states that ban or heavily restrict access to abortion care, it is nearly impossible for many students to obtain the hands-on learning required of all medical students prior to matriculation.

The ripple effects of the Supreme Court's decision are not limited to abortion-specific education in medical schools. For example, in the wake of abortion restrictions and the legal uncertainty that bans have created for institutions, providers, and learners, many training rotations and electives in other areas of family planning, such as contraception and fertility care, were canceled. Some institutions also expressed fear that they would no longer be able to provide education on subjects that are sometimes deemed "controversial," like medical ethics, and that they may be limited from providing learners with education about the full range of treatment options available for certain medical conditions, which in some cases includes abortion, without opening the institution or themselves to increased legal risk for providing or facilitating abortion care.²⁹

As learners matriculate through medical residency programs, they are also missing essential educational and training opportunities as a result of *Dobbs*. For more than twenty-five years the Accreditation Council for Graduate Medical Education (ACGME) has had an explicit requirement that all OB-GYN residency programs seeking accreditation provide access to routine abortion training. Following *Dobbs*, ACGME issued guidance stating that if a program is in a legally restrictive location, the program has a responsibility to provide access to abortion training in a place without legal restrictions.³⁰ Training in abortion care is considered a core competency in OB-GYN residencies and is essential for other physician specialties, including family medicine, adolescent medicine, and internal medicine physicians who often provide abortion care.³¹ Given that nearly one in four women will have an abortion in their lifetime, it is critical that providers acquire this skill. Abortion may also be indicated in urgent medical situations complicated by pregnancy such as pre-eclampsia, hemorrhage, and severe pulmonary hypertension. Additionally, when managing miscarriage or pregnancy

loss, abortion training can be lifesaving.³² This training also allows residents to achieve competency in skills they will use over the course of their careers, such as the provision of pelvic exams, administration of anesthesia, and patient education. In short, training in abortion care is essential to ensure the health and well-being of pregnant people and is especially necessary considering the country's ongoing — and worsening — maternal health crisis.

Dobbs has not only made it more difficult for physicians to get the training they require to adequately care for their communities, it has also impacted the decision of some graduating physicians regarding their chosen practice specialty and location — undermining access to essential forms of care and exacerbating inequities across communities. One survey found that among third and fourth year medical students, nearly 60% said they were unlikely to apply to residency programs in states that restrict abortion.³³ Relatedly, data from the Association of American Medical Colleges (AAMC) shows that applications for residency programs in states with abortion restrictions fell by 3%; this shift fell hardest in obstetrics and gynecology, in which programs saw a 5.2% drop in application volume.³⁴ In states with complete abortion bans, the number of applicants to OB-GYN residency programs fell by more than 10% when compared to the prior year.

Providers often remain in the communities in which they train.³⁵ However, the *Dobbs* decision is causing many residents to reconsider remaining in states where they have trained if those states restrict abortion care. In a 2023 survey of graduating residents from residencies with Ryan Residency Training Programs, a national initiative designed to integrate family planning and abortion training into OB-GYN residencies,* 17.6% of residents indicated that the *Dobbs* decision changed their location of intended future practice or fellowship plans.³⁶ Residents who, prior to *Dobbs*, indicated they intended to remain or practice in abortion-restrictive states were eight times more likely to have changed their practice plans as compared to those who intended to practice and remain in states with additional protections. When people seeking comprehensive sexual, reproductive, and maternal health care are unable to access providers in their community who are adequately trained to care for them, the consequences to individual health and well-being are devastating.

* To help programs meet the Accreditation Council for Graduate Medical Education (ACGME) mandate for routine abortion training in obstetrics and gynecology (OB-GYN) training programs, Dr. Uta Landy created the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning in 1999. The Ryan Program works directly with OB-GYN residency programs to integrate training in abortion and contraception care (family planning) as a required rotation. All programs establish or expand abortion services in their teaching hospitals and may also create new partnerships with local clinics to train residents. <https://ryanprogram.org/home/overview/>

"I am currently practicing in a state with restrictions. I am here because I have family and it is where I wanted to train however the restrictions have increased since I came here, and I feel that my patients and doctors are suffering because of them. I think patients' health is at risk, and I have seen patient care be altered due to the law. I think doctors are now under more stress because they have been put in a position to determine what a vague law means and potentially risk [their] freedom to provide evidence based and patient centered care."

— Abby Schultz, MD, North Carolina

Dobbs' overall erosion of the provider workforce is hurting patients

As discussed above, the *Dobbs* decision has cratered the availability of reproductive health care services for people across the country — precisely as intended. In the context of the escalating overall health care provider shortage, this is extremely worrying. A February 2023 HealthDay poll found that 35% of patients noticed or were affected by health care staffing shortages, and nearly three out of four adults who tried to obtain health care in the previous six months experienced delays in receiving care.³⁷ More than half of them noted they were worried they would not receive needed medical care due to staffing shortages.³⁸

In the reproductive health context specifically, *Dobbs* had an immediate and direct impact on access to essential forms of health care as states banned abortion care outright.³⁹ Even in states where abortion is nominally available — such as places where there are gestational age bans or so-called exceptions for the "life of the mother" — those exceptions are so narrow that they are meaningless. They do not increase the likelihood of a person's ability to access care or a provider's ability to provide it. For example, in states with gestational restrictions (in other words, limits on abortion after a certain point in pregnancy), only 10% of OB-GYNs offer abortion care, as opposed to states that do not have gestational restrictions where 29% offer abortion care.⁴⁰

Robust research demonstrates that when people seek abortions but are denied care, there are short- and long-term harms across nearly all dimensions of their lives, from decreased health and well-being, to lower educational and career attainment, to higher risks of poverty, to negative effects on any current and future children.⁴¹ For those who are able to access abortion, doing so often comes at considerable economic and personal cost. For example, people have to travel long distances, often across state lines, which requires arranging for time off work (often in the absence of paid sick days),

paying for childcare, shouldering transportation and lodging costs, and more.⁴² In 2023, it is estimated that one in five people are forced to travel for abortion care,⁴³ and 14% of the U.S. population is now more than 200 miles from the nearest abortion facility.⁴⁴ States without legal restrictions or barriers are also impacted. Providers in states where abortion remains legal report seeing at least double the number of patients now, which is increasing wait times for appointments and makes it more difficult for people to access care where they live.⁴⁵

Dobbs has also contributed to a significant reduction in the availability of health care services beyond abortion care.⁴⁶ This has been especially prevalent in the maternal health context, where, as a direct result of abortion bans, pregnant people are being denied miscarriage care, turned away from hospital emergency departments until their health deteriorates substantially enough to “qualify” for abortion care, or forced to travel long distances while in acute medical crisis in order to receive life-saving abortions.⁴⁷

Abortion restrictions — in combination with the lack of available and trained providers — have also pushed even routine pregnancy-related care far out of reach for millions of people. For example, providers have expressed that *Dobbs* has worsened the patient-provider relationship and negatively affected their ability to provide evidence-based care.⁴⁸ Providers are reporting delays of as many as three months for patients scheduling prenatal visits and ultrasound appointments.⁴⁹ Patients with pregnancy complications or medically complex pregnancies are also reporting long wait times to connect with providers and needed services.⁵⁰ Some hospitals have even been forced to close their labor and delivery units or shut down entirely in part due to provider shortages as a result of abortion bans, cutting off care for entire communities and especially harming pregnant people who lack the ability to travel long distances.⁵¹ Importantly, nearly one-third of U.S. counties, where more than 2.2 million people of childbearing age reside, have been designated as maternity care deserts, with neither a hospital maternity unit, nor a birth center, OB-GYN, or certified nurse-midwife.⁵² In these areas, it is virtually impossible for patients to receive any care, let alone high-quality reproductive and maternal health care. Delays in or inability to access care can result in poor health outcomes for both the pregnant person and the infant, including increased risk of potentially dangerous medical conditions and outcomes such as preeclampsia and gestational diabetes, low birth weight, and maternal and infant mortality.⁵³

This aspect of the provider workforce crisis, exacerbated by *Dobbs*, is especially egregious in light of the U.S.’s ongoing — and in fact worsening — maternal health crisis.⁵⁴ Data shows that maternal and infant death rates are higher and have increased twice as fast in states that ban or restrict abortion,⁵⁵ and both abortion bans and lack of

high-quality maternal health care disproportionately harm Black, Indigenous, and other people of color. More specifically, the pregnancy-related mortality rate for Black women in the U.S. is three to four times higher than the rate for white women, and other women and birthing people of color also face elevated rates of mortality and morbidity.⁵⁶ Given that people of color are both more likely to live in states with abortion bans and also face greater barriers to accessing care,⁵⁷ these inequities will likely get worse as the provider shortage and attacks on reproductive health care grow.

Policy Recommendations

Addressing the multifaceted harms caused by the *Dobbs* decision and abortion bans on the U.S. health care workforce and on access to health care requires bold congressional action. These legislative priorities must include investing in the reproductive health care provider pipeline and workforce and addressing broader shortages in primary care and maternal health care, in addition to enshrining protections for abortion access into law. Key bills include:

- S. 2024/H.R. 4147 Reproductive Health Care Training Act
- S. 1297/H.R. 2907 Let Doctors Provide Health Care Act
- S. 1031/H.R. 561 EACH Act
- H.R. 4303 Abortion Justice Act
- S. 701/H.R. 12 Women’s Health Protection Act
- S. 100/H.R. 547 Better Care Better Jobs Act
- S. 2840 Bipartisan Primary Care and Health Workforce Act
- Reproductive Health Care Accessibility Act
- S. 1851/H.R. 3768 Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act
- S. 1606 / H.R. 3305 Black Maternal Health Omnibus
- S. 1710 / H.R. 3523 Perinatal Workforce Act
- HRSA Title VII and Title VIII Programs

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¹ Association of American Medical Colleges. "AAMC Report Reinforces Mounting Physician Shortage," June 11, 2021, <https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage>.

² Linda Marsa, "Labor Pains: The OB-GYN Shortage," *Association of American Medical Colleges*, November 15, 2018, <https://www.aamc.org/news/labor-pains-ob-gyn-shortage>.

³ National Association of Community Health Centers. "Closing the Primary Care Gap," February 2023, <https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap-Full-Report-2023-digital-final.pdf>.

⁴ National Academies of Science: Engineering and Medicine. "The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity," *National Academies Press* (US), May 11, 2021, <https://www.ncbi.nlm.nih.gov/books/NBK573922>.

⁵ "Assessing Progress on the Institute of Medicine Report *The Future of Nursing*," Committee for Assessing Progress on Implementing the Recommendations of the Institute of Medicine Report, *The Future of Nursing: Leading Change, Advancing Health*; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine; Assessing Progress on the Institute of Medicine Report *The Future of Nursing*. Washington (DC): *National Academies Press* (US); Feb 22, 2016, <https://www.ncbi.nlm.nih.gov/books/NBK350160>.

⁶ Association of American Medical Colleges. "Diversity in Medicine: Facts and Figures 2019," <https://www.aamc.org/data-reports/workforce/data/figure-18-percentage-all-active-physicians-race/ethnicity-2018>.

⁷ Patrick Boyle, "Do Black patients fare better with Black doctors?," <https://www.aamc.org/news/do-black-patients-fare-better-black-doctors#:~:text=Research%20shows%20that%20racial%20concordance.and%20adherence%20to%20medical%20advice>; Megan Johnson Shed, et al., "The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature," *Journal of Racial and Ethnic Health Disparities*, March 8, 2017, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5591056/>; Anuradha Jetty, et al., "Patient-Physician Racial Concordance Associated with Improved Healthcare Use and Lower Healthcare Expenditures in Minority Populations," *Journal of Racial and Ethnic Health Disparities*, February 9, 2022, <https://pubmed.ncbi.nlm.nih.gov/33403653/>.

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- ⁸ Samantha Artiga, et al., "Survey on Racism, Discrimination and Health: Experiences and Impacts Across Racial and Ethnic Groups," *Kaiser Family Foundation*, December 2023, <https://www.kff.org/racial-equity-and-health-policy/poll-finding/survey-on-racism-discrimination-and-health/>.
- ⁹ Association of American Medical Colleges. "Diversity in Medicine: Facts and Figures 2019," <https://www.aamc.org/data-reports/workforce/data/figure-18-percentage-all-active-physicians-race/ethnicity-2018>.
- ¹⁰ H. Jack Geiger. "Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes," *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 2003, <https://www.ncbi.nlm.nih.gov/books/NBK220337/>.
- ¹¹ Beth Duff-Brown, "More Racial Diversity Among Physicians Would Lead to Better Health Among Black Men, Research Shows," *Stanford Freeman Spogli Institute for International Studies*, July 18, 2018, <https://fsi.stanford.edu/news/more-african-american-doctors-would-lead-better-outcomes-black-men>.
- ¹² Beth Duff-Brown, "More Racial Diversity Among Physicians Would Lead to Better Health Among Black Men, Research Shows," *Stanford Freeman Spogli Institute for International Studies*, July 18, 2018, <https://fsi.stanford.edu/news/more-african-american-doctors-would-lead-better-outcomes-black-men>.
- ¹³ Gabriela A. Aguilar, Lisbet S Lundsberg, Nancy L. Stanwood and Aileen M. Garipey, "Exploratory Study of Race-or-Ethnicity-Based Discrimination Among Patients Receiving Procedural Abortion Care," *Contraception Journal*, January 11, 2023, <https://doi.org/10.1016/j.contraception.2023.109949>.
- ¹⁴ Gabriela A. Aguilar, Lisbet S Lundsberg, Nancy L. Stanwood and Aileen M. Garipey, "Exploratory Study of Race-or-Ethnicity-Based Discrimination Among Patients Receiving Procedural Abortion Care," *Contraception Journal*, January 11, 2023, <https://doi.org/10.1016/j.contraception.2023.109949>.
- ¹⁵ H. Jack Geiger. "Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes," *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 2003, <https://www.ncbi.nlm.nih.gov/books/NBK220337/>.
- ¹⁶ Jesse M. Ehrenfeld, M.D., M.P.H., "SCOTUS Affirmative Action Ruling "Undermines the Health Of Our Nation," *American Medical Association*, June 29, 2023, <https://www.ama-assn.org/press-center/press-releases/scotus-affirmative-action-ruling-undermines-health-our-nation>.
- ¹⁷ Liliana M. Garces and David Mickey-Pabello, "Racial Diversity in the Medical Profession: The Impact of Affirmative Action Bans on Underrepresented Student of Color Matriculation in Medical Schools," *Journal of Higher Education*, 2015 Mar-Apr; 86(2): 264-294, doi: [10.1353/jhe.2015.0009](https://doi.org/10.1353/jhe.2015.0009).
- ¹⁸ Atul Grover, MD, PhD, "A Physician Crisis in the Rural US May Be About to Get Worse," *Jama Network*, June 15, 2023, <https://jamanetwork.com/journals/jama/article-abstract/2806454>.
- ¹⁹ Katherine Gallagher Robbins, Shaina Goodman and Josia Klein, "State Abortion Bans Harm More Than 15 Million Women of Color," *National Partnership for Women and Families*, June 2023, <https://nationalpartnership.org/report/state-abortion-bans-harm-woc/>.
- ²⁰ Marielle Kirstein, Joerg Dreweke, Rachel K. Jones, and Jesse Philbin, "100 Days Post-Roe: At Least 66 Clinics Across 15 States have Stopped Offering Abortion Care," *Guttmacher Institute*, October 2022, <https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care>; Allison McCann and Amy Schoenfeld Walker, "One Year, 61 Clinics: How Dobbs Changed the Abortion Landscape," *The New York Times*, June 22, 2023, <https://www.nytimes.com/interactive/2023/06/22/us/abortion-clinics-dobbs-roe-wade.html>.
- ²¹ Allison McCann and Amy Schoenfeld Walker, "One Year, 61 Clinics: How Dobbs Changed the Abortion Landscape," *The New York Times*, June 22, 2023, <https://www.nytimes.com/interactive/2023/06/22/us/abortion-clinics-dobbs-roe-wade.html>.
- ²² Ricky Zipp, "Health Workers Considering Quitting, Moving Over Abortion Bans," *Morning Consult*, June 28, 2023, <https://pro.morningconsult.com/trend-setters/abortion-bans-impact-health-workers>.
- ²³ Aiseosa Osaghae, Rebecca Reingold, Sonia L. Canzater, "Dobbs' Toll on OB-GYN's Mental Health and Emotional Well-Being," *O'Neill Institute For National & Global Health Law*, November 14, 2023, <https://pro.morningconsult.com/trend-setters/abortion-bans-impact-health-workers>.
- ²⁴ Joshua Ellis M.D., M.P.H., Onyeka Otugo, M.D., M.P.H., Adaira Landry, M.D., M.Ed., and Alden Landry, M.D., M.P.H., "Dismantling the Overpolicing of Black Residents," *The New England Journal of Medicine*, 2023; 389:1258-1261, <https://www.nejm.org/doi/full/10.1056/NEJM>.
- ²⁵ The Journal of Blacks in Higher Education. "New Study Documents the Racial Gap in Student Loan Debt of Medical Residents," January 23, 2023, <https://jbhe.com/2023/01/new-study-documents-the-racial-gap-in-student-loan-debt-of-medical-residents/>.
- ²⁶ Roshan M. Burns and Kate A. Shaw, "Standardizing Abortion Education: What Medical Schools Can Learn from Residency Programs," *Current Opinion in Obstetrics and Gynecology*, 2020 Dec; 32(6):387-392, DOI: [10.1097/GCO.0000000000000663](https://doi.org/10.1097/GCO.0000000000000663).
- ²⁷ Kevin B. O'Reilly, "AMA Holds Fast to Principle: Reproductive Care is Health Care," *American Medical Association*, November 17, 2022, <https://www.ama-assn.org/delivering-care/public-health/ama-holds-fast-principle-reproductive-care-health-care>; The American College of Obstetricians and Gynecologists. "Abortion Training and Education," Committee Opinion, Number 612, November 2014, <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/11/abortion-training-and-education>.

-
- ²⁸ The American College of Obstetricians and Gynecologists. "Abortion Training and Education," Committee Opinion, Number 612, November 2014, <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/11/abortion-training-and-education>.
- ²⁹ Liam Knox, "Studying Medicine in a Post-Roe America," *Inside Higher Education*, July 6, 2022, <https://www.insidehighered.com/news/2022/07/07/medical-schools-adapt-dobbs-abortion-decision>.
- ³⁰ Accreditation Council for Graduate Medical Education. "ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology," September 17, 2022, https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_9-17-2022.pdf. Note: "if a program is within a jurisdiction that legally restricts this clinical experience, the program must provide access to this clinical experience in a jurisdiction where there are no legal restrictions." ACGME requirements go on to state that "[i]f for some reason a resident is unable to travel to another jurisdiction for clinical experience, the program must provide the resident with a combination of didactic activities, including simulation, and assessment on performing a uterine evacuation and communicating pregnancy options."
- ³¹ Guttmacher Institute. "Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates," October 19, 2017, <https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates>.
- ³² The American College of Obstetricians and Gynecologists. "Early Pregnancy Loss," Practice Bulletin, Number 200, November 2018, <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss>.
- ³³ Stacy Weiner, "The Fallout of Dobbs On the Field of OB-GYN," *Association of American Medical Colleges*, August 23, 2023, <https://www.aamc.org/news/fallout-dobbs-field-ob-gyn>.
- ³⁴ Kendal Orgera, MPH, MPP, Hsan Mahmood and Atul grover, MD, PhD, "Training Location Preferences of U.S. Medical School Graduates Post *Dobbs v. Jackson Women's Health*," *Association of American Medical Colleges*, April 13, 2023, <https://www.aamcresearchinstitute.org/our-work/data-snapshot/training-location-preferences-us-medical-school-graduates-post-dobbs-v-jackson-women-s-health>.
- ³⁵ Association of American Medical Colleges. "Report on Residents," <https://www.aamc.org/data-reports/students-residents/data/report-residents/2020/table-c6-physician-retention-state-residency-training-state>
- ³⁶ Alexandra L. Woodcock, Gentry Carter, Jami Baayd, et al., "Effects of the *Dobbs v. Jackson Women's Health Organization* Decision on Obstetrics and Gynecology Graduating Residents' Practice Plans," *Journal of Obstetrics & Gynecology*, 2023 Nov 1;142(5):1105-1111,.
- ³⁷ Christopher Rowland, "A Challenge for Antiabortion States: Doctors Reluctant to Work There," *The Washington Post*, August 6, 2022, <https://www.washingtonpost.com/business/2022/08/06/abortion-maternity-health-obgyn/>.
- ³⁸ Christopher Rowland, "A Challenge for Antiabortion States: Doctors Reluctant to Work There," *The Washington Post*, August 6, 2022, <https://www.washingtonpost.com/business/2022/08/06/abortion-maternity-health-obgyn/>.
- ³⁹ Guttmacher Institute. "Interactive Map: US Abortion Policies And Access After Roe," Last Updated: January 24, 2024, <https://states.guttmacher.org/policies/>.
- ⁴⁰ Brittini Frederiksen, Usha Ranji, Ivette Gomez and Alina Salganicoff, "A National Survey of OBGYN's Experiences After *Dobbs*," *Kaiser Family Foundation*, June 21, 2023, <https://www.kff.org/report-section/a-national-survey-of-obgyns-experiences-after-dobbs-report/>. Note: Even in states without significant abortion restrictions, only about 20% of OB-GYNs provide abortion care. This speaks to decades of limitations on training opportunities to provide care, and an overall siloing and stigmatization of abortion care within medical institutions and in society.
- ⁴¹ Advancing New Standards in Reproductive Health (ANSIRH), "The Turnaway Study," <https://www.ansirh.org/research/ongoing/turnaway-study>.
- ⁴² Fortesa Latifi, "I Help People Travel For Abortions. My Job Is Already Unsafe- And It'll Get Worse if *Roe v. Wade* Falls," *Business Insider*, May 11, 2022, <https://www.businessinsider.com/i-help-people-travel-out-state-abortions-roe-v-wade-2022-5>.
- ⁴³ Kimya Forouzan, Amy Friedrich-Karnik, Isaac Maddow-Zimet, "The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care," *Guttmacher Institute*, December 2023, [The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care | Guttmacher Institute](https://www.guttmacher.org/press-releases/2023/12/the-high-toll-of-us-abortion-bans-nearly-one-in-five-patients-now-traveling-out-of-state-for-abortion-care).
- ⁴⁴ Selena Simmons-Duffin and Shelly Cheng, "How Many Miles Do You Have to Travel to Get Abortion Care? One Professor Maps It," *NPR*, June 21, 2023, [Maps show dramatic changes in access to abortion care : Shots - Health News : NPR](https://www.npr.com/2023/06/21/1181111111/maps-show-dramatic-changes-in-access-to-abortion-care-shots-health-news-npr).
- ⁴⁵ Aiseosa Osaghae, Rebecca Reingold and Sonia L. Canzater, "Dobbs Toll on OB-GYN's Mental Health and Emotional Well-Being," *O'Neill Institute for National and Global Health Law*, November 14, 2023, <https://oneill.law.georgetown.edu/dobbs-toll-on-ob-gyns-mental-health-and-emotional-well-being/>.
- ⁴⁶ Daniel Grossman, MD; Carole Joffe, PhD; Shelly Kaller, MPH, et al. "Care Post-Roe: Documenting Cases of Poor-Quality Care Since the *Dobbs* Decision," *Advancing New Standards in Reproductive Health (ANSIRH)*, 2023, HYPERLINK "https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf" <https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf>.
- ⁴⁷ Caroline Kitchener, "Two Friends Were Denied Care After Florida Banned Abortion. One Almost Died," *The Washington Post*, April 10, 2023, <https://www.washingtonpost.com/politics/2023/04/10/pprom-florida-abortion-ban/>; Selena Simmons-Duffin, "In Oklahoma, A Woman Was Told to Wait Until She's 'Crashing' for Abortion Care," *NPR Shots*, April 25, 2023,

<https://www.npr.org/sections/health-shots/2023/04/25/1171851775/oklahoma-woman-abortion-ban-study-shows-confusion-at-hospitals>; Pam Belluck, "They Had Miscarriages, and New Abortion Laws Obstructed Treatment," *The New York Times*, July 17, 2022, <https://www.nytimes.com/2022/07/17/health/abortion-miscarriage-treatment.html>; Selena Simmons-Duffin, "Her Miscarriage Left Her Bleeding Profusely. An Ohio ER Sent Her Home to Wait," *NPR Shots*, November 15, 2022, <https://www.npr.org/sections/health-shots/2022/11/15/1135882310/miscarriage-hemorrhage-abortion-law-ohio>; U.S. Department of Health and Human Services. "HHS Secretary Xavier Becerra Statement on EMTALA Enforcement, May 1, 2023, <https://www.hhs.gov/about/news/2023/05/01/hhs-secretary-xavier-becerra-statement-on-emtala-enforcement.html>; Sarah McCammon, "More Women Sue Texas Saying The State's Anti-Abortion Laws Harmed Them," *NPR*, May 22, 2023, <https://www.npr.org/2023/05/22/1177425651/texas-women-sue-abortion>; Frances Stead Sellers, Thomas Simonetti and Maggie Penman, "The Short Life of Baby Milo," *The Washington Post*, May 19, 2023, <https://www.washingtonpost.com/health/interactive/2023/florida-abortion-law-deborah-dorbert/>; Relias Media. "What Will Happen to the Reproductive Healthcare Workforce?" January 1, 2023, <https://www.reliasmmedia.com/articles/what-will-happen-to-the-reproductive-healthcare-workforce>; Tracy Smith, "Texas Mother Kate Cox on the Outcome of Her Legal Fight for an Abortion: 'It Was Crushing,'" *CBS News*, January 14, 2024, <https://www.cbsnews.com/news/kate-cox-on-her-legal-fight-for-abortion-trisomy-18/>.

⁴⁸ Stacy Weiner, "The Fallout of Dobbs On the Field of OB-GYN," *Association of American Medical Colleges*, August 23, 2023, <https://www.aamc.org/news/fallout-dobbs-field-ob-gyn>.

⁴⁹ Robin Buller, "Agonizing Delays For Women As Dobbs Decision Worsens OB-GYN Shortage," *The Guardian*, August 22, 2023, <https://www.theguardian.com/us-news/2023/aug/22/obgyn-shortage-pregnancy-care-dobbs-abortion>.

⁵⁰ Robin Buller, "Agonizing Delays For Women As Dobbs Decision Worsens OB-GYN Shortage," *The Guardian*, August 22, 2023, <https://www.theguardian.com/us-news/2023/aug/22/obgyn-shortage-pregnancy-care-dobbs-abortion>.

⁵¹ The American College of Obstetricians and Gynecologists, "Training and Workforce After Dobbs," <https://jamanetwork.com/journals/jama/article-abstract/2806454>.

⁵² March of Dimes. "Nowhere to Go: Maternity Care Deserts Across the U.S.," 2022, https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf.

⁵³ National Institute of Health, "What is Prenatal Care And Why Is It Important?" <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care>; Cristiane Quadrado da Rosa, Denise Silva da Silveira, and Juvenal Soares Dias da Costa, "Factors Associated with Lack of Prenatal Care in a Large Municipality," *Revisita de Saúde Pública*, 2014 Oct; 48(6): 977-984, doi: [10.1590/S0034-8910.2014048005283](https://doi.org/10.1590/S0034-8910.2014048005283).

⁵⁴ Donna L. Hoyert, Ph.D, "Maternal Mortality Rates in the United States, 2021," *The Centers for Disease Control and Prevention*, <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm>.

⁵⁵ Jacqueline Howard, "Maternal and infant Death Rates are Higher in States that Ban or Restrict Abortion, Report Says," *CNN Health*, December 16, 2022, <https://www.cnn.com/2022/12/14/health/maternal-infant-death-abortion-access/index.html>.

⁵⁶ Donna L. Hoyert, Ph.D, "Maternal Mortality Rates in the United States, 2021," *The Centers for Disease Control and Prevention*, <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm>.

⁵⁷ Katherine Gallagher Robbins, Shaina Goodman and Josia Klein, "State Abortion Bans Harm More Than 15 Million Women of Color," *National Partnership for Women and Families*, June 2023, <https://nationalpartnership.org/report/state-abortion-bans-harm-woc/>.

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