

**Aborting Autonomy:
OB/GYNs Reclaiming Professional Autonomy Amidst
Increasing Paternalistic Restrictions in Abortion Care**

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Abstract

Access to safe, legal abortions is crucial for women's reproductive healthcare. In 2022, *Dobbs v. Jackson* marked one of the most pivotal moments in restricting abortion access and women's reproductive rights in the United States. This ruling diminished reproductive healthcare access, and compromised professional autonomy of OB/GYNs who are caught between legal pressures and ethical concerns for patient safety.

An OB/GYN shortage already exists, and paternalistic restrictions have forced many to retire earlier and discouraged medical students from pursuing the field. Some OB/GYNs have resorted to relocating to abortion accessible states. This contributes to the growth of OB/GYN deserts, or areas with limited access to maternity and reproductive healthcare.

OB/GYNs are actively attempting to reclaim professional autonomy while supporting women regain bodily autonomy, by pairing technological advancements in telemedicine with state legal protections to safely provide abortion care across the nation; providing a virtual curriculum for the delivery of OB/GYN resident education; and advocating and communicating online through op-eds and online forums like Reddit.

Although these solutions are impactful, they are simply addressing the symptoms of a problem. The root remains intact and requires greater collaboration and legislative action to reclaim women's bodily autonomy.

Women's Reproductive Healthcare

Women were concerned experts in *women's* reproductive healthcare. Prior to the Civil War, midwifery¹ was the most common practice for childbirth and reproductive healthcare in the United States. About half of the midwives were Black women, while others were Indigenous and white (Goodwin, 2020). These women were skilled at providing support and care to women during childbirth and naturally administering other reproductive services such as abortion. However, the increasing professionalization and standardization of women's reproductive healthcare systematically drove women out of the field.

Dr. J. Marion Sims introduced the concept of surgery to women's reproductive healthcare by incorporating surgical tools and surgical techniques in patient care. Sims is referred to as the "father of modern gynecology" for his successful development of the surgical treatment for vesico-vaginal fistulas² in the 1840s. However, Sims' success is overshadowed by his racist and unethical exploitation of the enslaved women, Anarcha, Betsy, and Lucy on whom he performed various experimental procedures without consent and without addressing their pain (Wailoo, 2018).

Sims' surgical intervention in women's reproductive healthcare brought this field to the attention of the white, educated men who were already professionalizing medicine.³ As they began to establish the standardized discipline of obstetrics and gynecology these men desired recognition as trained professionals and practitioners of women's reproductive healthcare but found themselves in competition with many skilled midwives. Therefore, they began campaigns that aimed to discredit midwives for being unhygienic, unprofessional, and dangerous while

¹ Midwives are trained individuals that provide reproductive health care to women prepartum, antepartum, intrapartum, and postpartum. Today, midwives are professionally trained but in the past, knowledge was passed down from midwife to midwife.

² A tear between the bladder and vaginal wall which is a complication of childbirth.

³ The American Medical Association was founded on May 7, 1847 and consisted solely of white males.

gaining political traction for their own field and practices (Goodwin, 2020). Within several short decades, white, male obstetrician-gynecologists (OB/GYNs) removed women from the administration of reproductive healthcare. This transformation of women's reproductive healthcare created a cascade of paternalistic events that enabled the politicization of gynecology and obstetrics and obscured the purpose of serving women's health.

Some time after medicine was professionalized, the American Eugenics Movement, another crucial period of gynecological history, occurred in the 1900s. The idea of eugenics was coined by Francis Galton, a white English man in 1883. He argued that individuals with the best genetics should be incentivized to marry each other and reproduce to create the genetically "fittest" human population (Farber, 2008). This ideology became popular in America because with slavery, immigration, and assimilation of Indigenous populations, many white Americans were fearful of miscegenation, or interracial reproduction. Eugenics offered a "scientific" rationale for such fears, and means to preserve and promote "superior genes" which were defined as white, fit, and intelligent (National Human Genome Research Institute, n.d.). From the promotion of selective breeding, eugenics slowly evolved to justify scientific racism and forced sterilizations, when fallopian tubes are surgically tied or removed. During this era, state legislatures employed paternalistic laws under the guise of contributing to the betterment of society and the American population, although it was far from it. Minority women, including Indigenous, African American, Latina, poor, and women with mental and physical disabilities were disproportionately targeted and unethically sterilized often through force or coercion throughout the twentieth century. Women of color and marginalized communities would expect their physicians to deliver their children but the physicians would perform "hysterectomies and tubal sterilizations" (Smaw, 2022, p. 319), under the guise of "appendectomies or gallbladder

removals” (p. 321). Smaw (2022) mentions that on top of lying to the patients, physicians also falsified medical records and manipulated families into getting certain women in the family sterilized. By the 1970s, at least 60,000 women were involuntarily sterilized through 30 states’ laws (National Human Genome Research Institute, n.d.). The Eugenics Movement is a dark period in women’s reproductive healthcare; American women lost bodily autonomy as state legislatures introduced paternalistic laws to control reproductive healthcare. This caused a major transition in the fields of gynecology and obstetrics, shifting physician focus from serving women to serving the law.

Women’s Abortion Rights

Access to safe, legal abortions is crucial for women’s reproductive healthcare. An abortion is a relatively safe, medical procedure with minimal complications. It is a medical intervention that is often necessary for many women to improve their health and well-being. Some pregnancies may harm the health of the mother and in some cases, may even endanger the mother’s life. In other cases, carrying a pregnancy to term may cause complications that challenge the patient’s ability to have another child in the future. Women of color, particularly Black women, are disproportionately affected by pregnancy complications. In 2024, the maternal mortality rate for Black women in America was 44.8 deaths per 100,000 live births, which was 3.2 times greater than the rate for White women which was at 14.2 deaths per 100,000 live births (American College of Obstetricians & Gynecologists, n.d.; Hoyert, 2026). In other cases, a pregnancy may be the result of sexual assault, bringing great mental distress to the mother. Aside from the medical necessity for abortions, many women need access to safe, legal abortions because of financial and societal barriers. Some women are not ready to have children because they are too young, have not established their career, do not have enough money to raise a child,

might not have ample support from others in raising a child, already have a complete family, or simply do not want to be a parent. There are many different and valid reasons why a woman would opt for an abortion so it is essential that abortions are safe, legal, and accessible to all women.

Following the timeline of women's rights to abortion throughout American history, there are increasing legal paternalistic forces aimed at politicizing women's reproductive healthcare. As the field of gynecology and obstetrics advanced, state legislatures increasingly incorporated paternalistic laws that removed women's bodily autonomy, shifting the priority in reproductive healthcare from women's health to enforcing patriarchy. Before the establishment of obstetrics and gynecology in America, women were the sole practitioners of reproductive healthcare. Indigenous women employed various methods using abortifacient agents such as black root and cedar root to perform abortions (Acevedo, 1979). Colonial women legally performed abortions, with the assistance of midwives who knew which herbal poisons to use for abortions (Dine, 2013). The practice of performing abortions was always in the hands of women and the right to decide when she wanted to be a mother was always hers within certain parameters.⁴ The first abortion law passed was in 1821,⁵ when the state of Connecticut prohibited abortions by poison after quickening⁶ (*Teaching Women's History*, 2022). This law directly targeted midwives because now the only way women were able to obtain abortions in Connecticut was through a white, male doctor that used tools to induce an abortion.

⁴ It is important to note that colonial women still did not have the right to vote and remained the property of her husband.

⁵ The law was passed after Ammi Rogers was found to have administered poison and used a tool to physical disrupt Asenath Smith's pregnancy in efforts to conceal his pre-martital sexual relations. Ammi was convicted of sexual assault and this law was passed to protect pregnant women and ensure no other men used abortions to cover up their misbehavior (*Teaching Women's History*, 2022).

⁶ The first time the pregnant person feels fetal movement.

Shortly after, in 1847, the American Medical Association (AMA), a male dominated organization that professionalized medicine and enforced traditional gender norms, was founded and began pushing midwives out of practice through discrediting campaigns and began attacking abortion access (Dynak et al., 2003). This led to a vigorous criminalization campaign against abortions and by the 1880s, all state legislatures across America incorporated laws that restricted abortion. By 1910, abortion had become illegal regardless of the stage of pregnancy in all states. The few states that allowed abortions to be performed if the doctor, a man, did so only out of necessity to protect the patient's health (*Historical Abortion Law Timeline*, n.d.). At this point, women's abortion rights in America were completely governed by the state, ceding power to OB/GYNs only in extreme cases. However, these abortion restrictions did not prevent abortions. Instead, there was a rise in illegal and dangerous abortions until the early 1970s. In 1930, abortion was the official cause of death for about 2,700 women, and between the 1950s and 1960s, estimates of illegal or self-induced abortions ranged between 200,000 and 1.2 million (Gold, 2003). The health risk of illegal abortions disproportionately affected low-income women, women of color, and other minority women. During this period, many women acutely experienced the costs of these abortion restrictions, including health risks, loss of life, and loss of autonomy.

The next national event in women's reproductive healthcare in America was the 1973 U.S. Supreme Court case of *Roe v. Wade*, commonly known as the case that granted the constitutional right to abortion, with variances from state to state. In this case, "Jane Roe," or Norma McCorvey, was unable to receive an abortion in Texas because her pregnancy was not a threat to her life. Sarah Weddington and Linda Coffee, Texas lawyers seeking a case that could challenge the country's abortion bans, heard of McCorvey's situation and filed a suit on

McCorvey's behalf with her consent. On January 22, 1973, the Supreme Court ruled in favor of Roe, granting the constitutional right to abortion under the overarching right to privacy.

However, since the ruling was based on the right to privacy, many anti-abortion politicians across the nation restricted abortions or made them inaccessible to women in specific states by focusing restrictive policies on the protection of maternal and fetal health. *Roe v. Wade* highlighted how despite the federal government's ruling granting abortion rights to women across the nation, anti-abortion state lawmakers were able to find loopholes to make abortions difficult in their states (*Roe v. Wade*, n.d.).

Planned Parenthood v. Casey was the next case related to the right to abortion that the Supreme Court selected to hear, as a challenge to the Pennsylvania Abortion Control Act of 1982 that required spousal notification, information disclosure, a 24-hour wait period, and parental consent for minors. Although the US District Court of Eastern Pennsylvania declared these provisions unconstitutional, the State Court of Appeals later reversed this decision and declared that all provisions except spousal notification were constitutional. Thus, Planned Parenthood of Southern Pennsylvania appealed the court's decision to the US Supreme Court in 1992. Kathryn Kolbert, representing Planned Parenthood, argued that the provisions violated the right to privacy protected by *Roe v. Wade* and lead many women to seek unsafe abortion services/alternatives. The Supreme Court upheld the provisions in the Pennsylvania Abortion Control Act except the spousal notification provision. Although this case upheld *Roe v. Wade*, it introduced the concept of "undue burden" on abortion services. In order to challenge abortion restrictive laws moving forward, judges would require evidence that the laws explicitly created a significant obstacle in accessing or obtaining abortion services (Seward, 2009). Given the difficulty of proving "undue burden," state legislatures continued to pass abortion restrictions, chipping away at *Roe*.

In 2003, President George W. Bush signed legislation passed by Congress that criminalized abortions in the second trimester of pregnancy.⁷ Despite many leading OB/GYNs testifying that the ban negatively impacted their ability to provide patient-centered care, the US Supreme Court upheld this abortion ban in the cases of *Gonzales v. Carhart* and *Gonzales v. Planned Parenthood* in 2007.⁸ “Today the court took away an important option for doctors who seek to provide the best and safest care to their patients,” declared Eve Gartner, the Planned Parenthood Federation of America Deputy Director of Litigation and Law who argued *Gonzales v. Planned Parenthood* in response to the decision (Kiernon, 2014, p. 1). Highlighting the politicization of medicine, Gartner explains how “this ruling tells women that politicians, not doctors, will make their health care decisions for them” (Kiernon, 2014, p. 1). Although the ban still allowed some women to receive to abortions if deemed medically necessary, women seeking abortions for other reasons lost access to this service beyond the second trimester.

Whole Woman’s Health v. Hellerstedt (2016) was the next landmark case in abortion access. The Supreme Court ruled that two abortion restrictions in Texas were unconstitutional finding that medically unnecessary restrictions in that state targeted abortion providers through admitting privileges and expensive building requirements and constituted an “undue burden” on abortion services by creating a significant obstacle in abortion access (*Whole Woman’s Health v. Hellerstedt*, 2016). This ruling was crucial because Texas is an abortion restrictive state so reaffirmation of the constitutional right to legal abortion access signified hope towards stronger constitutional protections for abortions in the future. In fact, within 24 hours of this ruling,

⁷ The Partial-Birth Abortion Ban Act prohibited the late termination of pregnancy via the dilation and extraction procedure. This law lacked an exception for abortions necessary to protect the mother’s life because Congress noted that his procedure was never medically necessary (*Gonzales v. Planned Parenthood Federation of America, Inc.*, 2006).

⁸ The Supreme Court ruled that the Partial-Birth Abortion Ban Act of 2003 was constitutional because it did not impose an “undue burden” on women’s rights to abortions (*Gonzales v. Planned Parenthood Federation of America, Inc.*, 2006).

similar abortion restrictions in Alabama, Mississippi, and Wisconsin were thwarted. Following this ruling, there was a similar case in 2020, *June Medical Services v. Russo*, where the Supreme Court struck down two medically unnecessary laws that would have eradicated abortion access in Louisiana (Berg, 2020). This was the last case on abortion access that Justice Ruth Bader Ginsburg ruled on before passing and being replaced by Justice Amy Coney Barret, nominated by President Donald Trump (*Historical Abortion Law Timeline*, n.d.). This upheaval of the balance of the Supreme Court was a calculated move to chip away at *Roe* and eventually overturn it.

Soon after, Texas Governor Greg Abbott enacted Senate Bill 8 (S.B. 8) under the Texas Legislation on September 1st, 2021, banning abortions at six weeks of pregnancy. A study published in 2021 found that one in three people discover they are pregnant after six weeks and that later confirmation of pregnancy was more common amongst young people, people of color, and individuals with food insecurity (*One in Three People Learn They're Pregnant Past Six Weeks' Gestation*, 2021). For most women seeking abortions, S.B. 8 forces them to travel across state borders for abortion services or remain pregnant against their will, and would disproportionately affect marginalized populations, further exacerbating existing disparities. In other cases, it forces women to inch closer and closer to death as they await approval to receive an abortion. The AMA immediately denounced S.B. 8 and submitted an emergency application to block the law from taking effect. "This new law is a direct attack on the practice of medicine and patient reproductive health outcomes," Gerald E. Harmon, MD, president of the AMA explained. "As physicians and leaders in medicine, we urge our nation's highest court to take action immediately and stop the implementation of Texas SB 8" (O'Reilly, 2021, p. 1). Physicians and medical professionals knew first hand that this law would have a negative impact

on patient care and outcomes. They also understood that this law will challenge their clinical judgement. This emergency application was subsequently denied by the newly constituted Supreme Court (without Justice Ruth Bader Ginsburg).

In 2022, the final ruling on *Dobbs v. Jackson* marked one of the most pivotal moments in restricting abortion access and women's reproductive rights in the United States. To understand this case, we need to step back to 2018 when a Mississippi state law, The Gestational Age Act, banning abortion after fifteen weeks had been passed, directly violating the constitutional right to abortion outlined in *Roe v. Wade*. Hours after the law was signed, the Center for Reproductive Rights and its partners sued Mississippi on behalf of the only remaining abortion clinic in the state, the Jackson Women's Health Organization. The following day, the federal district court granted emergency relief, blocking enforcement of the law and the Fifth Circuit Court of Appeals ruled against Mississippi and granted a permanent injunction against this law in 2019 because the law removed a woman's right to abortion before viability, which is the stage at which a fetus can survive outside the uterus (typically between 24-26 weeks of pregnancy). However, the state of Mississippi appealed this decision to the Supreme Court in 2020 following this ruling. As the Supreme Court was reviewing this case, they were provided "several scientifically, medically, and ethically sound amicus briefs in strong opposition to Mississippi's abortion ban" (Palacio, 2023, p. 388). Written by leading medical institutions and organizations including the American College of Obstetricians and Gynecologists, the AMA, the American Association of Public Health Physicians, the American Academy of Family Physicians, the American Academy of Nursing, and the American Academy of Pediatrics, the briefs highlighted the safe and crucial nature of abortions and abortion access in the United States (Palacio, 2023). Despite this overwhelming but clear information, on June 24, 2022, the Supreme Court issued its final ruling

on the case of *Dobbs v. Jackson*, overturning *Roe v. Wade* and removing the constitutional right to an abortion (“*Dobbs v. Jackson Women’s Health Organization*,” 2022).

This decision in *Dobbs v. Jackson* not only allowed the Gestational Age Act to take effect in Mississippi, banning abortions after fifteen weeks of pregnancy, but it also allowed other states across the United States to employ similar abortion bans. This ruling marked the end of the constitutional right to abortion and a halt to the steady progress in women’s reproductive rights that had been ongoing for the past fifty years by giving power back to individual states in determining abortion access and regulation. As of January 30, 2026, a total of 41 states have abortion bans in place. Of the 41 states, 13 have a total abortion ban, 7 states have a ban at or before 18 weeks of gestation, and 21 states have a ban after 18 weeks of gestation. Only 9 states⁹ and the District of Columbia have no bans (Curhan, 2026). Twenty states in America currently have early abortion bans, severely limiting abortion access for women in those states.

The effects of this ruling have had devastating effects on women’s reproductive health outcomes due to limited access to care. A recent study found that abortion restrictive states had fewer maternity health resources, higher rates of maternal mortality, infant mortality, and perinatal mortality. Not to mention, most of the abortion restrictive states already had limited access to affordable health insurance, worse health outcomes, and reduced access to maternity care providers that disproportionately affected people of color and other marginalized communities prior to the implementation of the abortion bans (Declercq et al., 2022). This ruling serves to further exacerbate these health disparities among these populations. Furthermore, many studies have been conducted, highlighting the importance of abortion access in maternal health outcomes. A study from 2022 of women with pregnancy complications before 22 weeks of

⁹ Alaska, Colorado, Maryland, Michigan, Minnesota, New Jersey, New Mexico, Oregon, and Utah.

gestation found that 57% of the women who underwent expectant management¹⁰ in abortion restrictive states experienced serious maternal mortality compared to 33% of women who underwent abortions in more accessible states (Nambiar et al., 2022). Abortion access is evidently critical in supporting women's reproductive health outcomes and neonatal health outcomes. Thus, any restrictive state bans on abortions significantly compromise health outcomes and disproportionately harm women from marginalized communities.

***Dobbs* Impact on OB/GYNs**

The loss of women's autonomy in reproductive healthcare has made it especially challenging for OB/GYNs to practice medicine, as they often find themselves at a crossroads between the legal fear of losing their license and ethical concerns for patient safety. Dr. Kylie Cooper, a maternal-fetal medicine specialist that reluctantly relocated to Minnesota, shares what it felt like to practice reproductive medicine in Idaho following the *Dobbs v. Jackson* ruling: "It was consuming us. What if I lost my license? What would happen to our kids if I went to jail? What about my guilt if I didn't help a sick patient to my fullest ability?" (Weiner, 2023, p. 1). Dr. Cooper shares an experience many OB/GYNs have faced following the *Dobbs* ruling, revealing how this ruling has severely limited OB/GYN options for the treatment and care they can provide.

Moreover, abortion services are not the only forms of care that have been jeopardized by the *Dobbs* decision. The decision affects miscarriage¹¹ management, ectopic pregnancy¹² care, and *in vitro* fertilization (IVF) services. In states that ban abortions, about 40% of OB/GYNs have reported feeling constraints on their ability to provide care to patients with miscarriages and

¹⁰ Waiting for a miscarriage to occur without any treatment.

¹¹ Spontaneous pregnancy loss.

¹² Pregnancy that occurs outside the uterus, commonly in the fallopian tubes. Ectopic pregnancies can become life-threatening.

other pregnancy-related emergencies since *Dobbs* (Frederiksen et al., 2023). Miscarriages are virtually indistinguishable from medication abortions so OB/GYNs are required to obtain evidence before they proceed with miscarriage management services to ensure they are not reported or prosecuted for providing abortion services. For example, in 2023, Nevaeh Crain exhibited clear signs of infection at six months pregnant but was sent home from two Texas hospitals. The third doctor she saw, Dr. Marcelo Totorica required two fetal ultrasounds, 90 minutes apart, before he could perform any procedures that might end a pregnancy. By the time the ultrasounds were conducted, Crain was critically unstable and died with the fetus in her womb (Surana & Presser, 2026). Although abortion restrictive states have exceptions that claim to prioritize the mother's life, they require substantial documentation for procedures like dilation and curettage¹³ which can be time-sensitive and fatal for patients like Crain.

Similarly, ectopic pregnancy care and IVF may also be compromised because of confusions pertaining to the ban in which something like embryo loss (common in IVF) might raise legal red flags (Harris, 2022). The legality of their patient encounter now takes over a large portion of their decision making process, effectively infringing upon OB/GYNs professional autonomy and jeopardizing patient safety. These situations have also pushed many doctors and lawyers to question why medical boards in abortion restrictive states are not guiding doctors in navigating medical standards amidst vague, restrictive laws. Although the Texas Medical Board has taken steps in recent years to provide resources such as case studies to assist with this, some still argue for more robust guidance and support (Surana & Presser, 2026).

As Dr. Cooper's anxious questions highlight, these new legal concerns also introduce moral distress as OB/GYNs struggle to offer quality care to their patients. Regarding patient encounters, one OB/GYN explains, "Part of my oath is to be transparent and provide them

¹³ Minor procedure to remove uterine lining.

information. That's part of informed consent. And I can't do that for fear of personal criminal consequences. The aiding and abetting situation, what can I say? I can't tell her where to go" (Buchbinder et al., 2024, p. 6). OB/GYNs in abortion-restrictive states are constantly working in fear of losing their license or being punished for doing their jobs while also battling their internal moral dilemmas created from their inability to provide adequate care to patients requiring abortions. "[W]e must be careful about our wording. I feel shame admitting that I approach the situation in fear — of losing her life, but also of losing my job, which has taken so much of my life the past 14 years," Dr. Lucy Smith, an OB/GYN in Kansas City shares (p. 1). "I want to put all my effort into saving her life, into saving the life of the fetus if that is her wish. I am angry that I must think of my own legal consequences alongside my recommendations" (Smith, 2024 p. 1). Despite strong desires to help their patients and prioritize their safety, the unfortunate reality of OB/GYNs is what Dr. Smith describes: carefully articulated medical recommendations that comply with the law.

The overpoliticization of the OB/GYN field in abortion restrictive states is driving OB/GYNs like Dr. Smith to feel compelled to effectively enter the political discussion by writing about their experiences. It has also forced some medical professionals like Dr. Cooper to prioritize their safety and security by relocating to more abortion accessible states.

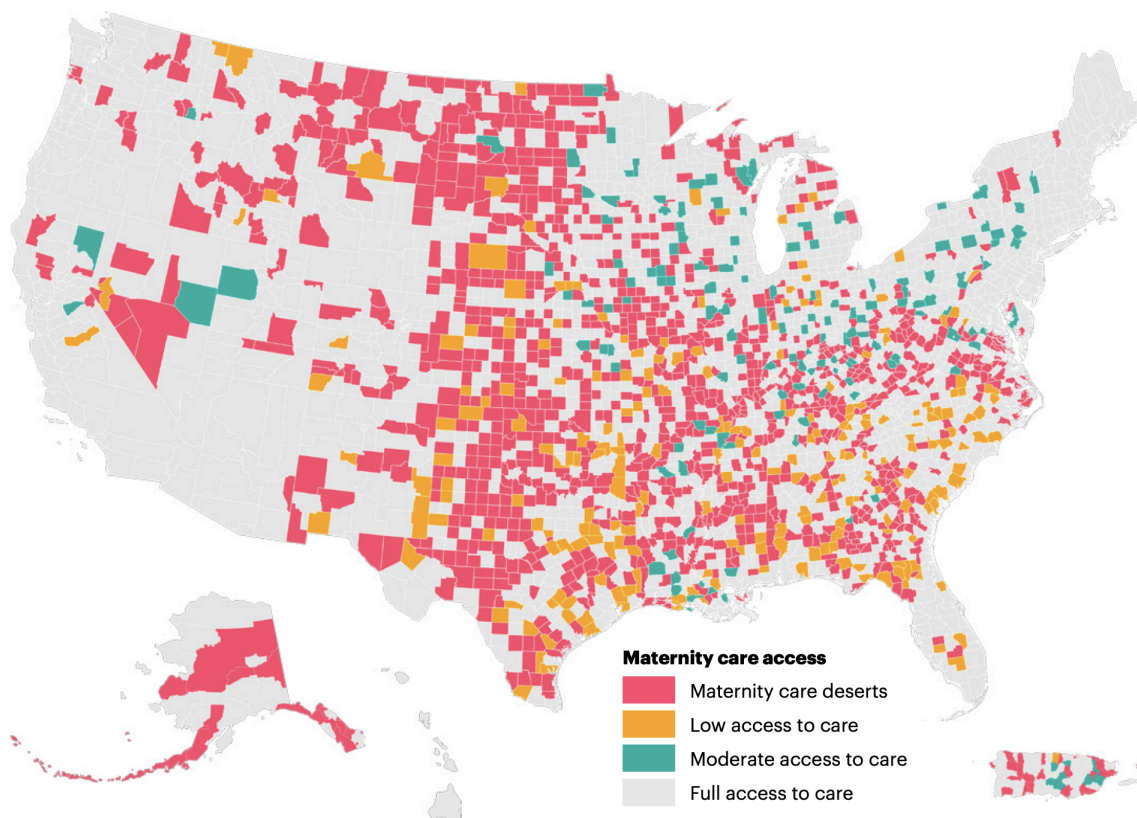
Although relocating to abortion accessible states may alleviate the pressures OB/GYNs face, this introduces another major issue in terms of care: OB/GYN deserts.¹⁴ Data from 2023 estimated that approximately 2.2 million U.S. women live in OB/GYN deserts and about 4.7 million women live in counties with limited access to OB/GYNs (Figure 1) (Weiner, 2023). The OB/GYN field had already been facing a shortage because OB/GYNs tend to retire earlier than other physicians. In his study on retirement from clinical practice, Rayburn et al. (2015) reveals

¹⁴ Counties or areas with limited access to maternity and reproductive healthcare.

that “[o]bstetrician-gynecologists retired earlier than their counterparts in all of the listed medical and surgical disciplines” because of burnout, high liability premiums, insufficient reimbursement, and worsening personal health (p. 335). This OB/GYN shortage paired with the motivation to relocate post-*Dobbs* exacerbates the prevalence of OB/GYN deserts in abortion restrictive states, disproportionately affecting women in these areas that cannot afford to travel for quality reproductive healthcare. Not only does this affect women seeking abortions, but it also negatively impacts women who want to have healthy pregnancies and births, women experiencing menopause, and women seeking other gynecological care.

Figure 1

OB/GYN (Maternity) Care Access by County



This map represents the OB/GYN deserts and counties with limited care across the United States in 2024. From *Nowhere to Go: Maternity Care Deserts Across the US 2024 REPORT*, by March of Dimes, 2024. (<https://www.marchofdimes.org/maternity-care-deserts-report>).

In addition to OB/GYNs intentionally moving out of abortion restrictive states, *Dobbs* is exacerbating OB/GYN deserts by discouraging medical students from applying to programs and practicing in abortion restrictive states because they are aware of the pressures OB/GYNs face there. A cross sectional survey examining OB/GYN residency application trends before and after the *Dobbs* decision found that applications nationally decreased from a mean of 895.9 to 856.7 between the 2021-2022 and 2022-2023 cycles. The study also found that programs in abortion-restrictive states received fewer applications and signals from medical students (Conklin et al., 2025). Upon graduation from medical school in Tennessee, an abortion restrictive state, Hannah Light-Olson shares, “I feel some guilt and sadness leaving a situation where I feel like I could be of some help” (Rovner, 2024, p. 1). Not to mention, many medical students are women who want access to quality reproductive care as well so they are less likely to apply to residency programs in abortions restrictive abortion states (Weiner, 2023). A study conducted in 2022 following the *Dobbs* ruling shares an anonymous quote from a medical student applying to residency, “States that do not respect basic human rights are not places I wish to live or raise a family” (Levy et al., 2025, p. 7). Unfortunately, this trend has always existed among female medical students who consistently consider their personal access to reproductive care and autonomy, pushing them away from historically abortion restrictive states. These new legal pressures have introduced this trend to male medical residents that are now considering their professional autonomy and access to reproductive healthcare for women in their families. Another example quote from the 2022 post-*Dobbs* study states, “I’m a guy, but what about my daughters in the future? What about a pregnancy complication with my wife? What about my patients? This is the problem when people claim moral high ground on the basis of their religion and are placed into positions of power; you end up with a sort of theocracy” (Levy et al., 2025, p.

7). Additionally, even with less applications, many newly graduated doctors are bound to attend residency programs in abortion restrictive states. However, most residents in these states, often leave after completion of the program to relocate to an abortion accessible state (Woods, 2026). The increased prevalence of OB/GYN deserts is well documented and many OB/GYNs and institutions have taken steps to address these issues.

OB/GYN Responses

OB/GYNs are actively attempting to reclaim their professional autonomy while supporting women across the nation in regaining bodily autonomy. Many OB/GYNs are taking time from their busy schedules to sit down and write about their experiences so they can raise awareness and encourage other OB/GYNs, state legislators, and others to become active players in change. OB/GYNs like Dr. Kylie Cooper and Dr. Lucy Smith must have felt so overwhelmed and ignored for them to have written and published articles, op-eds, and other online publications offering insight on the challenges they face as OB/GYNs in abortion restrictive states.

Additionally, many medical professionals are responding to increasing paternalism through advocacy efforts and civic engagement. For some, it can be difficult to leave their home and relocate to another state. A physician participant in a 2022 post-*Dobb* study assessing the effects of the ruling shares, “I live in a state with some of the most restrictive policies and have no ability to move. I cannot simply uproot my life to another state due to my feelings on abortion access. I work here, and my husband works here. My family is here. His family is here. The best I can do is to advocate for change” (Levy et al., 2025, p. 7). Therefore, they accept the reality of practicing in an abortion restrictive state and focus on advocating for women’s bodily autonomy alongside their own professional autonomy. Through civic engagement, OB/GYNs have the opportunity to support meaningful change or shield pre-existing protective laws. For example,

Connecticut Senate Bill 295 (SB00295), which extends state law protections for physicians and patients for legally protected healthcare including abortion care and gender affirming care, was first introduced by the Judiciary Committee on February 25, 2026. At the public hearing on March 2nd, many state residents, including OB/GYNs, medical residents, and medical students supported the bill (Connecticut General Assembly, 2026). Dr. Iyanna Liles, a board-certified OB/GYN and Vice Chair for the Connecticut section of the American College of Obstetricians Gynecologists (ACOG), submitted a supporting testimony on behalf of the Connecticut ACOG (*Testimony For Bill Number SB-00295*, 2026f). Similarly, OB/GYN Dr. Savannah Kaszubinski, gynecologist Dr. Amy Breakstone, Yale resident physician Animesh Upadhyay, UConn medical student Claire Chang, and Farmington medical student Claire Surkis, all submitted supporting testimonies for SB00295 (*Testimony For Bill Number SB-00295*, 2026a; *Testimony For Bill Number SB-00295*, 2026b; *Testimony For Bill Number SB-00295*, 2026c; *Testimony For Bill Number SB-00295*, 2026d; *Testimony For Bill Number SB-00295*, 2026e). Their civic engagement advocating for protective legislation highlights one way OB/GYNs and other medical professionals have taken an active role in enacting change.

Many OB/GYNs are also responding to increased paternalistic forces by taking advantage of medical and technological advancements that allow them to support and encourage patients seeking abortion services and/or alternative reproductive care, such as sterilizations. One way OB/GYNs are doing this is by pairing technology with shield laws¹⁵ to provide reproductive care across borders. Broadly, shield laws have been employed in healthcare to protect healthcare providers offering abortion care and gender affirming care from out of state

¹⁵ Shield laws are state statutes that protect certain individuals and organizations from legally reporting confidential information. Shield laws are primarily known for protecting reporters in the case that another state court prosecutes them or requires them to testify/reveal their confidential sources due to state law differences. Healthcare shield laws protect healthcare providers that provider

investigations/prosecution. As of July 2025, twenty two states in the United States have broad shield laws. However, only eight states have full shield laws that protect providers regardless of patient location, meaning that these providers can provide care and send abortion medication to patients located in restrictive states via telehealth (“State Shield Laws,” 2025).¹⁶ For example, New York has a strong healthcare shield law, allowing OB/GYNs to provide abortion care and send abortion medication to patients in restrictive states without being penalized.

How can providers in these eight states offer reproductive care services to patients in states with abortion restrictions? Luckily, technological advancements in telemedicine paired with state legal protections have provided a strategy to provide abortion care across the nation. Telemedicine provides patients an opportunity to receive confidential medical attention and care from their homes, while they travel, or if they simply don’t wish to make a trip to the doctor’s office. However, telemedicine can be cleverly paired with shield laws in the eight states mentioned above to provide reproductive care across state lines. OB/GYNs can provide a range of reproductive care via telemedicine, including medication abortions, which are performed not surgically, but through the use of abortion pills, specifically mifepristone and misoprostol.¹⁷ These medications are quite effective at inducing abortions up until about 11 weeks of pregnancy (*The Abortion Pill | Get the Facts About Medication Abortion*, n.d.). Given that pregnancy awareness falls at about 5.5 to 6 weeks, this can give pregnant women on average, about 4-5 weeks to schedule a telehealth visit with an OB/GYN (Branum & Ahrens, 2017). Women are still encouraged to see an OB/GYN in person to confirm their pregnancy and gestational age via an ultrasound because this is something that cannot effectively be accomplished through a telehealth

¹⁶ California, Colorado, Maine, Massachusetts, New York, Rhode Island, Vermont, and Washington.

¹⁷ In *Louisiana v. FDA* (October 2025), Louisiana challenged the mailing of mifepristone, claiming it violated the Administrative Procedure Act and the Comstock Act. The Fifth Circuit ruled in favor of Louisiana. On May 14, 2026, the US Supreme Court blocked the Fifth Circuit ruling, granting an emergency stay that allows the prescription of mifepristone via telehealth.

visit. With pregnancy awareness and confirmation, patients can consult providers in reproductively accessible states with strong shield laws, such as New York, who can subsequently mail abortion pills to these patients.

Although this is a clever way to provide care to patients who lack access to abortions, it has been contested in court. In December 2024, the Texas attorney general sued a New York based doctor in a Texas court for providing abortion telehealth care to a patient in Texas. Given that Texas is an abortion restrictive state, the Texas court issued a \$113,000 judgment against this New York doctor which would have to be enforced by New York courts in order to collect that money. Therefore, the Texas attorney general brought this case to the Ulster County Supreme Court (doctor's clinic location), where the court clerk rejected this judgment under New York's shield law. The Texas attorney general then sued the clerk and challenged the New York shield law. However, New York Attorney General Letitia James has been steadfast in her defense against anti-abortion politicians wishing to punish providers and medical professionals that offer abortion and reproductive care. On her website, Attorney General James emphasizes that "New York has led the nation in safeguarding reproductive rights, enacting one of the strongest shield laws in the country and expanding access to care" (James, 2025, p. 1). In New York, Attorney General James has been a firm believer of reproductive justice and has stood up for women and providers within the state while encouraging other attorney generals to do the same. States like New York are instrumental in the battle against anti-abortion sentiments that have reduced abortion and reproductive access to women. Their strong shield laws protect and encourage OB/GYNs to offer their services beyond state lines to improve access to abortion care. This reveals how support from the state government and state legal representatives can enhance the quality and scope of reproductive healthcare.

Another way individuals across the nation are responding to these paternalistic forces is by supporting women that decide to go child-free. In abortion restrictive states, it can still be difficult to access care across borders, even if it is virtual. Therefore, people are sharing resources and informing women about other contraceptive measures they can opt for such as sterilizations, also known as tubal ligations, a procedure that offers a more permanent form of contraception. Typically, older women opt for sterilizations after they no longer wish to have any more children. However, a new trend in sterilizations has been reported following the *Dobbs v. Jackson* ruling as more and more younger women opt for this procedure (Ellison et al., 2024). Dominique Bird, a 31 year old woman in Austin who has been on the birth control pill since a teenager, has always known she never wanted to have kids. When she noticed the current administration's stance on contraception and abortions, she opted for sterilization because pregnancy "just wasn't something that [she] wanted to take the chance on" (Gupta, 2025, p. 1). Sterilizations can be a simpler choice for some women who know they don't want (more) children but, for the majority, it is a rather difficult decision because they may want to have (additional) children in the future.

Despite it being a difficult decision, many women have begun opting for this procedure because it allows them to prevent unintended pregnancies, something they fear more now that their access to abortions has been reduced or removed completely. Trinity Zacharias from West Peoria, Illinois, has felt reluctant to become a mother for a while but hadn't opted for sterilization. Nevertheless, she decided on sterilization surgery before moving down south to a new job because she worried that strict reproductive health laws "might restrict her choices" (Gupta, 2025, p. 1). Even if motherhood is not something women are considering at the moment, it can be difficult to make a decision with a permanent outcome that can never be reversed. It is

clear that *Dobbs v. Jackson* and the current administration have forced women to begin to consider more permanent and perhaps consequential forms of contraception to maintain bodily autonomy.

Although sterilizations are not criminalized and are a choice women have been making autonomously, there are some OB/GYNs, typically the ones that support anti-abortion sentiments, that scrutinize women for making this decision and/or refuse to offer this service. This is critical because many women are turning to sterilizations as a safe, legal alternative to reclaim autonomy and ownership of their bodies. However, when providers refuse to provide this service, they feed into the paternalism that continues to strip women of their autonomy. Therefore, it is crucial that OB/GYNs educate and support patients seeking alternative services such as sterilizations.

This is where once again, technological advancements step in to provide assistance and support. Reddit has been a very popular platform for connecting with various communities and readily sharing information. The “r/childfree” Subreddit is a community where different child-free users share their lifestyles, meet and support other child-free individuals.¹⁸ On January 7, 2023, a page was created on this Subreddit community educating users on the various forms of sterilizations for women who have chosen or are considering sterilizations.¹⁹ This page was created post-*Dobbs*, indicating how it was created out of necessity as many women worried about their reproductive rights. This Subreddit’s community members share information about doctors and clinics in different states that offer sterilization services and are child-free friendly (Gupta, 2025). This page also contains a “Refusal to Treat” section that dives into what to keep in mind if they are refused this service and offers a list of “Childfree Friendly Doctors.” Despite

¹⁸ This Subreddit has been active since February 2009.

¹⁹ <https://www.reddit.com/r/childfree/wiki/sterilisation/>

the information and support this community provides, it is important to understand that it is still a social media platform that can be overwhelming and might contain strong opinions and language.²⁰ However, it can be a great way for women considering sterilizations to share their opinions, expand their understanding, and gather information on next steps if they choose sterilization.

Another concern post-*Dobbs* is the challenges posed in providing comprehensive reproductive health care training to medical residents based in abortion restrictive states. Medical residencies allow newly graduated doctors to apply and practice their skills under the guidance of attending physicians. Abortion restrictive states make it difficult for OB/GYN residents to practice procedures such as dilation and curettage, which may be life saving procedures they need to perform one day. One strategy that can be employed to ensure all OB/GYNs have been sufficiently educated and trained regardless of the state they are in is to have a virtual curriculum accessible for OB/GYN residents. A group of OB/GYNs and stakeholders in the field piloted an online, video-based abortion care curriculum for residents that showed a positive effect on resident knowledge and education (Mengesha et al., 2026). This reveals that a virtual curriculum can be beneficial and supplement resident learning and training in the absence of reproductive health care training amongst abortion restrictive states. The next steps for this pilot outlined by Mengesha et al. (2026) are to complete a “larger nationwide curriculum evaluation” and “curriculum validation” to modify course content to program needs in different settings across the nation (p. e3). This pilot program is an innovative way OB/GYNs and other medical professionals/educators have utilized technology to overcome some of the barriers posed by restrictive state laws in medical education and training. By implementing a plan that incorporates

²⁰ The Subreddit rules prohibit the use of AI and outline respectful guideline for users here: <https://old.reddit.com/r/childfree/about/moderators>

this virtual curriculum across the nation, OB/GYNs can alleviate concerns of both medical residents/students as well as patients seeking quality reproductive care.

A virtual OB/GYN residency curriculum may combat the growing OB/GYN shortage by ensuring OB/GYNs are learning and practicing in abortion restrictive states but in the current political climate, this is unfortunately not enough. As a pre-medical student focused on actively contributing to the advancement of women's health as a future OB/GYN, I have been facing a lot of uncertainty about my future and the choices I should make. As a New Yorker, I have the privilege of readily accessing quality reproductive care and this has never been something I had to worry about changing as elected officials, like General Attorney Letitia James, continue to reaffirm their commitments to maintaining abortion access. However, as I apply to medical schools, one crucial factor I have to consider is whether or not the state is accessible because of how it will affect me both as a woman, and as a prospective doctor. My access to various forms of reproductive care will be significantly reduced – and thus my own health and wellbeing potentially affected – in an abortion restrictive state. Furthermore, the current climate has made me wonder if I will have job security as an OB/GYN in the future because although there is a shortage nationwide, will I want to practice in an abortion-restrictive state if it makes me feel unsafe or anxious about losing my license as others have due to restrictive laws? Unfortunately, I am not alone in feeling this way. A post-*Dobbs* study assessing impacts of the ruling on the medical field shares a quote from a medical student applying to residency, “I was previously set on Ob-Gyn, but I am now looking seriously at other fields because of the politics surrounding women's health care. I don't want to have to worry about legal repercussions for providing the best care to my patients. This has strongly turned me away from Ob-Gyn as a medical specialty” (Levy et al., 2025, p. 6). Although model states such as New York have shield laws and offer

other protective measures like confidentiality protections that tackle this concern, addressing this issue in abortion restrictive states requires a large-scale change in state and/or federal legislation that both protect OB/GYNs and women from the consequences of providing and receiving certain reproductive care services including abortions. These concerns of personal reproductive healthcare and job security need to be addressed because women's reproductive health is an under-researched and vulnerable field requiring more attention, funding, and support. OB/GYNs deserts already exist throughout the nation and if the OB/GYN shortage is magnified, OB/GYN deserts may become the norm, leaving countless women without reproductive healthcare.

In today's political climate, post-*Dobbs*, it is evident that the professional autonomy of practicing OB/GYNs has been compromised by increasing legal paternalistic forces. Paired with the loss of women's bodily autonomy both pre- and post-*Dobbs*, the government has taken control of women's reproductive healthcare in many abortion restrictive states across the nation. Although navigating between legal pressures and patient safety has been challenging, OB/GYNs have innovatively taken advantage of technological advancements with the assistance of protective legislature to provide care across state lines via telemedicine through shield law protections, support women seeking sterilizations to reclaim bodily autonomy, and employ an alternative method to solidify abortion care and reproductive health care training among residents in abortion restrictive states. Although these solutions are impactful, they are simply addressing the symptoms of a problem. The root remains intact and requires greater collaboration and legislative action to reclaim women's bodily autonomy. State legislators must recognize the harmful impact of paternalistic state laws and employ protective measures and laws, using states like New York as models, that allow OB/GYNs to better serve their patients without fearing legal consequences for making informed medical decisions.

References:

- Acevedo, Z. (1979). Abortion in early America. *Women & Health, 4*(2), 159–167.
https://doi.org/10.1300/J013v04n02_05
- American College of Obstetricians & Gynecologists. (n.d.). *Abortion Access Fact Sheet*. ACOG.
Retrieved February 13, 2026, from
<https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet>
- Berg, M. (2020). *Supreme Court Protects Access Abortion—For Now*.
<https://www.plannedparenthoodaction.org/blog/supreme-court-protects-access-abortion-for-now>
- Branum, A. M., & Ahrens, K. A. (2017). Trends in Timing of Pregnancy Awareness Among US Women. *Maternal and Child Health Journal, 21*(4), 715–726.
<https://doi.org/10.1007/s10995-016-2155-1>
- Buchbinder, M., Arora, K. S., McKetchnie, S. M., & Sabbath, E. L. (2024). Sources of moral distress among obstetrician-gynecologists after Dobbs: A qualitative, multi-state study. *SSM - Qualitative Research in Health, 6*, 100483.
<https://doi.org/10.1016/j.ssmqr.2024.100483>
- Conklin, A. M., Rone, V., Arrocha, D., Scott, N. P., Peipert, J. F., & Shanks, A. L. (2025). *Impact of the Dobbs Decision on Obstetrics and Gynecology Residency Applications – an Exploratory Survey* [European Society of Medicine].
<https://doi.org/https://doi.org/10.18103/mra.v13i4.6376>
- Connecticut General Assembly (2026). <https://www.cga.ct.gov>

Curhan, T. (2026, March 10). *State Bans on Abortion Throughout Pregnancy, State Laws and Policies*. Guttmacher Institute.

<https://www.guttmacher.org/state-policy/explore/state-policies-abortion-bans>

Declercq, E., Barnard-Mayers, R., Zephyrin, L. C., & Johnson, K. (2022, December 14). *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*. The Commonwealth Fund.

<https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes>

Dine, R. (2013, August 8). *Scarlet Letters: Getting the History of Abortion and Contraception Right*. *Center for American Progress*.

<https://www.americanprogress.org/article/scarlet-letters-getting-the-history-of-abortion-and-contraception-right/>

Dobbs v. Jackson Women's Health Organization. (2022, June 24). *Center for Reproductive Rights*.

<https://reproductiverights.org/cases/scotus-mississippi-abortion-ban-dobbs-jackson-womens-health/>

Dynak, H., Weitz, T. A., Joffe, C. E., Stewart, F. H., & Arons, A. (2003). *Celebrating San Francisco's Abortion Pioneers*. *San Francisco, CA: UCSF Center for Reproductive Health Research & Policy*.

Ellison, J. E., Brown-Podgorski, B. L., & Morgan, J. R. (2024). Changes in Permanent Contraception Procedures Among Young Adults Following the Dobbs Decision. *JAMA Health Forum*, 5(4), e240424. <https://doi.org/10.1001/jamahealthforum.2024.0424>

- Farber, S. A. (2008). U.S. Scientists' Role in the Eugenics Movement (1907–1939): A Contemporary Biologist's Perspective. *Zebrafish*, 5(4), 243–245.
<https://doi.org/10.1089/zeb.2008.0576>
- Frederiksen, B., Ranji, U., Gomez, I., & Salganicoff, A. (2023, June 21). *A National Survey of OBGYNs' Experiences After Dobbs*. KFF.
<https://www.kff.org/womens-health-policy/a-national-survey-of-obgyns-experiences-after-dobbs/>
- Gold, R. B. (2003). Lessons from Before Roe: Will Past Be Prologue? *The Guttmacher Report on Public Policy*, 6(1), 8–11.
- Gonzales v. Planned Parenthood Federation of America, Inc.* (2006). Oyez.
<https://www.oyez.org/cases/2006/05-1382>
- Goodwin, M. (2020, July 1). The Racist History of Abortion and Midwifery Bans | ACLU. *American Civil Liberties Union*.
<https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans>
- Gupta, A. H. (2025, December 17). With Rights and Resources Uncertain, They're Seeking Sterilization. *The New York Times*.
<https://www.nytimes.com/2025/12/17/well/family/sterilization-tubal-ligation-younger-women.html>
- Harris, L. H. (2022). Navigating Loss of Abortion Services—A Large Academic Medical Center Prepares for the Overturn of *Roe v. Wade*. *New England Journal of Medicine*, 386(22), 2061–2064. <https://doi.org/10.1056/NEJMp2206246>

- Historical Abortion Law Timeline: 1850 to Today*. (n.d.). Planned Parenthood. Retrieved January 29, 2026, from <https://www.plannedparenthoodaction.org/issues/abortion/abortion-central-history-reproductive-health-care-america/historical-abortion-law-timeline-1850-today>
- Hoyert, D. L. (2026, March). *Maternal mortality rates in the United States, 2024*. NCHS Health E-Stats. <https://doi.org/10.15620/cdc/174651>
- James, L. (2025, September 8). *Attorney General James Defends New York's Shield Law Against Texas Attack*. <https://ag.ny.gov/press-release/2025/attorney-general-james-defends-new-yorks-shield-law-against-texas-attack>
- Kiernon, E. (2014, May 13). U.S. Supreme Court Upholds Federal Abortion Ban. *Planned Parenthood*. <https://www.plannedparenthood.org/about-us/newsroom/press-releases/supreme-court>
- Levy, M. S., Bernstein, S. A., McNeilly, S. M., Liberty, A., Fishbach, S., Jain, S., Gold, J. A., & Arora, V. M. (2025). Student and Physician Views of How the Dobbs Decision Affects Training and Practice Location Preferences: Cross-Sectional Questionnaire Study. *Interactive Journal of Medical Research*, *14*, e55035. <https://doi.org/10.2196/55035>
- Mengesha, B., Lutz, E., Connolly, A., Adler, A., Teal, A., Keller, J., Banks, E., & Steinauer, J. (2026). Pilot Implementation of a National, Web-Based Abortion Curriculum for Obstetrics–Gynecology Residents. *O&G Open*, *3*(2), e165. <https://doi.org/10.1097/og9.000000000000165>
- Nambiar, A., Patel, S., Santiago-Munoz, P., Spong, C. Y., & Nelson, D. B. (2022). Maternal morbidity and fetal outcomes among pregnant women at 22 weeks' gestation or less with

complications in 2 Texas hospitals after legislation on abortion. *American Journal of Obstetrics and Gynecology*, 227(4), 648-650.e1.

<https://doi.org/10.1016/j.ajog.2022.06.060>

National Human Genome Research Institute. (n.d.). *Eugenics and Scientific Racism*. NIH.

Retrieved January 28, 2026, from

<https://www.genome.gov/about-genomics/fact-sheets/Eugenics-and-Scientific-Racism>

One in Three People Learn They're Pregnant Past Six Weeks' Gestation. (2021, November 10).

ANSIRH.

<https://www.ansirh.org/research/research/one-three-people-learn-theyre-pregnant-past-six-weeks-gestation>

O'Reilly, K. B. (2021, September 2). *Texas SB 8 puts bounties on doctors' heads for delivering care*. American Medical Association. American Medical Association.

<https://www.ama-assn.org/health-care-advocacy/judicial-advocacy/texas-sb-8-puts-bounties-doctors-heads-delivering-care>

Palacio, H. (2023). Implications of Dobbs v Jackson Women's Health Organization. *American Journal of Public Health*, 113(4), 388–389. <https://doi.org/10.2105/AJPH.2023.307244>

Rayburn, W. F., Strunk, A. L., & Petterson, S. M. (2015). Considerations about retirement from clinical practice by obstetrician-gynecologists. *American Journal of Obstetrics and Gynecology*, 213(3), 335.e1-335.e4. <https://doi.org/10.1016/j.ajog.2015.03.027>

Roe v. Wade: Behind the Case That Established the Legal Right to Abortion. (n.d.). Planned Parenthood. Retrieved January 29, 2026, from

<https://www.plannedparenthoodaction.org/issues/abortion/roe-v-wade/roe-v-wade-behind-case-established-legal-right-abortion>

Rovner, J. (2024, May 9). Medical residents are starting to avoid states with abortion bans, data shows. *NPR*.

<https://www.npr.org/sections/health-shots/2024/05/09/1250057657/medical-residents-starting-avoid-states-abortion-bans>

Seward, S. (2009). *Planned Parenthood v. Casey (1992)*. Embryo Project Encyclopedia.

<https://embryo.asu.edu/pages/planned-parenthood-v-casey-1992>

Smaw, E. D. (2022). Uterus collectors: The case for reproductive justice for African American, Native American, and Hispanic American female victims of eugenics programs in the United States. *Bioethics*, 36(3), 318–327. <https://doi.org/10.1111/bioe.12977>

Smith, L. (2024, April 20). *I'm a Kansas City OB-GYN. The Supreme Court might put my patients in danger*. Kansas City Star.

<https://www.kansascity.com/opinion/readers-opinion/guest-commentary/article287848350.html>

State Shield Laws: Protections for Abortion and Gender-Affirming Care Providers. (2025, July).

KFF. <https://www.kff.org/state-health-policy-data/state-indicator/shield-laws/>

Surana, K., & Presser, L. (2026, April 17). Texas Medical Board Sanctions Three Doctors for Delayed Care That Led to the Deaths of Two Pregnant Women. *ProPublica*.

<https://www.propublica.org/article/tmb-disciplines-doctors-ngumezi-crain-cases>

Teaching Women's History: The Strange and Sordid Tale Behind the First U.S. Abortion Law.

(2022, April 25). The New York Historical.

<https://www.nyhistory.org/blogs/teaching-womens-history-the-strange-and-sordid-tale>

Testimony For Bill Number SB-00295: Hearing on SB00295 (2026).

[cga.ct.gov/2026/juddata/TMY/2026SB-00295-R000302-Breakstone,%20Amy,%20MD-Physicians%20for%20Women-s%20Health-Supports-TMY.PDF](https://www.cga.ct.gov/2026/juddata/TMY/2026SB-00295-R000302-Breakstone,%20Amy,%20MD-Physicians%20for%20Women-s%20Health-Supports-TMY.PDF)

Testimony For Bill Number SB-00295: Hearing on SB00295 (2026).

<https://www.cga.ct.gov/2026/juddata/TMY/2026SB-00295-R000302-Chang,%20Claire-UConn%20School%20of%20Medicine-Supports-TMY.PDF>

Testimony For Bill Number SB-00295: Hearing on SB00295 (2026).

<https://www.cga.ct.gov/2026/juddata/TMY/2026SB-00295-R000302-Kaszubinski,%20Dr.%20Savannah,%20OBGYN%20Physician-Reproductive%20Equity%20Now-Supports-TMY.PDF>

Testimony For Bill Number SB-00295: Hearing on SB00295 (2026).

<https://www.cga.ct.gov/2026/juddata/TMY/2026SB-00295-R000302-Surkis,%20Claire,%20Medical%20Student-Supports-TMY.PDF>

Testimony For Bill Number SB-00295: Hearing on SB00295 (2026).

<https://www.cga.ct.gov/2026/juddata/TMY/2026SB-00295-R000302-Anonymous%2052,%20Anonymous%2052,%20Resident%20Physician-Yale%20University-Supports-TMY.PDF>

Testimony For Bill Number SB-00295: Hearing on SB00295 before the FACOG (2026).

<https://www.cga.ct.gov/2026/juddata/TMY/2026SB-00295-R000302-Liles,%20Iyanna,%20Vice%20Chair%20CT%20ACOG-CT%20American%20College%20of%20OBGYN-Supports-TMY.PDF>

The Abortion Pill | Get the Facts About Medication Abortion. (n.d.). Planned Parenthood.

Retrieved March 13, 2026, from

<https://www.plannedparenthood.org/learn/abortion/the-abortion-pill>

Wailoo, K. (2018). Historical Aspects of Race and Medicine: The Case of J. Marion Sims.

JAMA, 320(15), 1529–1530. <https://doi.org/10.1001/jama.2018.11944>

Weiner, S. (2023, August 23). *The fallout of Dobbs on the field of OB-GYN.* AAMC.

<https://www.aamc.org/news/fallout-dobbs-field-ob-gyn>

Whole Woman's Health v. Hellerstedt. (2016). Planned Parenthood.

<https://www.plannedparenthoodaction.org/issues/abortion/roe-v-wade/whole-womans-health-v-hellerstedt>

Woods, A. (2026, March 4). Q&A: How the Dobbs decision and abortion restrictions changed where medical students apply to residency programs. *UW News.*

<https://www.washington.edu/news/2026/03/04/qa-how-the-dobbs-decision-and-abortion-restrictions-changed-where-medical-students-apply-to-residency-programs/>