ORIGINAL RESEARCH

Abortion Attitudes and Behavioral Intentions of Obstetrics and Gynecology Residents at Four Midwestern Residency Programs Prior to *Dobbs v Jackson Women's Health*

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ABSTRACT

Introduction: In June 2022, the United States Supreme Court announced its decision in *Dobbs v Jackson Women's Health Organization* to overturn *Roe v Wade*. As a result, half of US states now face proposed or in-effect abortion bans, which affect the ability of obstetrics and gynecology (ObGyn) residency programs to provide abortion training. We sought to establish ObGyn residents' pre-*Dobbs* attitudes toward abortion, desire to learn about abortion, and intentions about providing abortion care in their future practice.

Methods: From January through December 2021, we surveyed 70 ObGyn residents at 4 programs in Wisconsin and Minnesota to assess their attitudes toward abortion, desire to learn about abortion, and intentions about providing abortion care in their future practice.

Results: Fifty-five out of 70 (79%) ObGyn residents completed the survey. Most reported highly favorable attitudes toward abortion, nearly all found the issue of abortion important, and the majority planned to incorporate abortion care into their future work. There were no differences in median attitude scores or behavioral intentions among institutions.

Conclusions: Prior to the *Dobbs* decision, ObGyn residents in Minnesota and Wisconsin viewed abortion as important health care and intended to provide this care after graduation.

INTRODUCTION

The reversal of *Roe v Wade* by the United States Supreme Court on June 24, 2022, has resulted in proposed or in-effect abortion bans spanning half the country.[1] Despite that nearly a quarter of women will have an abortion in their lifetimes and that abortion training is a required component of obstetrics and gynecology (ObGyn) resident education by the Accreditation Council of Graduate Medical Education, nearly half of all ObGyn residency programs now struggle to provide clinical training in this common health care service.[2-6] The media has also raised concerns that wide geographic variations in abortion legality will adversely shape where physicians choose to train and ultimately practice, which could further exacerbate existing ObGyn shortages.[7-9] To better understand how the decision in *Dobbs v Jackson Women's Health Organization* may affect US ObGyn residents' career decisions, it is crucial to understand what their baseline attitudes toward abortion were prior to the reversal of *Roe v Wade*, what their desire was to learn about abortion, and the importance they placed on being able to provide abortion care in their future work. Current literature on these topics is sparse.[10]

Prior to the *Dobbs* decision, we assessed attitudes and career intentions toward abortion among ObGyn residents in Minnesota and Wisconsin, where 19.5% and 15.3% of counties, respectively, already qualify as maternity care deserts and access to abortion post-*Dobbs* significantly differs.[11,12]

METHODS

We included all ObGyn residents who were scheduled to participate in a workshop at the University of Minnesota Twin Cities (UMN), University of Wisconsin–Madison (UW), Medical College of Wisconsin (MCW), and Aurora-Sinai Milwaukee (Aurora) during January 2021 through December 2021. Adapted from the Values Clarification and Attitudes Transformation workshop published by Turner et al, this workshop was a required component of the residency didactics curriculum designed to

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Resident Characteristics	N (%)	Attitude Score, Median (IQR)	*P* value	Behavioral Intention Score, n (%) Saying "Yes" to All 6 Items	*P* value
Total	55 (100)	95 (87-98)		44 (80)	
Institution			0.436		0.298
University of Minnesota–Twin Cities	17 (31)	95 (93-99)		16 (94)	
Medical College of Wisconsin	14 (25)	92 (85-96)		10 (71)	
Aurora-Sinai Milwaukee	10 (18)	96 (91-99)		8 (80)	
University of Wisconsin–Madison	14 (25)	96 (87-98)		10 (71)	
Gender			0.413		0.179
Man	9 (16)	95 (95-99)		9 (100)	
Woman	46 (84)	95 (87-98)		35 (76)	
Birthplace			0.819		0.545
Outside the United States	5 (9)	91 (88-92)		4 (80)	
United States, not Midwest	22 (40)	95 (89-99)		16 (73)	
United States, Midwest	28 (51)	96 (86-98)		24 (86)	
Religiosity			0.046		
Do not identify with a religion	36 (65)	95 (90-99)		30 (83)	
Identify with religion; incorporate into daily life none/little	6 (11)	96 (92-99)		6 (100)	
Identify with religion; incorporate into daily life some/quite a bit/great deal	13 (24)	87 (84-96)		8 (62)	
Post-Graduate Year			0.773		0.831
1	17 (31)	95 (87-98)		14 (82)	
2	14 (25)	96 (85-99)		10 (71)	
3	12 (22)	96 (93-99)		10 (83)	
4	12 (22)	95 (89-97)		10 (83)	
Interested in pursuing a fellowship			0.533		0.712
No	39 (71)	95 (88-99)		32 (82)	
Yes	16 (29)	95 (86-97)		12 (75)	

Table. Median Attitude and Behavioral Intention Scores of Survey Participants, by Selected Demographic Characteristics

Wilcoxon rank sum or Kruskal-Wallis rank tests for attitude scores; Fisher exact test for behavioral intentions; *P* values <0.05 considered statistically significant.

help participants explore their attitudes toward abortion.[13,14] All residents were required to attend the workshop unless they had an approved absence (eg, post-call, vacation). We emailed all residents a link to a confidential, voluntary survey using a web-based platform (Qualtrics, Provo, UT). The first screen of the survey informed potential participants that completion of the survey would be considered consent to participate in the research study. Survey participants received a $10 Amazon gift card link.

We gathered demographic information and used a previously published questionnaire (adapted from workshop materials published by Turner et al; see Supplemental Materials) to assess attitudes toward abortion care and behavioral intentions for future practice.[13,14] To assess attitudes, we asked the degree to which participants agreed with 17 statements about abortion using a 5-point Likert scale. To assess behavioral intentions, we posed 6 yes/no questions regarding intent to learn about, advocate for, refer patients to, and provide abortion care. To compare attitudes among participants overall rather than item-by-item, we followed Turner et al's analytic methodology and created summative attitude scores that ranged from zero (most negative toward abortion) to 100 (most positive toward abortion). Summative attitude scores were calculated by summing the 5-point responses, dividing by the total number of items (n = 17) and multiplying by 100. Summative behavioral intention scores were calculated similarly, dividing the sum of positive responses by the total number of items (n = 6), and multiplying by 100.[14]

To compare attitude scores by demographic characteristics, we used the Wilcoxon rank sum test and the Kruskal-Wallis equality of distributions rank test, as appropriate. Given the observed distribution of answers to the behavioral intention questions (80% of respondents answered "yes" to all 6 items), we dichotomized responses into "all yes" versus "any no" and used Fisher exact test to test for significant differences by demographic characteristics. *P* values <0.05 were considered statistically significant. The study was reviewed and considered exempt by the University of Wisconsin-Madison Minimal Risk Institutional Review Board (IRB) and reviewed and approved by the University of Minnesota IRB.

RESULTS

A total of 55 out of 70 (79%) ObGyn residents completed the survey: 17 of 21 (81%) from UMN, 14 of 20 (70%) from UW, 14 of 16 (88%) from MCW, and 10 of 13 (77%) from Aurora. Of residents who completed the survey, a majority (n = 46, 84%) identified as women, were born in the Midwest (n =28, 51%), and

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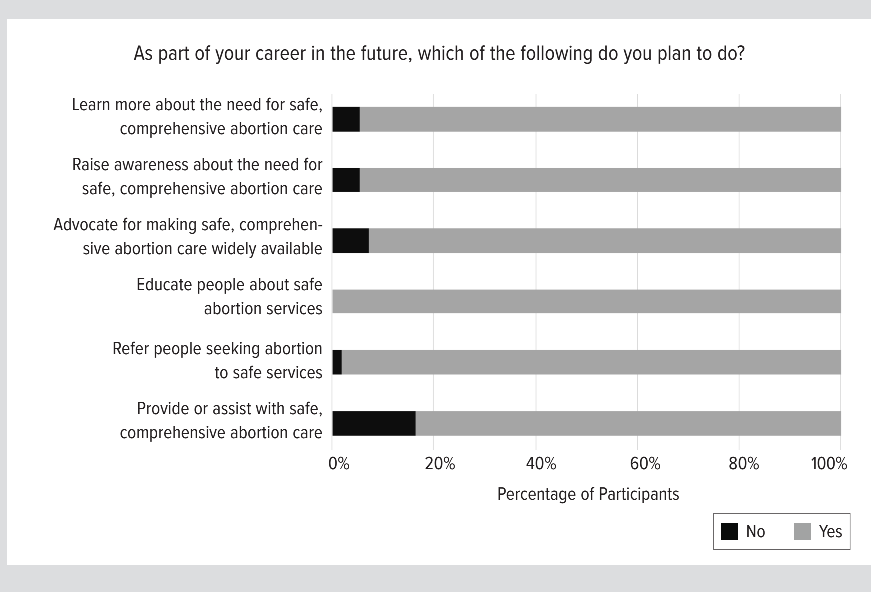
Figure 1. Percentage Breakdown of Attitudes Toward Abortion for All Participants (n = 55)

The issue of abortion is of little importance to me
I support the provision of family planning and contraceptive services
I feel comfortable working to increase access to family planning and contraceptive services
I support the provision of abortion services as permitted by law
I feel comfortable working to increase access to abortion services as permitted by law
I feel comfortable talking with my closest family members about my involvement with abortion care
I would feel comfortable observing an abortion procedure
I would feel comfortable performing or assisting an abortion procedure
I am clear about my personal values concerning abortion
I feel very conflicted about abortion
I can clearly explain my personal values concerning aboriton
I can respectfully explain values concerning abortion that conflict with mine
I feel empathy for people who have experienced abortion
All people should have access to safe, comprehensive abortion care in the first trimester
Access to first semester abortion should be restricted to certain circumstances
All people whould have access to safe, comprehensive abortion care in the second trimester
Access to second trimester abortion should be resticed to certain circumstances
0% 20% 40% 60% 80% 100%
Percentage of Participants
Strongly disagree Slightly disagree Neither Slightly agree Strongly agree

did not identify with a particular religion (n = 36, 65%) (Table).

The median attitude score for respondents was 95 (IQR 87-98). Differences in the distributions of attitude and behavioral intention scores among institutions were not statistically significant (Table). Behavioral intention scores did not significantly differ across participant characteristics. Attitude scores significantly differed only by religiosity: respondents who did not identify with a religion held more positive overall attitudes than those for whom religion impacted their daily lives (Table). Nearly all 55 respondents (n = 49, 89%) disagreed with the statement "the issue of abortion has little importance to me," while almost all respondents agreed that

Figure 2. Percentage Breakdown of Behavioral Intentions for All Participants (n = 55)



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"all people should have access to safe, comprehensive abortion care in the first (n = 55, 100%) and second (n=54, 98%) trimester." Nearly all respondents (n = 52, 95%) wanted to learn more about the need for safe, comprehensive abortion care, 54 (98%) planned to refer people seeking abortion to safe services, and 46 (84%) planned to provide abortion care in their future careers (Figures 1 and 2).

DISCUSSION

Our research demonstrates that prior to the *Dobbs* decision, ObGyn residents in our sample from Wisconsin and Minnesota held highly favorable attitudes toward abortion, believed abortion should be available to patients, desired education and training in abortion care, and planned to directly provide or refer patients for abortion care in their future practice. Notably, our study was conducted in 2 states that faced different abortion access restrictions even prior to the *Dobbs* decision. Unlike Wisconsin, where restrictions to abortion proliferated prior to *Dobbs*, Minnesota had fewer barriers to access in place.[15,16] Despite these differences in legal landscapes, we found no significant difference between state populations in attitudes toward abortion or respondents' plans to incorporate abortion into their future work.

Following *Dobbs*, the 2 states' legal landscapes have diverged even farther: Minnesota has codified abortion rights into its state constitution, and Wisconsin initially reverted to an 1849 state law that criminalizes the provision of abortion in nearly all circumstances.[17,18] Although our data do not offer insight into the extent to which post-*Dobbs* restrictions are shaping resident recruitment and decision-making, this study is strengthened by a high survey response rate and provides critical baseline data to understand how the *Dobbs* decision will affect ObGyn residents and future career plans going forward. Understanding the forces that shape the future ObGyn workforce is key – particularly in light of concerns predating *Dobbs* about impending ObGyn shortages in certain areas of the country.[19] As other researchers have noted, physician attitudes have the capacity to guide not only important stakeholders, such as media, policymakers, and voters, but they also can carry weight in their institutions, whose responsibilities include recruiting and retaining a robust and willing labor force.[10]

It is worth noting that even when abortion was a federally protected constitutional right, only 60% of respondents reported "routine" access to abortion training; satisfaction with abortion training was positively and independently correlated with the routine availability of this training.[20] As graduate medical education transitions to a post-*Dobbs* world, residency programs should evaluate their current recruitment and educational strategies to maximally ensure that all ObGyn residents who are legally able to receive adequate abortion training do so. This may necessitate establishing out-of-state training partnerships for programs in restricted states. Education leaders also should work within academic training sites to reduce or extinguish wherever possible all other institutional-level barriers to the provision of abortion care in inpatient and outpatient settings. Finally, new initiatives may include implementing and studying interventions designed to improve attitudes and behavioral intentions toward abortion care – such as mandated values clarification workshops – so that demand for training among residents remains high.[21]

CONCLUSIONS

Prior to the *Dobbs* decision, most ObGyn residents in 2 Midwestern states with significantly different abortion access held highly favorable attitudes toward abortion and planned to provide abortion care in their future practice. How and to what extent recent seismic changes in the legal landscape will shape the future, post-*Dobbs* ObGyn workforce remains unknown. While some graduating residents who value abortion training and provision may avoid practicing in states where abortion is restricted, others may be drawn to practice where the need for advocacy is high. Future research should directly evaluate how post-*Dobbs* state-level abortion restrictions, such as those in Wisconsin, impact both recruitment into ObGyn residency programs, career decision-making among graduating residents, and the availability, accessibility, and quality of pregnancy-related health care for patients.

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Appendix: Available online at www.wmjonline.org

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