Murtagh C, Fleischer S, Peterson LE. Abortion Provision by Family Physicians Before and After Dobbs: Trends Across Career Stages and State Restrictions. *JABFM*. 2026;39(1). doi:10.3122/jabfm.2025.250263R1

ORIGINAL RESEARCH

Abortion Provision by Family Physicians Before and After Dobbs: Trends Across Career Stages and State Restrictions

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https://doi.org/10.3122/jabfm.2025.250263R1

Journal of the American Board of Family Medicine

Vol. 39, Issue 1, 2026

Objectives: Family physicians (FPs) are well-positioned to integrate abortion into primary care. However, little is known about how FPs' abortion practices have been affected by the Dobbs v Jackson Women's Health Organization (Dobbs) Supreme Court decision. This study examines the percentage of FPs providing abortion, comparing across career stages, state restrictions, and before and after the Dobbs decision.

Methods: Data was collected from the American Board of Family Medicine National Graduate Survey (2016 to 2024) and the Practice Demographic Survey (2019 to 2024), representing early- and mid-to-late-career FPs, respectively. Respondents (n=60,077) were grouped by time of survey completion, before or after Dobbs. Bivariate analysis assessed associations between abortion provision and state restrictions, personal/practice characteristics, and reproductive health service provision. Regression analysis assessed changes in abortion provision after Dobbs.

Results: Of 31,553 respondents in the three years pre-Dobbs, 1.3% provided abortion, and of 28,544 respondents in the three years post-Dobbs, 1.4% provided abortion. Post-Dobbs in abortion legal states, early-career FPs increasingly provided abortion (2.8% to 6.3%) compared to mid-to-late-career FPs (1.3% to 1.8%), which was confirmed in adjusted analyses (adjusted OR= 2.12, 1.67-2.70).

Conclusion: While the overall percentage of FPs providing abortion remained stably low pre- and post- Dobbs, a modest but notable increase was observed among early-career FPs in abortion legal states. This trend among early-career FPs in specific states suggests a developing opportunity to enhance access, necessitating increased training and resources for this group.

Keywords: Abortion, Family Medicine, Family Physicians, Primary Health Care, Regression Analysis, Reproductive Health, Supreme Court Decisions, Surveys and Questionnaires

Background

Abortion is a common reproductive health service, with over one in six pregnancies terminated in 2020.[1] Despite its prevalence, many regions lack clinicians providing this service; in 2014, 39% of reproductive-aged women lived in one of the 90% of counties that lacked a healthcare professional offering abortion.[2] Legal constraints and workforce distribution further limit the ability of individuals to access abortion by creating travel requirements, financial constraints imposed by lost wages, accommodations, and childcare, and increased demand for appointments in counties offering abortion services.[3,4] The Supreme Court's June 2022 decision in *Dobbs v. Jackson Women's Health Organization* (Dobbs), which eliminated federal constitutional protection of abortion, further increased barriers to accessing abortion services as 16 states have 6 week bans or complete bans.[5] Thus, most pregnant individuals in these states seeking abortion must travel to other states.

Family physicians (FPs), who work in a specialty founded with relationships and social justice at its center, are uniquely positioned to expand abortion access, and they are the second-most common providers of abortion after OB/GYNs.[6,7] In comparison to other specialties, FPs are more likely to work in underserved and rural settings, where reproductive health services are often lacking.[8] Studies have shown many FPs agree that abortion fits within their scope of practice as it builds on skills they already have, such as counseling, early pregnancy evaluation, reproductive health procedures, and miscarriage management.[9-11] Outcomes of abortions in primary care settings are similar to those found in abortion specialty clinics.[12,13] Furthermore, research demonstrates that many people may prefer to receive abortion care in primary care settings for reasons such

as convenience, connection to clinicians and place, and privacy from protestors.[14-16]

Although FPs have long served as the second-most common specialty providing abortion, pre-Dobbs research found that only 3% of recent family medicine residency graduates went on to provide the service.[17] This may reflect the multitude of barriers facing FPs who seek to integrate abortion care into their practice, including lack of training, lack of knowledge about medications used in abortion, unsupportive administration, competing primary care demands and fear that abortion would dominate schedules, and Risk Evaluation and Mitigation Strategies (REMS) criteria for prescribing mifepristone, one of the medications commonly used for medication abortion.[9,18-22] The Dobbs decision exacerbated existing barriers and introduced new challenges, with one study citing changes in counseling practices, increased legal risks, and decreased trust in patients' self-reported reproductive history amongst FPs in states where abortion was restricted.[23]

While national survey data suggests that the proportion of OB/GYNs providing abortion dropped from 21% pre-Dobbs to 18% post-Dobbs, little is known about the rates of abortion provision amongst FPs in the wake of Dobbs.[24] Furthermore, recent literature on abortion rates in family medicine focuses on recent residency graduates as opposed to mid- and late-career physicians, but there is a lack of information on differences in abortion provision across careers.[17] Using national data, our objective is to examine the percentage of FPs providing abortion care while comparing across career stages, restrictive and nonrestrictive states, and before and after the Dobbs decision.

Methods

We used data from the American Board of Family Medicine (ABFM) National Graduate Survey (NGS) from 2016 to 2024 and the Practice Demographic Survey (PDS) from 2019 to 2024. During our study period, ABFM-certified FPs had 3-year certification stages. In the last year of every 3-year stage, FPs are asked to complete either the NGS or PDS. The NGS is administered in the first 3-year stage with data fed back to residency programs to assess residency outcomes.[25,26] NGS respondents were categorized as early-career. The PDS is administered at the end of all other 3-year stages, beginning 6 years after residency. PDS respondents were categorized as mid-to-late-career. Both surveys are open during the entire calendar year and are voluntary. Respondents to the NGS have been representative of their graduating residency class.[26] Over the time period of our study, FPs could respond to multiple surveys 3 years apart. Both surveys have common questions about scope of practice. Demographic information was obtained from ABFM administrative databases.

We created a variable to reflect the state restrictions on abortion using data from the Guttmacher Institute. We used the approach developed by Vinekar et al. to classify states as "Most Restrictive" or "Abortion Legal".[27] The most restrictive states included 16 states with complete or 6-week abortion bans as of April 2025, as well as 2 states with no procedural abortion clinics or healthcare professionals providing abortion. The abortion legal states included all other 32 states and Washington, DC. Although analysis of abortion practices was performed pre- and post-Dobbs (June 24, 2022), the year 2025 was chosen to classify states' abortion policies as "Most Restrictive" or "Legal" given that most states with abortion bans in 2025 had either bans that went into effect within 6 months of the Dobbs decision, increased hostility towards abortion with the Dobbs decision, or lack of healthcare professionals/procedural clinics providing abortion.[28] Thus, states' status as restrictive or legal in 2025 was effectively representative of status post-Dobbs.

Our primary outcome was a FPs self-report of personally providing abortion. From 2016-2020 the question asked, "pregnancy termination", and then from 2021-2024 the question asked, "abortion". We also used data on the provision of reproductive health services including deliveries, colposcopy, intrauterine device (IUD) insertion, insertion and removal of implantable contraception, uterine aspiration, basic OB ultrasound, and endometrial biopsy. We characterized physician self-reported race/ethnicity as Under-Represented in Medicine (URiM) according to the Association of American Medical Colleges typology.[29] We categorized practice settings as urban, large rural, small rural, and isolated by ZIP code rural-urban commuting area codes (RUCA).

We limited our sample to respondents with abortion restriction data, 50 states and DC. To test for differences in characteristics associated with providing abortion pre- and post-Dobbs, we created two samples of FPs who completed either survey 3 years prior to the Dobbs decision (June 24, 2022) and 3 years after. We used bivariate analyses within each cohort to test for association with providing abortion with state restrictions, personal and practice characteristics, and provision of reproductive health services.

To investigate trends over time, we first graphed data by state level restrictions for the early-career and mid-to-late-career FPs separately. We graphed these separately for 2 reasons: first, different time frames were available for the different datasets; second, in conducting descriptive analyses, we noted a large difference in the percent providing abortion between the groups. Next, we created a sample of physicians' first response to either the NGS or PDS. Using this sample, we conducted a logistic regression analysis that predicted providing abortion while controlling for physician demographics, practice rurality, pre- or post-Dobbs time period, mid-to-late-career vs early-career, and abortion legal state. We included an interaction between early-career stage and abortion legal state to test for a larger increase in abortion provision by these physicians in these states. This study was approved by the American Academy of Family Physicians Institutional Review Board. SAS v9.4 (Cary, NC) was used for all analyses.

Results

Between 2016 to 2024, the NGS was offered to 22,275 ABFM Diplomates 3 years post-residency, and 10,849 (48.7%) responded. Between 2019 to 2024, the PDS was offered to

170,475 ABFM diplomates, who were 6 years or greater post-residency, at 3-year intervals, and 51,797 (30.4%) responded. After applying inclusion criteria to both groups, 60,097 out of 192,767 (31.2%) responded. Although there were some significant year-to-year differences, there was no consistent pattern of bias in the PDS respondents, and respondents to the NGS have been found to be representative of their graduating class (Appendix Table 1).[26]

Demographic Characteristics

The demographic characteristics of FPs providing abortion were similar in the pre- and post-Dobbs eras (Table 1). While 1.3% (n=398) of respondents from the NGS and PDS reported providing abortion in the 3 years pre-Dobbs, including 1.6% in states where abortion is legal (n=347)

and 0.5% (n=51) where abortion is restricted, 1.4% of respondents (n=412) from both surveys provided abortion in the 3 years post-Dobbs, including 2.0% (n=376) in states where abortion is legal and 0.4% (n=36) where abortion is restricted. In both eras, younger FPs were more likely to provide abortion; pre-Dobbs, the majority of respondents that provided abortion were <40 years old (61.3%, n=244), compared to respondents that did not provide abortion, who were more evenly split between age brackets (p <0.0001). Post-Dobbs, a plurality of respondents who provided abortion were also less than 40 (48.1%, n=198), although a greater proportion were 40-49 (28.4%, n=117) than prior. Significantly more respondents who provided abortion in both time periods were female (p<0.0001). There were no differences with rurality. Overall, a greater proportion of the group that provided abortion services also provided other reproductive health services compared to those who did not provide abortion (p < 0.0001 for all services), although the overall percentage of FPs offering some reproductive health services declined slightly from the pre- to post-Dobbs era (Table 2).

Percentage of Family Physicians Providing Abortion Over Time

Overall, a greater percentage of total early-career FPs (2.5 to 5.2%) provided abortion from 2016 to 2024 compared to total mid-late-career FPs (0.6 to 1.3%) from 2019 to 2024 (Figure 1). Of the early-career FPs who provided abortion, a greater percentage were located in states where abortion is legal compared to states where abortion is restricted. The percentage of early-career FPs providing abortion in abortion legal states decreased from 2020 to 2021, reaching a low point of 2.8% in 2021, but increased afterwards, continuing to climb to 6.3% in 2024. The proportion remained relatively stagnant for early-career FPs in the most restrictive states from 2016 to 2024, between 1 to 2.7%, and for all mid-to-late-career FPs from 2019 to 2024, between 0.6 to 1.3%.

Regression

Restricting to the first response, we had 47,132 respondents with 666 (1.4%) providing abortion. In adjusted analyses, younger, early-career females with MDs, from US medical schools, in the post-Dobbs era had significantly higher odds of providing abortion care (Figure 2). Rurality and URiM status were not associated with abortion provision. Post-Dobbs time period was associated with higher odds of providing abortion (adjusted odds ratio 1.33, 95% confidence interval 1.14 to 1.56). Notably, early-career physicians in abortion legal states had higher odds than their mid-to-late-career counterparts to provide abortion (adjusted OR= 2.12, 1.67-2.70).

Discussion

In this national study, we found a modest increase in early-career FPs providing abortion in abortion legal states since the June 2022 Dobbs decision, although the overall rate of abortion provision by FPs remained stably low, from 1.3% pre-Dobbs to 1.4% post-Dobbs. Our findings suggest that there may be an increased interest amongst younger FPs in filling gaps in abortion care in abortion legal states, although the specialty overall has not changed its practice patterns post-Dobbs. Expansion of FP abortion practice will likely require allocation of more training, administrative, and advocacy resources to interested residents and early-career physicians seeking to practice abortion, especially those committed to working in high-need areas.

A major contribution of our study is the discovery of the variation in abortion provision between early and mid-to-late-career FPs, with early-career FPs providing abortion at increasing rates in abortion legal states. A frequently cited earlier study found that 3% FPs provide abortion but included only early-career FPs.[17] Our study's lower overall rate may be more reflective of the entire workforce, given that the sample included FPs across their careers. Notably, 6.3% of early-career FPs reported providing abortion by 2024 in states where abortion is legal, and early-career FPs in abortion legal states were more than twice as likely to provide abortion compared to their mid-to-late-career colleagues. This finding builds on a past study that indicated younger clinicians who had been practicing for less time were more likely to be interested in providing abortion care.[19] The higher rates of early-career FPs providing abortion could have multiple causes. First, this may reflect increasing opportunities to train in abortion care during family medicine residency, particularly in abortion legal states, as one study demonstrated a greater percentage of programs offering some training in abortion in 2024 as compared to 2011.[30] Research has shown that exposure to abortion training during residency is an important predictor of abortion practice.[9,22,31] Second, there may have been heightened interest in preserving access to this service post-Dobbs, as past studies show internal motivation and social justice as important facilitators to abortion provision.[18,32] Third, the discrepancy between groups could be due to mid-to-late-career FPs discontinuing the practice of abortion. Other studies have found that the scope of practice of FPs does tend to decrease over time, and older physicians stopping providing abortion care may be subject to the same forces.[33] Still, further research on the volume of

Table 1. **Demographic Characteristics of Family Physicians (FPs) by Abortion Provision Pre- and Post-Dobbs.**

		Pre-Dobbs				Post-Dobbs			
		Provides Abortion				Provides Abortion			
		No	Yes	All	P-Value	No	Yes	All	P-Value
Total		31,155	398	31,553		28,132	412	28,544	
State Restrictions	Abortion Legal	21,134 (67.8%)	347 (87.2%)	21,481 (68.1%)	<0.0001	18,709 (66.5%)	376 (91.3%)	19,085 (66.9%)	<0.0001
	Most Restrictive	10,021 (32.2%)	51 (12.8%)	10,072 (31.9%)		9,423 (33.5%)	36 (8.7%)	9,459 (33.1%)	
Age Category	<40	8,450 (27.1%)	244 (61.3%)	8,694 (27.6%)	<0.0001	6,136 (21.8%)	198 (48.1%)	6,334 (22.2%)	<0.0001
	40-49	8,464 (27.2%)	74 (18.6%)	8,538 (27.1%)		7,144 (25.4%)	117 (28.4%)	7,261 (25.4%)	
	50-59	8,083 (25.9%)	52 (13.1%)	8,135 (25.8%)		8,036 (28.6%)	62 (15.0%)	8,098 (28.4%)	
	60+	6,158 (19.8%)	28 (7.0%)	6,186 (19.6%)		6,816 (24.2%)	35 (8.5%)	6,851 (24.0%)	
Gender	Female	14,345 (46.0%)	283 (71.1%)	14,628 (46.4%)	<0.0001	13,172 (46.8%)	301 (73.1%)	13,473 (47.2%)	<0.0001
	Male	16,736 (53.7%)	109 (27.4%)	16,845 (53.4%)		14,888 (52.9%)	105 (25.5%)	14,993 (52.5%)	
	Non-binary	16 (0.1%)	5 (1.3%)	21 (0.1%)		12 (0.0%)	4 (1.0%)	16 (0.1%)	
	Prefer not to answer	54 (0.2%)	1 (0.3%)	55 (0.2%)		54 (0.2%)	2 (0.5%)	56 (0.2%)	
	Prefer to self-describe	4 (0.0%)		4 (0.0%)		6 (0.0%)		6 (0.0%)	
Under-Represented in Medicine	Not URiM	26,206 (85.4%)	341 (86.3%)	26,547 (85.4%)	0.595	23,169 (83.4%)	348 (85.5%)	23,517 (83.4%)	0.2601
	URiM	4,488 (14.6%)	54 (13.7%)	4,542 (14.6%)		4,607 (16.6%)	59 (14.5%)	4,666 (16.6%)	
Degree Type	DO	3,985 (12.8%)	31 (7.8%)	4,016 (12.7%)	0.0037	3,868 (13.7%)	40 (9.7%)	3,908 (13.7%)	0.0206
	MD	27, 170 (87.2%)	367 (92.2%)	27,537 (87.3%)		24,264 (86.3%)	372 (90.3%)	24,636 (86.3%)	
Degree Nationality	USMG	24,388 (79.2%)	331 (83.6%)	24,719 (79.2%)	0.0365	20,840 (75.1%)	350 (85.4%)	21,190 (75.3%)	<0.0001
	IMG	6,414 (20.8%)	65 (16.4%)	6,479 (29.8%		6,903 (24.9%)	60 (14.6%)	6,963 (24.7%)	
Rurality	Isolated	755 (2.4%)	10 (2.5%)	765 (2.4%)	0.2155	702 (2.5%)	5 (1.2%)	707 (2.5%)	0.0682
	Small Rural	1,780 (5.7%)	15 (3.8%)	1,795 (5.7%)		1,591 (5.7%)	18 (4.4%)	1,609 (5.6%)	
	Large Rural	2,906 (9.3%)	30 (7.5%)	2,936 (9.3%)		2,539 (9.0%)	28 (6.8%)	2,567 (9.0%)	
	Urban	25,696 (82.5%)	343 (86.2%)	26,039 (82.6%)		23,288 (82.8%)	361 (87.6%)	23,649 (82.9%)	

Abbreviations: International Medical Graduate (IMG), Under-Represented in Medicine (URiM), US Medical Graduates (USMGs)
Data was collected from the National Graduate Survey (NGS) and Practice Demographic Survey (PDS) during board certification from 2019 - June 24, 2022 and June 25, 2022 - 2024, representing a national sample of family physicians.

abortions provided by early-career FPs is necessary to understand whether they are helping to fill gaps in abortion services. It is also unclear whether OB/GYNs have experienced a similar demographic trend post-Dobbs. While an earlier national study conducted pre-Dobbs found that OB/GYNs providing abortion were distributed across age brackets, with the greatest proportion between 46-55, further research is necessary to understand the impact of Dobbs on OB/GYNs across career stages.[34]

As expected, the distribution of FPs providing abortion differed significantly between states with and without severe restrictions. This was true both pre- and post-Dobbs, reflecting persistent inequities in abortion care across geographies. Thus, while past research demonstrates the 2022 change in federal policy altered reproductive care for FPs in restrictive states,[23] FPs likely faced other barriers to abortion care that may have been more prevalent in restrictive states pre-Dobbs.[9,18,19,21,22] Furthermore, the low, stagnant rate of FPs providing abortion in restrictive states

Table 2. **Practice Characteristics of Family Physicians (FPs) by Abortion Provision Pre- and Post-Dobbs.**

		Pre-Dobbs				Post-Dobbs			
		Provides Abortion				Provides Abortion			
		No	Yes	All	P-Value	No	Yes	All	P-Value
Delivers Babies	No	28,802 (92.5%)	249 (62.6%)	29,051 (92.1%)	<0.0001	26,451 (94.1%)	275 (66.7%)	26,726 (93.7%)	<0.0001
	Yes	2,351 (7.5%)	149 (37.4%)	2,500 (7.9%)		1,672 (5.9%)	137 (33.3%)	1,809 (6.3%)	
Provides Colposcopy	No	27,854 (89.4%)	189 (47.5%)	28,043 (88.9%)	<0.0001	25,664 (91.2%)	228 (55.3%)	25,892 (90.7%)	<0.0001
	Yes	3,301 (10.6%)	209 (52.5%)	3,510 (11.1%)		2,468 (8.8%)	184 (44.7%)	2,652 (9.3%)	
Provides IUD Insertion	No	22,741 (73.0%)	25 (6.3%)	22,766 (72.2%)	<0.0001	21,041 (74.8%)	40 (9.7%)	21,081 (73.9%)	<0.0001
	Yes	8,414 (27.0%)	373 (93.7%)	8,787 (27.8%)		7,091 (25.2%)	372 (90.3%)	7,463 (26.1%)	
Provides Implantable Contraception (e.g. Nexplanon)	No	23,682 (76.0%)	35 (8.8%)	23,717 (75.2%)	<0.0001	21,462 (76.3%)	48 (11.7%)	21,510 (75.4%)	<0.0001
	Yes	7,473 (24.0%)	363 (91.2%)	7,836 (24.8%)		6,670 (23.7%)	364 (88.3%)	7,034 (24.6%)	
Provides Uterine Aspiration	No	30,259 (97.2%)	162 (40.7%)	30,421 (96.4%)	<0.0001	27,486 (97.7%)	227 (55.1%)	27,713 (97.1%)	<0.0001
	Yes	886 (2.8%)	236 (59.3%)	1,122 (3.6%)		638 (2.3%)	185 (44.9%)	823 (2.9%)	
Provides Basic OB Ultrasound	No	28,596 (91.8%)	132 (33.2%)	28,728 (91.0%)	<0.0001	25,973 (92.3%)	163 (39.6%)	26,136 (91.6%)	<0.0001
	Yes	2,559 (8.2%)	266 (66.8%)	2,825 (9.0%)		2,159 (7.7%)	249 (60.4%)	2,408 (8.4%)	
Provides Endometrial Biopsy	No	24,934 (80.0%)	88 (22.1%)	25,022 (79.3%)	<0.0001	23,467 (83.4%)	121 (29.4%)	23,588 (82.6%)	<0.0001
	Yes	6,221 (20.0%)	310 (77.9%)	6,531 (20.7%)		4,665 (16.6%)	291 (70.6%)	4,956 (17.4%)	

Abbreviations: Intrauterine Device (IUD), Obstetrics (OB)
Data was collected from the National Graduate Survey (NGS) and Practice Demographic Survey (PDS) during board certification from 2019 - June 24, 2022 and June 25, 2022 - 2024, representing a national sample of Family physicians.

demonstrates that, even with possible increased interest amongst early-career FPs, legal barriers severely limit FPs from offering the service in the places that it is needed most. The distribution of FPs who provided abortion by rurality matched their overall distribution, with the greatest proportion residing in urban areas. While past studies demonstrate that FPs often fill gaps in maternal health provision in rural settings, this study suggests that the same is not true for abortion care, as FPs are not providing abortion at greater rates in rural areas.[35,36] Possible reasons include increased likelihood of restrictive policies, stigma, lack of equipment, and administration challenges. Additionally, the Hyde Amendment prohibits the use of federal funds for abortion. A greater proportion of rural populations are publicly insured through Medicaid, and although some states use state funding to pay for abortions, others follow the Hyde Amendment.[37,38]

Similar to prior, this research indicates that FPs who provide abortion are more likely to practice other reproductive health services.[17] The rates at which they provided these services decreased slightly post-Dobbs, reflecting a trend toward decreasing scope of practice, particularly in urban areas.[39] Still, the association between abortion care and other reproductive healthcare may reflect transferability of skills between procedures.[10,40]

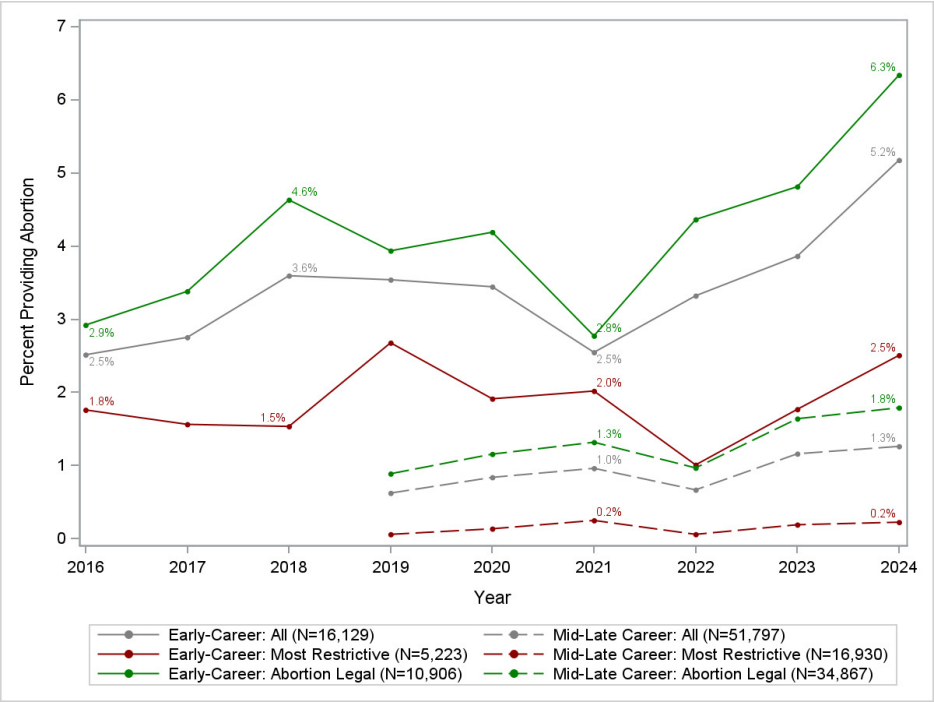
Limitations

This study has several limitations. First, survey questions did not differentiate between medication and procedural abortion during our study period. It's possible that some FPs who provide medication abortion did not indicate they provide abortion as they may have interpreted abortion as a procedural, and the abortion rates found in this study may be underestimated. Second, survey questions initially asked about "pregnancy termination," but later asked about "abortion." Self-reporting may have been affected if pregnancy termination was viewed more broadly, or if abortion was perceived as stigmatizing. Third, respondents were not asked the number of abortions they provide annually, and we are unable to determine how significant abortion is to respondents' scope of practice. Finally, survey questions did not ask where individuals practice abortion, and it is unknown whether those who reported providing abortion, including those in the most restrictive states, travel to locations outside of their primary practice.

Conclusion

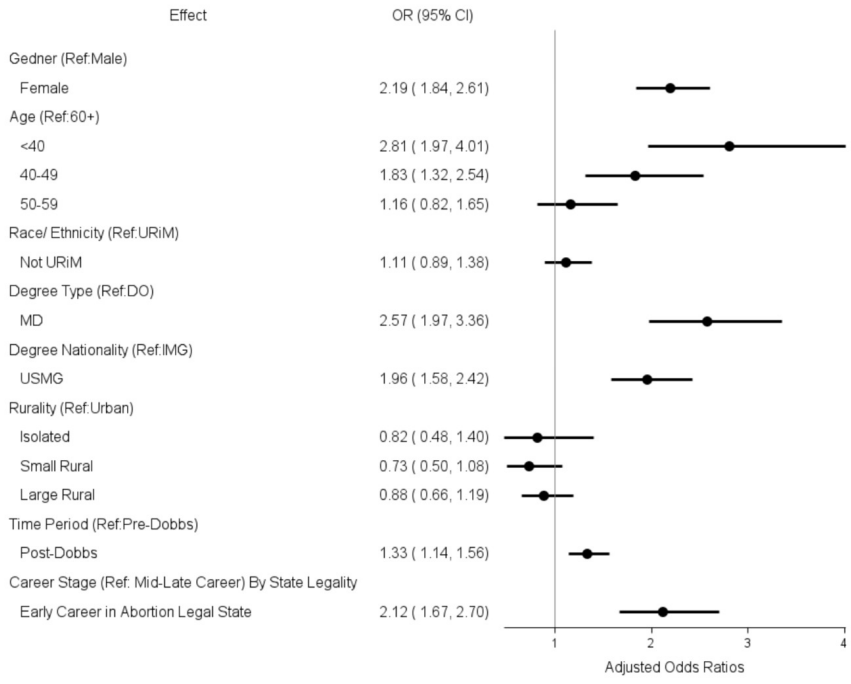
Despite the overall proportion of FPs offering abortion care remaining low, our study reveals a promising increase in

Figure 1. Percentage of Early-Career and Mid-to-Late-Career Family Physicians (FPs) Providing Abortion Over Time in States Where Abortion Is Legal and States Where Abortion Is Most Restricted.



Data was collected from the National Graduate Survey (NGS) and Practice Demographic Survey (PDS) during board certification from 2019 - June 24, 2022 and June 25, 2022 - 2024, representing a national sample of Family physicians.

Figure 2. Adjusted Odds Ratio of Abortion Provision Amongst Family Physicians.



Abbreviations: International Medical Graduate (IMG), Under-Represented in Medicine (URiM), US Medical Graduates (USMGs)
Data was collected from the National Demographic Survey (NGS) and Practice Demographic Survey (PDS) during board certification from 2019 - June 24, 2022 and June 25, 2022 - 2024, representing a national sample of Family physicians.

abortion provision among early-career FPs, particularly in states where abortion is legal. This trend, potentially driven by heightened interest and increased training opportunities, suggests a developing opportunity for this specific cohort to contribute to abortion access. However, further research is necessary to monitor whether the proportion of

early-career FPs practicing abortion continues to increase, and how FPs start, stop, or retain abortion practice later on in their careers. Additionally, future studies should explore differences between provision of medication and procedural abortion along with the number of abortions provided by FPs to better understand the workforce's impact at a population level. Knowledge about the impact of federal policy changes on the number, characteristics, and distribution of FPs providing abortion care can inform future efforts to expand abortion access.

Funding

Dr. Murtagh was supported by the ABFM Foundation.

Conflicts of Interest

We have no conflicts of interest to disclose.

Acknowledgements

We would like to thank Dr. Grace Walter and Dr. Madeline Taskier for their important work that preceded this project.

Data Statement

Data are available from the ABFM via its external collaborations process after approval of a research proposal, ethical clearance, and completing a data use agreement.

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This article was externally peer reviewed.

Submitted: July 09, 2025 EDT. Accepted: October 06, 2025 EDT.

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Appendix

Appendix 1. Differences in Demographic Characteristics Between Respondents and Non-Respondents to the Practice Demographic Survey (PDS) Survey Over Time.

	Respondent	Non-Respondent	P Value
2019	10,757	18,948	
Mean Age in years	51.84 (9.52)	53.97 (9.92)	<.0001
Female gender	4,659 (43.3%)	7,946 (41.9%)	0.1094
MD	9,645 (89.7%)	17,254 (91.1%)	0.0002
International Medical Graduate	1,841 (17.4%)	3,571 (19.1%)	0.0003
Under Represented in Medicine	1,497 (14.1%)	2,451 (13.6%)	0.2569
2020	7,163	21,491	
Mean Age in years	51.41 (9.93)	52.01 (10.28)	<.0001
Female gender	3,218 (44.9%)	9,495 (44.2%)	0.3359
MD	6,387 (89.2%)	19,236 (89.5%)	0.4168
International Medical Graduate	1,344 (19.1%)	4,887 (23.1%)	<.0001
Under Represented in Medicine	1,011 (14.4%)	3,479 (16.8%)	<.0001
2021	6,033	17,880	
Mean Age in years	51.92 (10.01)	52.14 (10.53)	0.1869
Female gender	2,721 (45.1%)	8,036 (44.9%)	0.1869
MD	5,318 (88.1%)	15,869 (88.8%)	0.2016
International Medical Graduate	1,246 (20.9%)	3,995 (22.6%)	0.0164
Under Represented in Medicine	802 (13.5%)	2,574 (14.9%)	0.0215
2022	10,349	21,158	
Mean Age in years	54.38 (9.92)	53.45 (10.74)	<.0001
Female gender	4,587 (44.3%)	9,427 (44.6%)	0.4439
MD	9,264 (89.5%)	18,840 (89.0%)	0.3080
International Medical Graduate	2,210 (21.7%)	4,193 (20.0%)	0.0015
Under Represented in Medicine	1,463 (14.3%)	3,044 (14.6%)	0.4439
2023	9,567	20,771	
Mean Age in years	53.05 (10.13)	52.08 (10.66)	<.0001
Female gender	4,448 (46.5%)	9,678 (46.6%)	0.0359
MD	8,433 (88.1%)	18,289 (88.1%)	0.8103
International Medical Graduate	2,341 (24.9%)	4,723 (23.1%)	0.0008
Under Represented in Medicine	1,648 (17.4%)	3,351 (16.5%)	0.0633
2024	7,928	18,430	
Mean Age in years	53.21 (10.49)	51.83 (11.00)	<.0001
Female gender	3,653 (46.1%)	8,781 (47.6%)	0.0496
MD	6,930 (87.4%)	15,931 (86.4%)	0.0496
International Medical Graduate	1,899 (24.3%)	4,283 (23.5%)	0.1987
Under Represented in Medicine	1,217 (15.6%)	2,803 (15.5%)	0.9334

Although there were some significant year-to-year differences, there was no consistent pattern of bias in the PDS respondents.