

ORIGINAL ARTICLE

Conscience, Competence, and Compliance: A Proposal for Ethical and Legal Reform of ACGME Abortion Training Standards Post-*Dobbs*

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ABSTRACT

The reversal of *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organization* (2022) has reshaped the legal and moral landscape of reproductive health care in the United States. In this new era of state-level variation and ongoing conscience-driven conflict, the ACGME's current abortion training standards expose significant fault lines between medical education, law, and ethics. What was once considered a settled requirement of comprehensive reproductive training has become, in many regions, a point of legal contradiction and moral tension. From a bioethical standpoint, the current standards fail to strike an equitable balance among the principles of autonomy, beneficence, nonmaleficence, and justice. By privileging one conception of beneficence, procedural access, over others, the ACGME inadvertently undermines autonomy and justice for institutions and individuals who hold sincere moral objections. Moreover, through the lens of virtue ethics, the standards neglect the formative purpose of medical education: to cultivate physicians of integrity and moral prudence who can navigate pluralistic ethical landscapes.

This paper proposes a set of four-tiered reforms that reconcile medical competency with conscience and legality:

- At the federal level, the separation of GME funding from abortion training ensures compliance with federal appropriations law and public accountability.
- At the state level, a model of state-consistent compliance respects federalism while maintaining educational equivalence through alternative training pathways.
- At the institutional level, conscience-based exemptions safeguard the participation of faith-based hospitals in medical education without diluting academic rigor.
- At the individual level, an opt-in framework for abortion training affirms the autonomy and moral agency of each trainee, fostering authentic professional formation.

Collectively, these reforms do not diminish the ACGME's commitment to high-quality, comprehensive training. Rather, they reorient it towards a more ethically pluralistic and legally coherent model, one that aligns with the values of a diverse society and the principles of professional freedom.

Keywords ACGME; abortion training; graduate medical education; conscientious objection; institutional conscience; *Dobbs v. Jackson Women's Health Organization*; opt-in training model; medical ethics

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1. Introduction – The Post-*Dobbs* Landscape and the Public Policy Importance

The Supreme Court's 2022 decision in *Dobbs v. Jackson Women's Health Organization*¹ fundamentally reshaped the legal terrain of reproductive health in the United States by overturning *Roe v. Wade* (1973)² and returning authority to regulate abortion to the individual states. This seismic shift has created profound implications not only for clinical practice and patient access but also for medical education and accreditation. Within obstetrics and gynecology (OB-GYN) residency training, the *Dobbs* decision has placed longstanding accreditation standards of the Accreditation Council for Graduate Medical Education (ACGME) in direct tension with emerging state laws, institutional conscience protections, and federal funding restrictions.^{3,4}

Since 1996, the ACGME has required that all OB-GYN residency programs provide training or access to training in

the provision of induced abortion, while permitting individual residents to opt out for moral or religious reasons.⁵ This mandate, initially framed as ensuring comprehensive reproductive health education, was relatively uncontroversial under the national constitutional protection afforded by *Roe*. However, in the aftermath of *Dobbs*, more than half of U.S. states have enacted laws that restrict or prohibit abortion procedures, creating a patchwork of legal regimes in which the ACGME's uniform national standard may compel programs to violate state statutes or institutional mission statements.⁶

The policy conflict extends beyond mere curricular logistics. Because ACGME accreditation is a prerequisite for federal Graduate Medical Education (GME) funding through both Direct Medical Education (DME) and Indirect Medical Education (IME) payments,⁷ as well as for eligibility for specialty board certification, the organization wields de facto

regulatory authority over the training and credentialing of physicians in the United States.⁸ Consequently, noncompliance with ACGME standards can jeopardize not only a program's accreditation but also the flow of federal funds and residents' professional futures. When those standards require programs to facilitate access to training activities that contravene state law or institutional conscience, and structure individual participation as the default from which residents must affirmatively opt out, a collision arises among federal funding mechanisms, state sovereignty, and individual rights of conscience.

From a bioethical standpoint, the issue implicates fundamental principles of autonomy, nonmaleficence, and justice. Requiring residency programs to facilitate abortion training regardless of state law or institutional mission and structuring individual participation as a presumed default that trainees must actively reject, risks eroding respect for moral integrity and pluralism within the profession.⁹ Residents who exercise the opt-out have reported fear of stigmatization, negative evaluations, and career disadvantage, concerns sufficiently widespread that they have prompted federal legislative action in the form of the Conscience Protections for Medical Residents Act, introduced in the U.S. Senate in 2025.¹⁰ These harms flow not from formal compulsion but from the structural normalization of participation that the opt-out model creates. From a legal and public policy perspective, it raises urgent questions about the proper scope of federal influence in medical education and the tension between federal funding conditionality, national accreditation standards, and the authority of states to regulate medical practice within their borders.

This paper argues that the ACGME's current abortion-training requirement, though historically grounded in a commitment to comprehensive education, has become ethically and legally untenable in the post-*Dobbs* landscape. To realign accreditation policy with contemporary law and ethical pluralism, the ACGME should revise its standards to (1) respect state sovereignty by adopting a legally neutral position on abortion training, (2) create institutional exemptions for faith-based hospitals, and (3) replace the current "opt-out" clause for residents with a voluntary "opt-in" model. These reforms would preserve educational integrity while restoring ethical coherence and legal compliance across the nation's obstetrics and gynecology training programs.

2. Background: Abortion and Medical Training Before and After *Dobbs*

2.1 Abortion Training Under *Roe v. Wade*

For nearly five decades after *Roe*, the constitutional right to abortion created a relatively stable framework for medical education in reproductive health. Within this environment, the ACGME codified abortion training as a necessary component of comprehensive OB-GYN residency education. In 1996, the ACGME formally required that all OB-GYN programs "provide training or access to training in the

performance of abortions," while allowing individual residents with moral or religious objections to opt out.⁵ The stated rationale was that competency in family planning, which included induced abortion, was essential to the comprehensive practice of obstetrics and gynecology.¹¹

The constitutional framework established by *Roe* provided a nationally uniform legal floor for abortion access, but it did not eliminate conflicts between accreditation standards and the varied legal and institutional landscape in which residency programs operated. Throughout the post-*Roe* decades, states continued to enact restrictions (including mandatory waiting periods, gestational age limits, and facility licensing requirements) that complicated abortion training in ways that varied significantly by jurisdiction. Faith-based hospitals that declined to offer abortion services could technically meet ACGME requirements by arranging off-site training, but this "out of sight, out of mind" accommodation depended less on genuine compliance than on the ACGME's consistent choice not to enforce its own standards aggressively. Indeed, the ACGME wielded arguably greater enforcement authority under *Roe* than it does today, yet largely declined to use it, a pattern of selective non-enforcement that allowed institutional conscience objections to persist quietly beneath a nominally uniform national standard. The tensions exposed by *Dobbs* are therefore not entirely new; they are the surfacing of conflicts that were present but suppressed throughout the *Roe* era.

2.2 The ACGME's Regulatory Role in Graduate Medical Education

The ACGME's influence over graduate medical education (GME) cannot be overstated. As the sole accrediting body for residency and fellowship programs in the United States, the ACGME sets the minimum educational standards that determine program accreditation status and thereby eligibility for federal and state GME funding.¹² Accreditation is also a prerequisite for graduates to sit for specialty board certification through the American Board of Obstetrics and Gynecology (ABOG) and the American Osteopathic Board of Obstetrics and Gynecology (AOBOG).^{13,14} Thus, ACGME policies carry both financial and professional implications for institutions and trainees.

This interconnected structure effectively links accreditation standards to federal funding mechanisms: specifically, Direct Medical Education (DME) and Indirect Medical Education (IME) payments provided through Medicare and administered by the Centers for Medicare & Medicaid Services (CMS). DME payments reimburse hospitals directly for the costs of operating residency programs, including resident salaries and teaching faculty time, while IME payments provide additional reimbursement to teaching hospitals to offset the higher costs of care associated with training programs. Together, these funding streams represent billions of dollars annually distributed to the nation's teaching hospitals.⁷ Because ACGME accreditation is the gateway to this funding, any accreditation requirement, including the abortion training mandate, carries

the practical force of a federal funding condition. Any requirement that a program must provide abortion training therefore indirectly ties these federal dollars to a politically and ethically contested procedure. While federal law, through the Hyde Amendment,¹⁵ prohibits the use of federal funds for most abortion services, the ACGME's standards raise complex questions about whether GME funds are functionally supporting abortion-related training activities.

It bears noting that the current opt-out framework did not arise from ACGME policy alone. The 1996 ACGME standard emerged in direct response to the Coats-Snowe Amendment,¹⁶ which Congress enacted that same year to prohibit discrimination against entities that decline to provide abortion training. The opt-out model was thus a legislative and regulatory compromise, one that Congress shaped and that Congress retains the authority to revisit. The post-*Dobbs* environment provides a compelling basis for precisely such reconsideration.

2.3 The *Dobbs* Decision and the Fragmentation of Abortion Law

The Supreme Court's ruling in *Dobbs* upended this equilibrium by declaring that the Constitution confers no right to abortion and returning the authority to regulate abortion to the states. In the wake of *Dobbs*, at least 12 states have implemented near-total abortion bans, and several others have imposed gestational limits or additional procedural restrictions.¹⁷ This legal fragmentation has produced profound challenges for OB-GYN residency programs, particularly those operating in states where abortion is now restricted.

Programs in restrictive states face a stark dilemma: comply with ACGME standards by facilitating abortion training and potentially violating state law, or forgo compliance and risk loss of accreditation. Even when abortion is not banned outright, logistical and legal barriers, such as mandatory waiting periods, licensing restrictions, and potential criminal liability, complicate training arrangements.⁶ The ACGME's policy of requiring access to abortion training, without providing exemptions for programs in such states, effectively creates a national standard that overrides state-level determinations of legality.

It should be acknowledged that state abortion prohibitions are directed primarily at the performance of abortion procedures rather than at educational training activities as such. The degree of legal exposure therefore varies significantly by jurisdiction and by the specific statutory language in effect. However, in states operating under broad civil enforcement frameworks, including Texas's Senate Bill 8¹⁸ mechanism, the legal risk extends beyond direct procedural participation. Arranging, facilitating, or funding out-of-state training in abortion procedures may expose programs and supervising faculty to civil liability under aiding and abetting theories that have not yet been fully tested in court. The uncertainty itself constitutes a cognizable burden: programs cannot be expected to operate in good faith

under accreditation standards that require activities whose legal status in their jurisdiction remains genuinely unresolved.

2.4 Emerging Ethical and Educational Strains

The post-*Dobbs* era has also brought light to longstanding ethical tension within medical education. For residents and faculty who hold religious or moral objections to abortion, participation in or facilitation of abortion training, even indirectly, may violate deeply held convictions. Similarly, under current ACGME rules, institutions are not granted exemptions based on conscience or religious identity. Faith-based hospitals, many of which play a critical role in obstetric training, are thereby placed in an untenable position to comply with ACGME mandates to facilitate abortion training in contradiction to existing federal health care conscience protections under statutes such as the Church Amendments, Public Health Service Act 245 (The Coats-Snowe Amendment), and the Weldon Amendment.¹⁹

Moreover, the United States (U.S.) faces a growing trend of obstetric unit closure and workforce shortages. More than half of U.S. counties lack a hospital that provides obstetric care, a condition known as maternity deserts.²⁰ Therefore, the ACGME abortion training mandate poses a risk to further exacerbate workforce shortages by challenging the viability of the national training pipeline and further polarizing the profession along ideological and geographic lines.

2.5 Summary

In short, the ACGME's abortion training mandate, which was originally conceived under a nationally uniform legal landscape, now operates within a fragmented, post-*Dobbs* system that pits federal accreditation standards against state sovereignty, institutional conscience, and individual moral integrity. These overlapping conflicts underscore the urgent need to revisit and reform the ACGME's standards to ensure that they remain legally compliant, ethically defensible, and educationally sound in an era of profound moral and legal diversity.

3. The Role and Influence of the ACGME

3.1 Nature and Function of the ACGME

The ACGME is a private, not-for-profit organization that serves as the sole accrediting body for residency and fellowship programs in the U.S. Although it is not a governmental entity, the ACGME functions as a de facto regulator of graduate medical education (GME) through its authority to establish educational standards, conduct program reviews, and grant or revoke accreditation. Its standards are intended to ensure that residency programs provide comprehensive training, produce competent physicians, and maintain a consistent quality of medical education across the country.²¹

The ACGME operates through specialty-specific Review Committees, which evaluate program curricula, faculty qualifications, clinical experiences, and resident outcomes. By defining core competencies, procedural requirements, and

ethical expectations, the organization exerts a major influence over the content and structure of medical training, effectively shaping the professional formation of physicians.

3.2 Importance of ACGME Accreditation

ACGME accreditation is essential for multiple practical and regulatory reasons:

1. Eligibility for Federal and State Funding

- Accreditation is required for programs to receive federal GME payments through Direct Medical Education (DME) and Indirect Medical Education (IME) funding, administered by the Centers for Medicare & Medicaid Services (CMS) and described in Section 2.2 above. These payments provide substantial financial support to hospitals hosting residency programs and represent the primary mechanism through which ACGME accreditation carries federal financial force.¹²
- Certain state-level funding streams also hinge upon accredited status, making ACGME compliance crucial for financial sustainability.²²

2. Professional Credentialing

- Graduation from an ACGME-accredited program is a prerequisite for board certification through the American Board of Obstetrics and Gynecology (ABOG) and the American Osteopathic Board of Obstetrics and Gynecology (AOBOG).^{13,14} Without accreditation, residents may be ineligible for certification exams, limiting their ability to practice independently or pursue fellowship training.

3. Standardization and Quality Assurance

- By enforcing uniform standards across the nation, the ACGME ensures that all residency programs, regardless of size, location, or institutional affiliation, provide exposure to key clinical competencies. In OB-GYN, this includes the full breadth of obstetrical care, ambulatory gynecology, and surgical training.²³
- Accreditation serves as a quality assurance mechanism, signaling to patients, employers, and state regulators that programs meet minimum educational benchmarks.

3.3 The ACGME's De Facto Regulatory Power

Although a private organization, the ACGME's requirements carry regulatory weight for several reasons:

- **Indirect Legal Influence:** Hospitals and residency programs depend on accreditation for access to federal and state funds. Noncompliance with ACGME standards can trigger financial penalties, loss of funding, and even closure of residency programs.
- **Professional Consequences:** Residents' future licensure and board eligibility are contingent upon graduating from accredited programs. Consequently, the ACGME's policies effectively determine which residents have access to specialized training and career advancement.

- **National Standard-Setting:** In areas of medical practice subject to ethical and legal debate, such as abortion, the ACGME's policies operate as a national norm. Even in states with restrictive laws, programs may feel compelled to provide access to abortion training to avoid accreditation risk, thereby creating tension between federal-standard expectations and state law.⁶

3.4 Implications for Abortion Training Post-Dobbs

In the post-*Dobbs* landscape, the ACGME's role as an accrediting body magnifies conflicts between educational standards, legal compliance, and ethical pluralism. By mandating access to abortion training without providing state-based or institutional exemptions, the ACGME inadvertently places programs in states with restrictive laws at risk of violating state statutes. Faith-based institutions face analogous challenges: failure to comply with accreditation standards may jeopardize funding or certification, while compliance may conflict with their mission and conscience protections. These dynamics highlight the unique position of the ACGME as a private organization wielding quasi-regulatory authority with direct legal, financial, and professional consequences.

3.5 Summary

The ACGME occupies a central role in U.S. medical education, shaping curricula, setting national standards, and linking accreditation to funding and professional credentialing. While not a governmental entity, its influence functions as a regulatory force. In the context of abortion training, this power has significant implications: programs, institutions, and trainees are caught between compliance with national educational standards and adherence to state law and personal conscience. Understanding the scope and impact of ACGME authority is essential for evaluating the legal and bioethical conflicts arising from its current abortion training requirements.

4. Legal and Bioethical Conflicts in Current ACGME Standards

The ACGME's continued requirement that all OB-GYN residency programs provide "training or access to training in the performance of abortions"²³ has become increasingly fraught in the aftermath of *Dobbs*. While the policy intent was to ensure comprehensive reproductive health training, its implementation now intersects with complex legal, ethical, and constitutional tensions. These conflicts manifest at four distinct but overlapping levels: federal, state, institutional, and individual.

4.1 Federal Level: GME Funding and Federal Appropriations Concerns

At the federal level, the primary concern involves the intersection of ACGME accreditation standards with federal funding streams for GME. As described in Section 2.2, hospitals receive substantial financial support through DME and IME payments administered by CMS, and ACGME

accreditation is a prerequisite for that funding. Because hospitals are therefore effectively required to comply with ACGME standards, including those related to abortion training, to maintain eligibility, the accreditation mandate carries the practical force of a federal funding condition.

This arrangement raises potential conflicts with federal appropriations restrictions, most notably the Hyde Amendment,¹⁵ which prohibits the use of federal funds for abortions except in cases of rape, incest, or life endangerment of the mother. While GME funds are not directly used to pay for abortion procedures, the absence of any policy delineation between educational and procedural funding streams creates a structural tension that Congress has not resolved. The Hyde Amendment reflects a legislative judgment that federal resources should not support abortion services; whether that judgment extends to accreditation-conditioned training mandates is an open question that highlights the need for explicit policy guidance from CMS and Congress, rather than reliance on private accreditation standards to fill the gap.

From a bioethical perspective, this tension highlights the principle of justice: specifically, the fair and lawful allocation of public resources. Federal GME payments are taxpayer-funded resources distributed through a congressionally authorized program. When the gateway to those resources (ACGME accreditation) conditions eligibility on compliance with a mandate to facilitate a procedure that Congress has separately restricted, it uses public funds to enforce a policy position without explicit democratic authorization. Justice requires that publicly funded programs maintain neutrality on contested moral and political questions; the current structure compromises that neutrality.

4.2 State Level: Tensions Between ACGME Standards and State Sovereignty

The *Dobbs* decision explicitly restored the authority to regulate abortion to the states, creating a diverse and enforceable patchwork of state statutory law. While the Tenth Amendment governs the division of powers between governmental actors, not private accrediting bodies,²⁴ the practical effect of the ACGME's national mandate is analogous to preemption: programs, supervising faculty, and trainees in restrictive states are placed in the position of having to violate state law in order to maintain accreditation compliance. The constitutional problem is therefore not that the ACGME itself violates the Tenth Amendment, but that federal funding conditionality, linking GME payments to ACGME accreditation, creates a federal pressure architecture that effectively overrides state-level determinations about the legality of abortion.

In states such as Texas, Tennessee, and Idaho, where near-total abortion bans are in effect, compliance with ACGME requirements would expose programs and supervising physicians to potential civil or criminal penalties.¹⁷ Even arranging off-site training opportunities across state lines introduces legal uncertainty, including potential liability for “aiding or abetting” prohibited abortions. Thus, the ACGME's national policy functions as a *de facto* preemption

of state law, despite the organization's private status and lack of statutory authority to override state regulations.

From an ethical standpoint, this conflict implicates the principle of nonmaleficence, as residents and faculty could be forced into legally perilous or morally compromising situations. Moreover, it raises questions of procedural justice: should a national accrediting body impose uniform requirements that negate the moral and legal diversity deliberately restored by the Supreme Court?

4.3 Institutional Level: Faith-Based Hospitals and Organizational Conscience

Faith-based hospitals represent approximately 16% of all U.S. short-term acute care hospitals and play a particularly prominent role in obstetric and gynecologic training.²⁵ Many of these institutions operate under ethical and religious directives that explicitly prohibit abortion. However, the ACGME's abortion training requirement does not currently provide exemptions for institutions based on religious or moral convictions.²³

This lack of accommodation creates a direct institutional conscience conflict. Faith-based programs must either:

1. Arrange external abortion training partnerships (potentially contrary to their mission statements);
2. Risk noncompliance and loss of accreditation; or
3. Withdraw from residency training altogether.

Such outcomes would significantly reduce the training capacity of the national OB-GYN workforce, disproportionately affecting rural and underserved regions where faith-based hospitals are often primary teaching sites.

From a legal standpoint, this situation conflicts with federal conscience protections such as the Church Amendments,¹⁹ which prohibit recipients of certain federal funds from discriminating against individuals or entities that refuse to perform or participate in abortions due to moral or religious beliefs. It also contravenes the ethical principle of respect for moral integrity, a cornerstone of pluralistic bioethics. The absence of an institutional exemption in ACGME policy, therefore, not only disregards conscience rights but creates an untenable choice for faith-based hospitals: either employ an “out of sight, out of mind” approach and find ways to facilitate abortion training at other hospitals or withdraw from participation in the graduate medical education of OB-GYN trainees.

4.4 Individual Level: Trainee Conscience and Autonomy

At the level of the individual trainee, the ACGME's current “opt-out” framework for abortion training raises serious bioethical and legal concerns. Under this policy, residents who object to participating in abortion procedures for moral or religious reasons may decline to do so, but programs are still required to make training available.²³ While framed as a balance between autonomy and access, this model effectively normalizes participation and places the burden of moral objection on the trainee.

This structure may result in implicit coercion, as residents may fear stigmatization, retaliation, or career disadvantage if they opt out. Furthermore, the “opt-out” model presumes participation as the default, inverting the traditional bioethical presumption that moral agency should be protected unless explicitly waived.⁹ A true respect for conscience would instead employ an “opt-in” model, ensuring that participation in abortion training is voluntary and affirmatively chosen.

Legally, forcing participation or penalizing refusal could expose programs to liability under federal conscience protection statutes, including the Weldon Amendment¹⁹ and Coats-Snowe Amendment,¹⁹ both of which prohibit discrimination against healthcare professionals who decline involvement in abortion-related activities.

4.5 Summary

The ACGME’s abortion training requirement, though originally intended to ensure competency and patient access, now sits at the nexus of conflicting federal funding restrictions, state laws, institutional missions, and individual conscience rights. At each level, these conflicts engage both legal principles (such as federalism, statutory compliance, and religious freedom) and foundational bioethical principles of autonomy, justice, and nonmaleficence. Without revision, the ACGME’s uniform national policy risks undermining its own educational mission by forcing programs and trainees into untenable legal and moral positions.

5. Ethical Framework for Analyzing the ACGME Standards

The conflicts surrounding the ACGME’s abortion training requirements cannot be adequately understood through legal analysis alone. They demand a careful bioethical evaluation that considers the moral principles guiding both medical education and professional conduct. This section applies two dominant frameworks, principlism and virtue ethics, to analyze how the ACGME’s current standards align or conflict with core ethical commitments in medicine and medical education.

5.1 Principlism: The Four Core Principles of Biomedical Ethics

The framework of principlism, articulated by Beauchamp and Childress,⁹ provides a structured method for analyzing biomedical ethics through four primary principles: autonomy, beneficence, nonmaleficence, and justice. Each of these principles offers insight into the ethical tensions that arise from the ACGME’s abortion training mandate.

5.1.1 Autonomy. Respect for autonomy demands that both patients and clinicians retain moral self-determination. In the context of residency training, this includes the freedom of resident physicians and institutions to make conscientious choices consistent with deeply held moral or religious beliefs. The ACGME’s current “opt-out” model implicitly privileges participation in abortion training as the normative path, placing the burden of moral justification on those who object. This inversion of moral presumption undermines authentic

autonomy by creating an environment of implicit coercion and moral dissonance. In educational ethics, genuine respect for autonomy should extend not only to patient decision-making but also to the learner’s conscience and professional identity formation.²⁶

5.1.2 Beneficence. Beneficence, acting in the best interests of others, underlies the ACGME’s rationale for requiring abortion training. The intent is to ensure that future obstetricians and gynecologists possess the full spectrum of reproductive health competencies, thereby promoting patient welfare and access to care. However, the principle of beneficence must be balanced against competing moral goods. Mandating abortion training in contexts where it is legally restricted or morally contested may yield unintended harms: moral injury to trainees, institutional instability, or loss of training capacity in regions with limited educational infrastructure. Thus, beneficence cannot be narrowly defined as procedural access alone; it must encompass the broader flourishing of patients, trainees, and the healthcare system as a whole.

Some have argued that reduced procedural participation rates under a more permissive training framework would diminish abortion access and therefore compromise both beneficence and justice. This argument merits direct engagement. It rests on the premise that increased abortion provision is an unqualified social and medical good, a premise that is itself morally contested and that a genuinely neutral bioethical framework cannot assume without begging the question. The principle of beneficence cannot be operationalized by embedding one side’s resolution of a contested moral question into the structure of public medical education. A training mandate justified on grounds of beneficence must be able to specify the good it serves in terms that do not presuppose the moral permissibility of the procedure being mandated. Where that permissibility is genuinely disputed, as it is here, beneficence cannot carry the full normative weight the mandate’s proponents assign to it. This does not foreclose the access argument entirely, but it does mean that access alone cannot justify overriding the competing claims of conscience, legal compliance, and institutional integrity that this paper has identified.

5.1.3 Nonmaleficence. The principle of nonmaleficence, to “do no harm,” serves as a critical counterbalance to beneficence. By maintaining a national abortion training requirement in states where the procedure is illegal, the ACGME exposes institutions and trainees to legal jeopardy. Moreover, residents compelled to participate in morally objectionable procedures may experience profound psychological distress, constituting a form of moral harm. Educational mandates that disregard the conscience rights of learners thus violate nonmaleficence by inflicting foreseeable and avoidable injury: psychological, moral, and professional.

5.1.4 Justice. The principle of justice demands equitable treatment and fair distribution of burdens and benefits. In the context of the ACGME’s abortion training mandate, justice is implicated at three distinct levels.

First, at the level of resource allocation, federal GME funding, distributed through DME and IME payments administered by CMS, is a public resource financed by Medicare taxpayers and allocated through the accreditation system. When that system conditions funding eligibility on compliance with a mandate to facilitate a contested procedure, it uses public resources to enforce a particular policy position without explicit democratic authorization. Justice requires that publicly funded programs maintain neutrality on contested moral and political questions; the current accreditation structure fails this standard by making federal support contingent on institutional facilitation of abortion training.

Second, at the level of distributional equity, a uniform national requirement applied in a post-*Dobbs* landscape fails to account for the vast disparities in state laws, institutional missions, and individual convictions. Programs in restrictive states bear disproportionate legal and financial burdens, compelled to seek costly out-of-state training arrangements or risk accreditation loss, while programs in permissive states operate without constraint. This asymmetry is not incidental; it is a structural feature of applying a nationally uniform standard to a legally fragmented landscape.

Third, at the level of workforce equity, faith-based programs are uniquely burdened by the abortion training mandate in ways that undermine distributive justice in physician workforce development. Faith-based institutions disproportionately serve rural and underserved communities where maternity care deserts are already acute. Policies that threaten the viability of these programs do not distribute the burdens of accreditation compliance equitably. They concentrate those burdens on the institutions and communities least equipped to absorb them.

Taken together, these three dimensions of justice reveal that the ACGME's abortion training mandate, though well-intentioned, lacks ethical equilibrium. Its pursuit of beneficence through access and competency has come at the expense of autonomy, nonmaleficence, and justice, principles no less central to the moral practice of medicine.

5.2 Virtue Ethics: Character Formation and Moral Integrity in Medical Training

While principlism provides a framework for evaluating specific decisions or policies, virtue ethics offers a lens for understanding the moral formation of physicians within their professional and institutional contexts. Rooted in Aristotelian thought and adapted by modern bioethicists such as Pellegrino and Thomasma,²⁷ virtue ethics emphasizes the development of character traits (prudence, compassion, integrity, and courage) that enable clinicians to act rightly amid moral complexity.

5.2.1 Moral Formation as a Core Aim of Medical Education. Medical training is not only the transmission of technical skills but also the cultivation of moral character. Residency represents a formative period in which professional identity and moral intuition are shaped by institutional culture and mentorship.²⁸ When training structures normalize morally

contested procedures without space for conscientious engagement, they risk distorting this formative process. The ACGME's abortion training requirement, as currently written, prioritizes procedural proficiency over moral discernment. In doing so, it may inadvertently foster moral compartmentalization, a state in which residents separate their personal convictions from their professional duties, leading to ethical fragmentation rather than integrity.²⁸

5.2.2 Integrity and the Role of Conscience. In virtue ethics, integrity is not merely an adherence to external norms but fidelity to one's moral commitments within the context of professional responsibility. The formation of physicians capable of moral integrity requires educational environments that respect conscience, encourage moral dialogue, and acknowledge ethical pluralism. A policy that either compels participation or stigmatizes nonparticipation in morally controversial acts corrodes integrity by teaching conformity over conscience. Such an environment produces technically skilled but morally uncertain clinicians, undermining the very trust upon which the patient-physician relationship depends.

5.2.3 The Virtue of Prudence. Finally, the virtue of prudence, practical wisdom, requires balancing moral principles with contextual realities. In the post-*Dobbs* landscape, prudence calls for an adaptive educational policy that honors legal diversity and moral conscience while maintaining professional competency. A prudent ACGME framework would differentiate between required knowledge and required participation, ensuring that all residents understand the medical, ethical, and legal dimensions of abortion without compelling direct involvement. This approach would preserve both educational integrity and moral agency.

5.3 Summary

Applying principlism and virtue ethics reveals that the ACGME's current abortion training standards, while aimed at beneficence and competency, fail to uphold a balanced ethical framework. The principles of autonomy, nonmaleficence, and justice are compromised, and the virtues of prudence and integrity are undervalued. To sustain moral legitimacy in medical education, the ACGME must reexamine its standards not only considering shifting legal realities but also in fidelity to the deeper ethical commitments that define the healing professions.

6. Proposed Reforms to the ACGME Abortion Training Standards

The preceding sections have demonstrated that the current ACGME standards on abortion training create significant legal, ethical, and institutional conflicts in the post-*Dobbs* environment. To preserve the integrity of graduate medical education while respecting the pluralism of American law and conscience, targeted reforms are necessary. These reforms should uphold the principles of autonomy, justice, and prudence without compromising medical competency or patient care.

The following recommendations constitute a unified policy framework, herein termed the **Proposed Revised**

Standard, comprising four integrated components addressing the federal, state, institutional, and individual trainee dimensions of the problem. Together, these components are designed to function as a single coherent revision to Section 4.11.i of the ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology,²³ the Family Planning section, replacing the current abortion training mandate in its entirety.

6.1 Federal Level: Protecting the Integrity of Public Funding

6.1.1 Separation of GME Funds from Abortion Training. As discussed in Section 2.2, ACGME accreditation functions as the gateway to federal GME funding. Thus, accreditation standards that require abortion training access create an indirect but traceable link between federal dollars and a procedure that Congress has chosen to restrict through the Hyde Amendment and related appropriations riders.

To address this, the ACGME should adopt the following policy statement as part of its Program Requirements:

“Federal Graduate Medical Education funding, including Direct Medical Education and Indirect Medical Education payments, shall not be used to directly support procedural abortion training activities. Programs that elect to provide procedural abortion training shall document that such training is supported through institutional, philanthropic, or other non-federal funding mechanisms. This requirement does not preclude didactic instruction, case-based education, simulation, or ethics training related to abortion care, which may be supported through standard GME funding streams.”

6.1.2 Transparency, Accountability, and the Question of Congressional Action. CMS and the ACGME should jointly develop a reporting mechanism requiring programs to delineate how GME funds are allocated in relation to reproductive health training. This transparency would prevent inadvertent violations of federal appropriations law and provide assurance to policymakers that taxpayer dollars are not used in ways that conflict with legislative intent.

It should be noted that the deeper structural problem (an unelected, non-governmental body exercising de facto control over the distribution of federal funds) may ultimately require a legislative solution. Congress retains the authority to decouple ACGME accreditation from GME funding eligibility, either on abortion-specific grounds or more broadly, and the current policy tensions provide a compelling basis for such reconsideration. The reforms proposed here represent what the ACGME can accomplish through internal policy revision; whether that is sufficient will depend in part on whether Congress acts to clarify the relationship between accreditation standards and federal funding conditions.

6.2 State Level: Respecting Legal Diversity Through State-Consistent Compliance

In the wake of *Dobbs*, abortion regulation has returned to the purview of the individual states. Yet the ACGME continues

to apply a uniform national requirement for abortion training regardless of a state’s legal stance. This approach not only puts programs in restrictive states in legal jeopardy but also places programs and trainees in direct conflict with enforceable state statutes, undermining the legal diversity that *Dobbs* deliberately restored to the states.

6.2.1 State-Consistent Compliance. The ACGME should adopt the following as a proposed revision to Section 4.11.i of its Program Requirements, replacing the current requirement at 4.11.i.4:

“Residency programs shall align procedural abortion training with the statutory law of the state in which the program is located. Programs in states where abortion is legally permitted shall provide or arrange access to procedural abortion training for residents who voluntarily elect to participate. Programs in states where abortion is legally restricted or prohibited shall fulfill abortion-related educational competencies through non-procedural modalities, including but not limited to: structured didactic instruction, ethics seminars, case-based learning, simulation, and clinical management of pregnancy loss (including uterine evacuation for fetal demise, incomplete abortion, and miscarriage) which develop procedurally equivalent surgical skills. All programs, regardless of state law, shall ensure that graduates demonstrate cognitive competency in the indications, risks, alternatives, and medical management of pregnancy termination.”

This formulation is significant in two respects. First, it preserves genuine educational equivalence. The existing ACGME Program Requirements already mandate clinical experience in the management of spontaneous abortion and pregnancy loss, including uterine evacuation, under Section 4.11.j. The procedural skills involved in uterine evacuation for fetal demise and management of incomplete miscarriage, including suction curettage and misoprostol administration, are identical to those used in induced abortion. Residents in restrictive states can therefore achieve full procedural competency through morally uncontested clinical encounters that are already required by the Program Requirements, directly refuting the objection that conscience-protective alternatives necessarily produce less competent physicians. Second, by anchoring the standard to state law rather than a national procedural mandate, it eliminates the legal jeopardy currently faced by programs and supervising faculty in restrictive jurisdictions.

It should be acknowledged that the American College of Obstetricians and Gynecologists (ACOG) and related professional organizations have argued that management of pregnancy loss does not fully substitute for induced abortion training, citing differences in clinical context, patient counseling requirements, and case volume and regularity.¹¹ This position is noted. The procedural equivalence argument advanced here is intentionally narrow: it is limited to the specific manual and pharmacological skills involved in

uterine evacuation, which are clinically identical across the two contexts, and does not claim equivalence in the broader clinical, ethical, or counseling dimensions of abortion care. Importantly, the ACGME itself implicitly recognizes this procedural overlap by separately mandating clinical experience in pregnancy loss management under Section 4.11.j of the current Program Requirements. The argument is not that induced abortion training is unnecessary for those who choose it, but that residents who do not opt in can nonetheless achieve full procedural competency through clinical encounters that are already required, uncontested, and widely available across all training environments.

6.3 Institutional Level: The Conscience-Compliant Accreditation Track

Faith-based hospitals represent approximately 16% of all U.S. short-term acute care hospitals and play a particularly prominent role in obstetric and gynecologic training, especially in rural and underserved regions. Many operate under ethical and religious directives that prohibit participation in induced abortion. Under current ACGME standards, such institutions face an untenable choice: arrange abortion training in contradiction to their mission and federal conscience protections, risk loss of accreditation, or withdraw from residency training altogether, removing critical educational infrastructure from communities that depend on it.

6.3.1 Institutional Conscience Protection. The ACGME should formally establish a **Conscience-Compliant Exemption (CCE)** as an alternative pathway to full accreditation for programs at faith-based or religiously affiliated institutions. The following language should be added to Section 4.11.i of the Program Requirements:

“Programs sponsored by institutions whose governing ethical and religious directives prohibit participation in induced abortion may apply for accreditation under the Conscience-Compliant Exemption (CCE). To qualify, programs must demonstrate: (1) a documented institutional religious or ethical directive that prohibits participation in induced abortion; (2) a structured curriculum ensuring resident competency in the cognitive, ethical, and procedural dimensions of pregnancy loss management, including uterine evacuation for fetal demise and incomplete abortion; (3) a written policy providing residents who voluntarily seek procedural abortion training with referral to an affiliated or partner institution offering such training; and (4) compliance with all other applicable ACGME Program Requirements. Programs exercising the CCE shall not be subject to adverse accreditation action solely on the basis of their religious or ethical directives, provided all other requirements are met.”

This framework mirrors conscience protections already recognized in federal law under the Church Amendments, the Coats-Snowe Amendment, and the Weldon Amendment, and extends their logic into the accreditation context. Critically, the CCE is not a general waiver of educational standards. It

is a defined, auditable alternative pathway that preserves educational rigor while honoring institutional identity.

6.3.2 Maintaining Educational Equity. The CCE does not create a lesser tier of training. By defining specific competency metrics and requiring documented referral pathways for residents who wish to seek procedural training, the ACGME ensures that all graduates, regardless of their program’s religious affiliation, meet a consistent standard of cognitive and clinical competency. The distinction is between required procedural *participation* and required procedural *knowledge*, a distinction that is both ethically defensible and educationally sound.

6.4 Individual Trainee Level: Moving from Opt-Out to Opt-In

The ACGME currently requires programs to provide access to abortion training while permitting individual residents to opt out for moral or religious reasons. The Background and Intent accompanying Section 4.11.i.4 of the current Program Requirements makes explicit that an opt-in curriculum, one in which procedural abortion training is offered only when requested by a resident, renders a program non-compliant. While intended as a balance between access and conscience, this model implicitly normalizes participation and places the moral burden on dissenting trainees, creating documented risks of stigmatization, career disadvantage, and implicit coercion for those who exercise the opt-out. A structurally neutral policy would instead treat participation as a voluntary, affirmatively chosen act.

6.4.1 Proposed Opt-In Standard. The ACGME should adopt the following revision to Section 4.11.i.4 and its accompanying subsections (4.11.i.4.a–b) of its Program Requirements, replacing the current opt-out framework:

“Resident participation in procedural abortion training shall be voluntary. Programs shall provide structured didactic and simulation-based instruction in abortion care to all residents as part of the core curriculum. Procedural participation in induced abortion shall require the resident’s affirmative written enrollment, documented in the resident’s training file. No adverse action shall be taken against a resident, nor shall a resident’s evaluation, promotion, or credentialing be adversely affected, solely on the basis of the resident’s decision to enroll or not to enroll in procedural abortion training. Programs shall maintain records of enrollment decisions and make such records available to the ACGME upon request.”

This revision directly supersedes the current Background and Intent language specifying that an opt-in curriculum is non-compliant. By inverting the default from participation to non-participation, it removes the structural coercion inherent in the opt-out model while preserving robust educational access for residents who wish to pursue procedural training.

6.4.2 Safeguarding Professional Integrity. The opt-in model accomplishes several things simultaneously. It respects the autonomy and moral agency of each trainee. It creates a clear, documented record of voluntariness that serves as a legal

safeguard for both residents and programs under federal conscience protection statutes including the Weldon Amendment and the Coats-Snowe Amendment. And it reorients the culture of residency training away from conformity and toward genuine professional formation: the cultivation of physicians whose clinical competency and moral integrity are developed together, not in opposition.

6.5 The Proposed Revised Standard: A Unified Framework

The four components described above (federal funding delineation, state-consistent compliance, the Conscience-Compliant Exemption, and the opt-in individual participation standard) are not independent proposals. They constitute a single, integrated revision to Section 4.11.i of the ACGME Program Requirements, each component reinforcing the others. Federal funding clarity enables state-level flexibility; state-consistent compliance makes the CCE legally coherent; and the opt-in standard gives individual expression to the conscience principles that animate both. Together, they replace a mandate that has become legally untenable and ethically imbalanced with a framework that is legally defensible, educationally rigorous, and morally pluralistic.

The ACGME retains the authority to implement all four components through its existing standard-setting processes, without requiring legislative action. Congressional action, whether to decouple GME funding from ACGME accreditation or to codify conscience protections in the graduate medical education context, would reinforce and stabilize these reforms but is not a prerequisite for them. The ACGME can and should act now.

7. Conclusion

The reversal of *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organization* (2022) has reshaped the legal and moral landscape of reproductive health care in the United States. In this new era of state-level variation and ongoing conscience-driven conflict, the ACGME's current abortion training standards expose significant fault lines between medical education, law, and ethics. What was once considered a settled requirement of comprehensive reproductive training has become, in many regions, a point of legal contradiction and moral tension.

The ACGME occupies a unique and powerful position within graduate medical education. As a private, nonprofit accrediting body, it wields quasi-regulatory authority by linking accreditation to federal and state funding, professional certification, and institutional reputation. This influence carries profound ethical responsibility. Yet in maintaining a uniform abortion training mandate in the post-*Dobbs* environment, the ACGME risks overstepping its moral and legal bounds, imposing a national policy that disregards state sovereignty, institutional conscience, and individual moral integrity.

From a bioethical standpoint, the current standards fail to strike an equitable balance among the principles of autonomy, beneficence, nonmaleficence, and justice. By

privileging one conception of beneficence, procedural access, over others, the ACGME inadvertently undermines autonomy and justice for institutions and individuals who hold sincere moral objections. Moreover, from the lens of virtue ethics, the standards neglect the formative purpose of medical education: to cultivate physicians of integrity and moral prudence capable of navigating pluralistic ethical landscapes.

This paper has proposed a set of four-tiered reforms that reconcile medical competency with conscience and legality:

1. **At the federal level**, the separation of GME funding from abortion training ensures compliance with federal appropriations law and public accountability.
2. **At the state level**, a model of state-consistent compliance respects federalism while maintaining educational equivalence through alternative training pathways.
3. **At the institutional level**, conscience-based exemptions safeguard the participation of faith-based hospitals in medical education without diluting academic rigor.
4. **At the individual level**, an opt-in framework for abortion training affirms the autonomy and moral agency of each trainee, fostering authentic professional formation.

Collectively, these reforms do not diminish the ACGME's commitment to high-quality, comprehensive training. Rather, they reorient it toward a more ethically pluralistic and legally coherent model, one that aligns with the values of a diverse society and the principles of professional freedom.

Revising the ACGME standards in this direction would achieve three essential goals:

- **Preserve access** to robust medical education and reproductive health knowledge for all residents.
- **Protect conscience** at the institutional and individual levels, reinforcing moral integrity within the profession.
- **Promote collaboration** between federal, state, and accrediting bodies to ensure that medical education remains both excellent and lawful.

Ultimately, the integrity of American graduate medical education depends not only on its scientific rigor but also on its ethical coherence. The ACGME has the opportunity, and the obligation, to lead with wisdom, crafting standards that respect conscience while sustaining competence. Doing so would reaffirm that medical education, at its best, forms not only skilled practitioners but also morally grounded physicians capable of serving a diverse public with both compassion and conviction.

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