Episode: *Ethics Talk* Series on US Abortion Care After *Dobbs: How Do We Teach Evidence-Based Standard of Care Now?*

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[mellow theme music]

TIM HOFF: Welcome to a special edition of *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff.

This multipart series examines ethical and clinical fallout from the recent United States Supreme Court holding for *Dobbs, State Health Officer of the Mississippi Department of Health v Jackson Women's Health Organization*. This decision upends 50 years of legal and clinical precedent established on abortion, privacy, and other rights foundational in everyday health care practice. *Dobbs* challenges clinicians and organizations everywhere in the US in unprecedented ways, including whether, where, and when to defy law to give their patients standard health care, and how far to go to offer standard care to patients who are medical refugees from restrictive states.

Abortions, when delivered by health care professionals, are safe, common, and until recently, legal. Whether as a request to end an unwanted pregnancy or in response to complications indicating risk to a patient's health, abortion is part of standard health care practice. In places where abortion care is restricted or banned, abortions will likely remain common. We know this from global research showing that regardless of changes in legality, abortion frequency remains steady, but that medical risk to women and legal risk to women, clinicians, and organizations increase when abortion is restricted to unduly infringe upon decision making and care planning that have, up until *Dobbs*, taken place within patient-clinician relationships.

Regardless of legality, abortions are often clinically indicated standard of care for pregnant people, especially in response to incomplete miscarriages or secondary to fetal development anomalies or complications. And regardless of legality, all clinicians are still legally and ethically required to practice according to standard of care. Though in restricted states, this is now extremely difficult for most clinicians who are motivated clinically to continue to provide safe abortion care and motivated ethically to prioritize their patients' best interests above the intrusive demands of an unjust law.

When abortions occur naturally and spontaneously, they're called miscarriages, which are common. Once straightforwardly managed according to clinical indications, miscarriage management in restricted states now requires navigating a labyrinth of unscientific legal requirements. For example, restriction exceptions allowing abortion to "save the life of the mother" de facto incentivize clinicians to watch their patients

decompensate, that is become increasingly ill, to the point at which a complication formerly safely managed with an abortion becomes a life-threatening emergency, though it is worth noting that these kinds of exceptions are increasingly rare, as many have or look to simply ban abortion without any nod to a pregnant person's right to life or to a clinician's duties to do no iatrogenic harm and to provide standard of care.

In this series we'll cover what students and clinicians need to know about how the changing legal landscape of abortion influences their practices. This series also considers how restrictions will influence health professions and a generation of students and trainees now at risk for possibly never learning how to manage according to standard practice complications from one of the most common human experiences: pregnancy.

On this third episode of the podcast, we're joined by Dr Jody Steinauer, a Professor of Obstetrics and Gynecology and Reproductive Services in the School of Medicine at the University of California, San Francisco. Dr Steinauer's here to discuss the health professions education implications for a post-June 2022 legal, ethical, and clinical landscape. Dr Steinauer, thank you so much for being on the podcast with me. [music fades out]

DR JODY STEINAUER: Thank you for having me.

HOFF: So, even if health professions students, especially in restricted states, are not trained on how to perform abortions, they will still need to be trained well in how to respond to the needs of patients for whom abortion care is clinically indicated. So, what does this mean for educators and academic health centers, regardless of whether they're in standard of care states or in restricted states?

STEINAUER: Well, for health professions students, I'm thinking about medical students and residents. So, I do a lot of work really focused on educating medical students and residents to become physicians and specialists. Abortion education is really critical no matter what kind of physician they are or will be. And this means that this Supreme Court decision is going to have big impacts potentially on the next generation of physicians. So, no matter what the policy of the state one is in, one is really obligated to give information and to refer patients for health care. Many doctors see patients who are newly diagnosed as being pregnant and are obligated to give those patients information about their options and to refer them to the care that they want, and patients will come to see physicians after they have had an abortion and need care. So, those are just some basic principles, even if one is not going to be the person providing abortion care. So, when I think about the new landscape that we are in, where we have maybe up to half of states in which abortion will be severely restricted or banned, and then we have half with standard of care, we all have a responsibility as educators of physicians to make sure that these physicians are prepared to care for patients.

So, what I'm seeing is a potential for a real professional identity crisis in which our physicians believe so strongly that we have to give information and refer patients, and we're really obligated to do the right thing. And so, what I'm seeing is medical students

and residents and practicing physicians in states that are either already restricted or about to be being very distressed. They are worried. They're being told by their lawyers in some places that they cannot give information, that they cannot refer, that they cannot do the right thing for patients who are having miscarriage or for those patients who qualify for legal abortion or for whom an abortion is going to save the patient's life or prevent morbidity. And so, it's this really complicated situation, I think, where they're grappling, they're distressed, they feel that they're not doing the right thing for patients. And I think we have to just admit that this is going to be a big crisis for our learners and our physicians. So, we are obligated as physicians to protect patient autonomy, to put patients' welfare above our own, to provide patient-centered care, to promote social justice, to do the right thing, to prevent harm. We have all of these obligations, and we're being asked basically by our state governments or by our hospitals to not abide by those principles. And so, all of those medical students we're training, we're obligated to train all of them to provide information, to refer, and to provide post-abortion care.

For OB-GYN, which is my specialty, it is our responsibility to have the skills we need to be able to provide an abortion in the setting of an emergency. This is an obligation. Even if an individual OB-GYN is not including abortion in their practice or feels that abortion is wrong, if that person is the only person available to do an abortion in a setting of emergency, they have to. And so, what I'm worried about is in all of those states, not only are patients not going to be able to access care now, but we have about 44 percent of OB-GYN residents being trained in those states in which abortion will be or will probably be banned. How are we going to train those OB-GYN physicians to do the right thing for their future patients? So, I'm worried we're going to see a long-lasting impact of this on future patient care wherever those graduated OB-GYNs are providing care.

HOFF: I'm glad you brought up the fact that regardless of how an individual clinician might feel, they still have this obligation, perhaps, to provide care. And so, with that in mind, since both safe and unsafe abortions can generate complications to which clinicians need to be prepared to respond competently and with care, which training should be taught as standard practice regardless of clinicians' practice site and standard of care or restricted states?

STEINAUER: Well, I mean, if you're focusing on OB-GYNs, all OB-GYNs need to have the skills to safely empty the uterus, to provide counseling, doing ultrasounds, and managing the rare complications of abortion. And so, that's just basic for all OB-GYNs. I do think that people who seek, who are seeking, abortion care in these restricted states either will access abortion on their own without seeing a clinical care provider in the state, or they'll leave the state for care. And medication abortion is very safe. Procedural abortion is very safe. But what I imagine is that because they're seeking care outside of the health care system within their community, if they have any questions, if they're worried about the bleeding or worried about some symptoms they're having, they're going to need to be seen. They're going to want to be seen. And so, I sort of envision a world in which all primary care physicians, all emergency physicians, and all gynecologists, OB-GYNs, in their community will be prepared to provide post-, what we call post-abortion care for patients. And I don't mean to imply that those are

complications. It's just sort of if a patient has any questions or concerns after they've had a procedure or a medication abortion, I want them to be able to be seen in their community.

And so, that means that all primary care physicians, all OB-GYNs, all emergency physicians need to just have the basic information about what to expect after a procedural abortion, what to expect after a medication abortion, what would mean there's, what is too much bleeding? What are the signs that maybe it wasn't complete? That kind of question, you know, those kinds of basic, basic skills and knowledge. And that they provide that care with compassion, being supportive, and also to not criminalize those people who potentially did access medication abortion pills through an online pharmacy or who did leave the state for a legal abortion, and now they're coming back. And, I mean, we've heard stories of people who are then reported to the police and then end up getting sort of charged with a crime for seeking care. That's such a basic principle. It's shocking to me that we even have to remind physicians that we are ethically obligated to not report anything patients tell us.

HOFF: Mm, mmhmm.

STEINAUER: I mean, I think about a lot of the patients seen in emergency departments who come in having had an accident in their car after driving under the influence, who have used substances that are technically illegal. There are a lot of things people do. We do not report them to the police.

HOFF: Mmhmm. Yeah, exactly. Referrals and handoffs are key to good abortion care. Now, as you stated, people might be traveling to get abortion care across state lines, so this necessitates interprofessional collaboration in order to motivate patient safety. So, what's your view of what good interprofessional education looks like in the post-June 2022 legal landscape?

STEINAUER: Well, I mean, one thing that I am learning about throughout the country is that there is better collaboration between, for example, clinicians who are working in hospital systems, academic centers, freestanding clinics, not only within different cities or regions, but also across state lines. And this is really critical because if I'm seeing a patient in a restricted state, and I need that patient to be able to get access to an abortion in a neighboring state as soon as possible, it works, it's optimized if I have a close relationship with people in that clinic. I could potentially even do some of the preoperative work or the pre-abortion work to support that patient, getting that patient quick access to the clinic, and then offering to see the patient if needed when they come back, right? So, I think it's sort of, it's like interstate collaboration, inter-region collaboration.

And one of my hats is that I direct the national organization called the Ryan Residency Training Program, and we have supported 107 departments of OB-GYN in the United States to integrate abortion training. And so, one thing we really focus on is training for OB-GYN residents. But the other thing is we're really in a network of academic institutions, and so what we've been able to do is facilitate these meetings that are

within states, within regions, now across banned states, standard of care states, and we get to support all this collaboration with each other. And what I'm learning is that all of these teams in different regions are doing exactly that. They're establishing closer relationships with the nearest clinic, whether it's one, two, three states away. They're also working within their communities between many potential hospitals in the same city to figure out how they can support each other. And similarly, in the less restricted, or the standard of care states, there are hospitals and clinics working together to say, okay, as we see more people coming to us for abortion care, how can we as a bigger system support them so that they're not just calling one clinic and then that clinic has a two-week delay in when they can see them, they can also call the local hospital, the local OB-GYN office, the other family planning clinic? And so, I actually think this is beautiful. And yes, of course, it's interprofessional, too, because all abortion care is provided by a team. It's certainly not just physicians providing the care, and it requires everyone to work together.

HOFF: So, do you feel that the current state of interprofessional education is supporting and preparing students and trainees to participate in that kind of collaboration? Or is there some kind of need for a more robust, interprofessional education system now that it's maybe more necessary than it was before?

STEINAUER: I don't know of interprofessional education projects that are focused on this. I know there are people trying to reform nursing education, pharmacy education in the same ways that I'm really focused on medical education. And I think we all could do a much better job of supporting interprofessional education to support this work. I think that's absolutely important. I know of sort of workforce training programs of people working on training the entire team in the emergency room on this—the nurses, the clerks, the medical assistants, the physicians—but I don't know of it so much from like an undergraduate training perspective. I think that's a really important idea.

HOFF: Hmm. So, sort of leading off from that, how should accreditation bodies such as the ACGME guide health professions schools' adaptations to this new legal landscape?

STEINAUER: Well, it's interesting that you bring up the accreditation council, the ACGME, because back in 1995, was a really important moment for the ACGME from OB-GYN training in abortion. In 1992 there was a study done in which only 12, sorry, in 1992 there was a study done that found that only 12 percent of OB-GYN programs had integrated routine abortion training. And there were a lot of events that were all happening at the same time that sort of combined to inspire the ACGME to think about whether they should require OB-GYN training programs to include abortion. And for example, the Medical Students for Choice organization petitioned from a medical student perspective for this change. There were a lot of meetings hosted by the American College of OB-GYN and the National Abortion Federation, and basically saying, we're worried about our workforce. We need to make sure there's enough people who are being trained to provide abortion care. And so, in 1995, the ACGME said all OB-GYN programs must have abortion training, and individual residents can opt out of the training. And programs do not have to do the training in their hospitals if they're unable to do that. And so, it was enacted in 1996. And since then, we've had an

increase in the number, in the proportion of programs that have integrated abortion training throughout the United States.

And now the ACGME has been really thinking about what they should do. And because it is a requirement for all OB-GYNs to have the skills they need to provide abortion care in the setting of an emergency, they feel very strongly that this is part of the identity, the requirements, the professional expectations of OB-GYNs. And at the same time, they're faced with this situation in which can they really expect programs, if it's illegal in their state, to train in abortion? And so, right now they're working on the language. They're thinking about how they can maintain this expectation. A lot of us are working together nationally to think about how can we support residents to travel, to be trained in other states?

I really think that if training hospitals and training institutions were to step up to provide the care that they need, I think residents would be pretty well trained even without going to a clinic. So, for example, if hospitals started doing the right thing and provided the pre-abortion care, post-abortion care, and really stepped up for all patients who qualify for a legal abortion to be able to provide that care, that would help a lot. I mean, most OB-GYN residents train both in their main institution and in a freestanding clinic. So, yes, the freestanding clinics may close and not be providing abortion care, but I do think if the hospitals are doing the right thing for patients, that will also help resident training in those states. So, the ACGME really is maintaining that requirement and that expectation but trying to also just be somewhat flexible. We're also thinking about standard curricula, simulation training that should be required of all residents. We're all really trying to work hard to make sure that all of those residents do graduate with the skills they need.

HOFF: Mmhmm. And it sounds like those training adaptations are important, but they do take time to sort of implement and then see the effects of. So, what should health professions students be prepared to demand of their schools and training programs now in order to be well prepared to provide equitable care for all of their pregnant patients?

STEINAUER: Well, I think health professions students just need to.... I should say all health professions learners should be just demanding that this is part of their training, that their administration, their educators, train them in the skills they need. All medical students have to demand that their schools meet the Association of Professors of Gyn and Obstetrics requirements for training. That includes learning how to do pregnancy options counseling, referral, understanding what abortion is, understanding the public health implications of policy restrictions. So, those are just like basic requirements. And then I think when we get to residency programs, I think that all primary care residents and emergency medicine residents should demand that they learn how to provide excellent options counseling, referral, pre-abortion care, post-abortion care.

And I personally have trained many emergency room physicians, internists, and family physicians to do abortions. I mean, especially family medicine. It really is a core part of family medicine practice to be able to provide abortion care. So, I think some residents, certainly in family medicine, residents should demand that they learn to provide abortion

care. [mellow music gently returns] And even if they're in a banned state, learn to provide medical and procedural management of pregnancy loss, so that they can learn the skills they need, that they could then apply to people providing abortion care for people who qualify for a legal abortion or who, you know, which might be limited currently, but that might change. Laws will change, or they might be living in a different state.

HOFF: Dr Steinauer, thank you so much for your time and expertise on the podcast today.

STEINAUER: Oh, thank you so much for having me.

HOFF: That's all for this episode of the podcast. Thanks to Dr Jody Steinauer for joining us. Music was by the Blue Dot Sessions. You can find earlier episodes of this podcast series on our website, JournalofEthics.org, or on any streaming platforms. Be sure to join us next week when we consider key questions about risk management for clinicians trying to practice and patients trying to stay healthy. Talk to you then.