

Original Research

The Impact of the *Dobbs* Decision on Access to Gender Diverse Care at a Midwest Academic Health Center

Sarah Dreibelbis, D.O.¹, Valerie French, M.D.¹, Quinn Jackson, M.D., MPH², Sharon Fitzgerald Wolff, Ph.D., MPH³, Meredith Gray, M.D.¹

The University of Kansas School of Medicine-Kansas City,
Kansas City, Kansas

¹Department of Obstetrics and Gynecology

²Department of Family Medicine and Community Health

³Department of Population Health

Received Feb. 4, 2025; Accepted for publication May 13, 2025; Published online Aug. 15, 2025
Kans J Med 2025 Jul-Aug; 18:70-74. <https://doi.org/10.17161/kjmvol18.23425>

ABSTRACT

Introduction. The *Dobbs* decision returned the regulation of abortion to individual states. In the Midwest, several legislative efforts have included restrictions on both abortion and gender-affirming care. Clinics that provide abortion services sometimes offer gender-affirming care. Given this intersection, recent laws restricting abortion may have unintended consequences for access to gender-affirming care in the Midwest.

Methods. Authors of this retrospective study analyzed medical records of patients seen at a Midwestern health center. We included patients aged 18 or older who attended a new patient visit at either the gender diversity clinic (GDC) or the general gynecology (GYN) clinic between July 1, 2021 and June 30, 2023. We used generalized estimating equations to assess changes in wait times and distance traveled pre- vs. post-*Dobbs*. Differences in new patient volume were analyzed using Poisson regression.

Results. We reviewed 5,260 charts, 4,552 from the GYN clinic and 708 from the GDC. Following *Dobbs*, the GYN clinic experienced a 6% increase in new patients, while the GDC saw a 21% increase ($p < 0.001$). The average wait time for a GYN appointment increased by two days, whereas the wait time for GDC appointments decreased by 21 days. The average distance traveled by new GYN patients decreased by 6.3 miles ($p < 0.001$), while distance for GDC patients increased by 2.5 miles ($p = 0.738$).

Conclusions. Patients continue to seek gender-affirming care in the post-*Dobbs* landscape. Despite an increase in patient volume, wait times for gender diversity appointments decreased, likely reflecting expanded appointment availability around the time of the *Dobbs* decision.

INTRODUCTION

In the Midwest, abortion care frequently is provided at free-standing family planning clinics. In addition to abortion and contraception services, these clinics offer primary care, sexually transmitted infection (STI) testing, and transgender hormone therapy and gender-affirming care.¹ On June 24, 2022, the *Dobbs v. Jackson Women's Health Organi-*

zation decision by the U.S. Supreme Court returned abortion regulation to individual states, effectively overturning the constitutional right to abortion.^{2,3} In the aftermath of *Dobbs*, family planning clinics in states where abortion remained legal saw a sharp increase in patient volume.⁴ As a result, these clinics likely had to adjust the availability of care for patients with non-abortion-related needs, including gender-affirming services.

General gynecology (GYN) clinics provide comprehensive women's health services, addressing concerns from menarche to menopause, including pregnancy, menstruation, and preventive care. Some GYN clinics also may provide pregnancy-related services, including abortion, while others do not. In certain clinics, providers may offer gender-affirming care, such as hormone therapy, surgical consultation, and preventive services, but this is not typically expected or guaranteed. GYN clinics are not always welcoming environments for gender-diverse individuals. For example, a waiting room full of pregnant patients may feel unwelcoming or dysphoric for a transgender person.

In contrast, gender diversity clinics (GDCs) are designed to offer affirming care to gender-diverse patients and provide a wide range of services in one location. These clinics typically feature providers experienced in caring for the gender-diverse community and have established networks for in-house or local referrals, including electrolysis technicians, voice coaches, and cosmetic or gender-affirming surgeons.

After *Dobbs*, several Midwestern states enacted legislation restricting or banning abortion, and in some cases, transgender care. In 2019, the Kansas Supreme Court upheld the right to access abortion up to 22 weeks gestation.⁵⁻⁷ However, as of 2017, only four clinics in the state publicly offered abortion care.⁷ Following *Dobbs*, Kansas became a referral hub for patients from surrounding states with near-total abortion bans, including Missouri, Texas, Oklahoma, Nebraska, and Arkansas. In Missouri, House Bill 126 banned abortion except in medical emergencies.⁸ In Texas, Chapter 170A implemented a near-total ban on abortion.⁹ The number of pregnant individuals traveling out of Texas for abortion care has increased tenfold.¹⁰ Kansas clinics have anecdotally reported a significant rise in patients from Texas. Oklahoma's 1910 law classifies performing or aiding an abortion as a felony.¹¹ Arkansas enacted a similar trigger law banning nearly all abortions.¹² In Nebraska, LB574 bans abortion after 12 weeks and, as of October 2023, restricts puberty blockers and prohibits gender-affirming surgeries for minors.¹³

We hypothesized that as family planning clinics adjusted to increased abortion-related care demands, they became less available to provide gender-affirming care, prompting patients to seek services elsewhere. To our knowledge, no existing literature has evaluated this trend. This study aimed to assess whether abortion restrictions in the Midwest indirectly affected access to gender-affirming care. Specifically, we examined changes in wait times and distance traveled for new patient visits to a GDC at a large academic health center before and after the *Dobbs* decision. We compared these patterns with those seen at the same institution's general GYN clinic, anticipating that gender-diverse patients may now be traveling farther and waiting longer to access care.

METHODS

We conducted a retrospective cohort study of patients accessing gender diversity care at The University of Kansas Health System. The

study included patients aged 18 or older who were seen for a new patient appointment in the GDC between July 1, 2021 and June 30, 2023. This two-year period was selected to enable a year-long comparison of pre- and post-*Dobbs* data within an academic calendar. New patient appointments at the GYN clinic served as the control group (Figure 1).

We evaluated and compared wait times and clinic distance (defined as the distance from a patient's home to either the GDC or the main campus GYN clinic) for both clinics during the pre- and post-*Dobbs* time frames. All eligible patients seen at either clinic during the study period were included in the analysis.

Patient charts were identified using the Healthcare Enterprise Repository for Ontological Narration (HERON), a query tool that accesses de-identified data from the electronic medical record.¹⁴ A retrospective chart review was conducted to collect the following variables: demographics (age, insurance, race, ethnicity, marital status), home ZIP code and county, date of initial intake (phone or office contact) for scheduling, date of the new patient appointment, and visit type (in-person or telemedicine).

Statistical Analyses. We summarized patient characteristics using descriptive statistics (frequencies, means, medians). Differences in travel distance (miles) and wait time (days) by clinic type and time frame (pre- vs. post-*Dobbs*) were assessed using generalized estimating equations. Models controlled for visit type (telemedicine vs. in-person) and included an interaction term for clinic type \times *Dobbs* period.

We also summarized the number of patients seeking care at the GDC by county during each time frame. These data were used to create a choropleth map, displaying quintiles of patient prevalence to visualize geographic changes in access to care before and after the *Dobbs* decision.

Lastly, we assessed changes in monthly and annual new patient volume at both clinics using Poisson regression analysis.

All statistical analyses were conducted using SAS Version 9.4 (SAS Institute, Cary, NC, USA). Mapping analyses were performed in ArcGIS Pro 3.1 (ESRI, Redlands, CA, USA). The study was approved by The University of Kansas Medical Center Institutional Review Board (IRB).

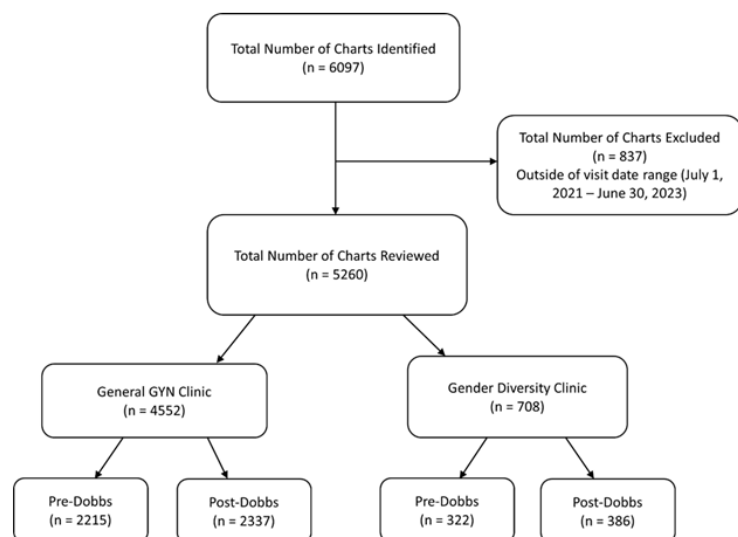


Figure 1. Flow diagram of study participants included in data analysis.

RESULTS

We identified 6,097 patient charts for review. Of these, 837 were excluded for not meeting the date range inclusion criteria, leaving 5,260 charts for analysis. Among them, 708 were from new patients seen at the GDC, and 4,552 were from the GYN clinic.

The average age of patients at the GDC was 29 years, 10 years younger than the average age of 39 years in the general GYN clinic (Table 1). Patients at the GDC primarily were Caucasian and single, whereas the GYN clinic had a more racially diverse and more frequently married patient population. Most visits to the GDC were via telemedicine, while visits to the GYN clinic were primarily in-person.

Insurance distribution was similar between clinics for private insurance. However, the GYN clinic had a higher proportion of patients with public insurance (16% vs. 13%), while the gender diversity clinic had more self-pay patients (5% vs. 3%).

There was no statistically significant change in distance traveled to the clinic for patients in the GDC before and after the *Dobbs* decision ($\beta = 2.5$; 95% CI, -11.9 to 16.8). In contrast, patients at the GYN clinic traveled an average of 6.3 fewer miles post-*Dobbs* ($\beta = -6.3$; 95% CI, -12.0 to -0.5). An interaction model, controlling for visit type, found a statistically significant decrease in distance traveled of 6.4 miles for GDC patients compared to GYN patients ($\beta = -6.4$; 95% CI, -6.8 to -6.4). Figure 2 illustrates the geospatial distribution of patients seeking gender-affirming care before and after *Dobbs*.

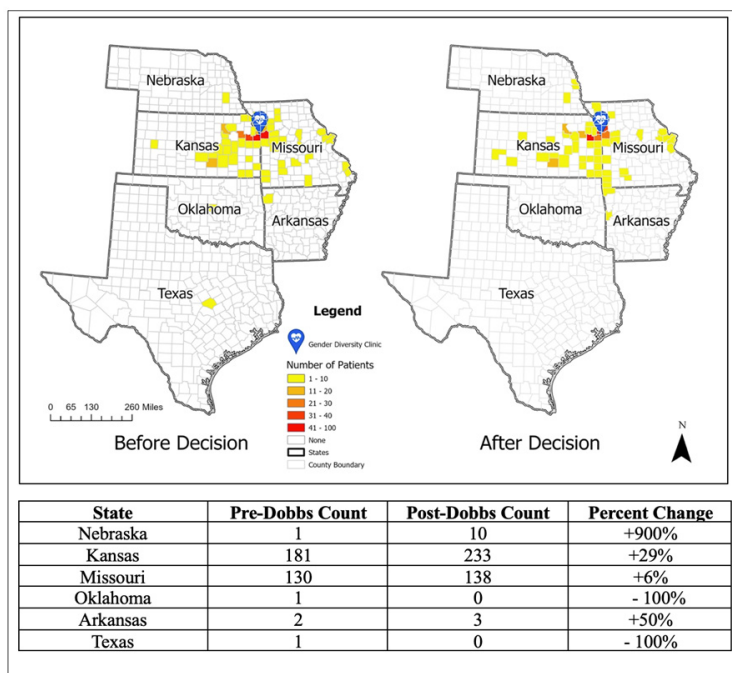


Figure 2. Geospatial distribution and percent change in patients attending a visit at The University of Kansas Medical Center gender diversity clinic before and after *Dobbs*.

Table 1. Characteristics of patients seeking gender diversity and general gynecology care at a Midwest academic center.

	Gynecology Clinic N = 4,552			Gender Diversity Clinic N = 708		
Demographic Variable	Total Population N = 4,552	Pre-Dobbs n = 2,215	Post-Dobbs n = 2,337	Total Population N = 708	Pre-Dobbs n = 322	Post-Dobbs n = 386
Age, mean (SD) ^a	38.9 (15.2)	39.1 (15.4)	38.7 (15.0)	28.5 (10.7)	29.5 (11.0)	27.8 (10.4)
Insurance, n (%) ^{a,b,c}						
Private	3,698 (81.4)	1,825 (82.4)	1,873 (80.1)	583 (82.3)	274 (85.1)	309 (80.1)
Public	733 (16.1)	341 (15.4)	392 (16.8)	90 (12.7)	40 (12.4)	50 (13.0)
Self-Pay	121 (2.7)	49 (2.2)	72 (3.1)	35 (4.9)	8 (2.5)	27 (7.0)
Race, n (%) ^c						
African American	724 (15.9)	342 (15.4)	382 (16.4)	34 (4.8)	17 (5.3)	17 (4.4)
American Indian/Alaska Native	21 (0.5)	14 (0.6)	7 (0.3)	7 (1.0)	1 (0.3)	6 (1.6)
Asian	129 (2.8)	71 (3.2)	58 (2.5)	17 (2.4)	7 (2.2)	10 (2.6)
Native Hawaiian or Other Pacific Islander	10 (0.2)	6 (0.3)	4 (0.2)	2 (0.3)	2 (0.6)	0 (0.0)
Caucasian	2,913 (64.0)	1,416 (63.9)	1,497 (64.1)	589 (83.2)	265 (82.3)	324 (83.9)
Not otherwise specified	710 (15.6)	344 (15.5)	366 (15.7)	52 (7.3)	27 (8.4)	25 (6.5)
Not reported	52 (1.0)	22 (1.0)	23 (1.0)	7 (1.0)	3 (0.9)	4 (1.0)
Ethnicity, n (%) ^c						
Hispanic or Latino	597 (13.1)	291 (13.1)	306 (13.1)	37 (5.2)	11 (3.4)	26 (6.7)
Not Hispanic or Latino	3,883 (85.3)	1,888 (85.2)	1,995 (85.4)	654 (92.4)	301 (93.5)	353 (91.5)
Not reported	72 (1.6)	36 (1.6)	36 (1.5)	17 (2.4)	10 (3.1)	7 (1.8)
Marital status, n (%) ^{c,d}						
Single	2,086 (45.8)	1,029 (46.4)	1,057 (45.2)	419 (59.2)	218 (67.7)	201 (52.1)
Married	1,980 (43.5)	949 (42.8)	1,031 (44.1)	126 (17.8)	63 (19.6)	63 (16.3)
Not reported	32 (0.7)	15 (0.7)	17 (0.7)	99 (14.0)	6 (1.9)	93 (24.0)
Divorced	309 (6.8)	150 (6.8)	159 (6.8)	41 (5.8)	26 (8.1)	15 (3.9)
Life partner	54 (1.2)	26 (1.2)	28 (1.2)	23 (3.3)	9 (2.8)	14 (3.7)
Widowed	91 (2.0)	46 (2.1)	45 (2.0)	0 (0.0)	0 (0.0)	0 (0.0)
Visit type, n (%) ^{c,e}						
Clinic	3,766 (82.7)	1,790 (80.8)	1,976 (84.6)	35 (4.9)	20 (6.2)	15 (3.9)
Telemedicine	786 (17.3)	425 (19.2)	361 (15.5)	673 (95.1)	302 (93.8)	371 (96.1)

^ap <0.05 for pre- vs. post-*Dobbs*, Gender Diversity Clinic.^bp <0.05 for pre- vs. post-*Dobbs*, Gynecology Clinic.^dp <0.01 for Gynecology Clinic vs Gender Diversity Clinic.^ep <0.01 for pre- vs. post-*Dobbs*, Gender Diversity Clinic.^cp <0.01 for pre- vs. post-*Dobbs*, Gynecology Clinic.Table 2. Distance from clinic and wait time by clinic pre- and post-*Dobbs* at a Midwest academic center and results from generalized estimating equation models.

	GYN Clinic			Gender Diversity Clinic			
Variable	Pre- <i>Dobbs</i>	Post- <i>Dobbs</i>	β (95% CI) ^a	Pre- <i>Dobbs</i>	Post- <i>Dobbs</i>	β (95% CI) ^b	β (95% CI) ^c
Distance traveled in miles, mean (SD)	37.3 (117.7)	29.7 (79.1)	-6.3 (-12.0, -0.5)	73.3 (111.9)	74.7 (84.1)	2.5 (-11.9, 16.8)	-6.4 (-6.8, -6.0)
Wait time in days, mean (SD)	42.9 (38.1)	45.4 (39.8)	1.9 (-0.4, 4.1)	55.0 (50.4)	33.9 (27.6)	-21.2 (-27.0, -15.3)	1.9 (1.8, 2.0)

^aBeta coefficient and 95% confidence interval calculated from generalized estimating equation model controlling for visit type (telemedicine vs. in-person) evaluating the change in each outcome by *Dobbs* among patients seeking care in the general GYN clinic. Pre-*Dobbs* = reference group.^bBeta coefficient and 95% confidence interval calculated from generalized estimating equation model controlling for visit type (telemedicine vs. in-person) evaluating the change in each outcome by *Dobbs* among patients seeking care in the gender diversity clinic. Pre-*Dobbs* = reference group.^cBeta coefficient and 95% confidence interval for interaction term (*Dobbs**clinic) in generalized estimating equation model controlling for visit type (telemedicine vs. in-person). Pre-*Dobbs* = reference group.

A breakdown by state showed an increase in patients seeking gender-affirming care post-*Dobbs* in Kansas (181 to 233), Missouri (130 to 138), Nebraska (1 to 10), and Arkansas (2 to 3). Conversely, the number of patients from Oklahoma and Texas dropped from 1 to 0 in each state.

Regarding appointment wait times, there was no statistically significant change in either clinic. The GYN clinic saw a small, non-significant increase in wait time ($\beta = 1.9$; 95% CI, -0.4 to 4.1), while the GDC showed a non-significant decrease ($\beta = -21$; 95% CI, -27.9 to 15.3; Table 2). However, the interaction model, again controlling for visit type, revealed a statistically significant increase of two days in wait time for the GDC compared to the GYN clinic ($\beta = 1.9$; 95% CI, 1.8 to 2.0).

Poisson regression analysis demonstrated statistically significant differences in new patient volume between clinics before and after *Dobbs*. The GYN clinic experienced a 6% increase in new patients (from 2,215 to 2,337), while the GDC saw a 21% increase (from 322 to 386; $p < 0.001$).

DISCUSSION

Post-*Dobbs*, we observed a significant increase in patients establishing gender-affirming care, in contrast to more modest volume changes in the GYN clinic. While wait times in the GDC decreased by 21 days, this change was not statistically significant. However, a repeated measures model found a two-day increase in wait time relative to the GYN clinic, coinciding with a 21% increase in new patient volume. This small increase likely reflects expanded clinic capacity rather than access delays. To meet demand, the GDC increased from six half-days covered by four providers to nine half-days covered by six providers post-*Dobbs*.

Importantly, the distance traveled by patients to the GDC did not increase significantly. Its location on the Kansas–Missouri border near Kansas City likely contributed to sustained accessibility. Post-*Dobbs*, there was a 29% increase in Kansas-based patients and a 900% increase from Nebraska, with no patients from Texas or Oklahoma—suggesting reduced access or increased legal barriers in those states.

Transgender and gender-diverse individuals already face significant barriers to care, which are exacerbated in regions where gender-affirming services are limited or legally restricted.¹⁵ Many Midwest clinics have ceased providing these services following legislation like Missouri's SAFE Act (SB 49), which bans gender transition procedures for minors and excludes coverage under Medicaid.^{16,17} Such laws compound access challenges for an already marginalized population.¹⁸

Abortion and gender-affirming care are increasingly linked in legislative discourse.¹⁸ Since *Dobbs*, over 500 anti-LGBTQ+ bills have been introduced in 40 states, many targeting gender-affirming care.¹⁹ In Alabama, similar legal rationale from *Dobbs*, that gender transition care lacks historical precedent, has been cited to justify bans.²⁰

Figure 3 highlights the overlap of restrictive laws targeting both types of care. These policy trends risk reducing availability of essential services and may contribute to the creation of regional care deserts.

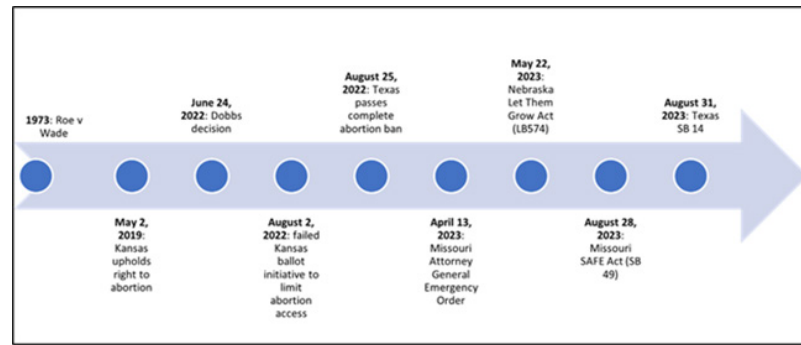


Figure 3. Timeline of select bills restricting or banning abortion and gender affirming care.

Limitations. This single-center, retrospective study has limitations, including potential selection bias and reliance on estimated zip code distances rather than actual travel routes. Only patients who scheduled and attended visits were included, potentially excluding those unable to access care. Additionally, the observed wait time changes are difficult to interpret considering increased provider availability post-*Dobbs*, which may have contributed to the rise in new patient volume.

CONCLUSIONS

Providers have reported that many new patients seeking gender-affirming care relocated or transferred care to Kansas due to safety concerns post-*Dobbs*. Kansas City, a region that has resisted legislative bans, may be perceived as a “safe haven” for gender-affirming care.^{21–23} However, this shift raises concern for patients unable to move. As legal restrictions limit provider’s ability to provide comprehensive health care by state, care deserts may emerge, especially for marginalized groups such as transgender patients.

ACKNOWLEDGEMENTS

The authors thank Nathan Do, Hannah Coggeshall, and Muriel Lund for assistance with chart review.

REFERENCES

- 1 Planned Parenthood Federation of America, Inc. Transgender Hormone Therapy. 2025. <https://www.plannedparenthood.org/get-care/our-services/transgender-hormone-therapy>. Accessed April 10, 2025.
- 2 Liang AC, Gliwa C, Loder CM, Dalton VK, Smith RD. Tubal sterilization requests at a single institution following the supreme court decision to overturn the constitutional right to abortion. *JAMA* 2023; 330(4):374–375. PMID: 37490094.
- 3 Guttmacher Institute. Roe v. Wade Overturned: Our Latest Resources - Abortion Rights and Access in the Post-Roe Era. 2025. <https://www.guttmacher.org/abortion-rights-supreme-court>. Accessed April 10, 2025.
- 4 Kimport K. Abortion after *Dobbs*: Defendants, denials, and delays. *Sci Adv* 2022; 8(36):eade5327. PMID: 36070372.
- 5 Center for Reproductive Rights. After Roe Fell: Abortion Laws by State - Kansas. 2024. <https://reproductiverights.org/maps/state/kansas/>. Accessed April 10, 2025.
- 6 Center for Reproductive Rights. Kansas Supreme Court Says State Constitution Protects Abortion. 2019. <https://reproductiverights.org/kansas-supreme-court-says-state-constitution-protects-abortion/>. Accessed April 10, 2025.
- 7 Guttmacher Institute. Interactive Map: US Abortion Policies and Access After Roe - Kansas. 2025. <https://states.guttmacher.org/policies/kansas/abortion-policies>. Accessed September 15, 2023.

⁸ Missouri Senate. Missouri Stands for the Unborn Act. SS SCS HB 126: Missouri House of Representatives; 2019. p. H2825-2826.

⁹ Texas State Law Library. Is abortion illegal in Texas? 2025. <https://www.sll.texas.gov/faqs/abortion-illegal-texas/#:~:text=Chapter%20170A%20of%20the%20Texas,pregnant%20patient%20is%20at%20risk>. Accessed April 10, 2025.

¹⁰ White K, Arey W, Whitfield B, et al. Abortion patients' decision making about where to obtain out-of-state care following Texas' 2021 abortion ban. *Health Serv Res* 2023; 59(1):e14226. PMID: 37700552.

¹¹ Oklahoma Judicial Center. Oklahoma Statutes Citationized - Procuring an Abortion. 21: Oklahoma State Courts Network; 1999.

¹² Arkansas Senate. Senate Approves Legislation Repealing the Licensure of Abortion Facilities. 2023. <https://senate.arkansas.gov/senate-news/posts/2023/february/senate-approves-legislation-repealing-the-licensure-of-abortion-facilities/#:~:text=Wade%2C%20a%20precedent%20that%20allowed,life%20states%20in%20the%20country>. Accessed April 10, 2025.

¹³ Nebraska Unicameral Legislature. LB574: Adopt the Let Them Grow Act and the Preborn Child Protection Act and provide for discipline under the Uniform Credentialing Act. 2023. p. 1-17.

¹⁴ Adagarla B, Connolly D, McMahon T, et al. SEINE: Methods for Electronic Data Capture and Integrated Data Repository Synthesis with Patient Registry Use Cases. 2014. <https://kuscholarworks.ku.edu/entities/publication/9fac5b17-c599-4d9f-aa71-b6a5cce4bd1e>. Accessed September 15, 2023.

¹⁵ Ingraham N, Fox L, Gonzalez AL, Riegelsberger A. "I just felt supported": Transgender and non-binary patient perspectives on receiving transition-related healthcare in family planning clinics. *PLoS One* 2022; 17(7):e0271691. PMID: 35862408.

¹⁶ Salter JB. Missouri clinics halt transgender care for minors in wake of new state law. <https://www.kansascity.com/news/nation-world/national/article279246134.html>. Accessed April 10, 2025.

¹⁷ Missouri Senate. SB 49: Establishes the "Missouri Save Adolescents from Experimentation (SAFE) Act" and modifies provisions relating to public funding of certain gender transition procedures. 2023. https://www.senate.mo.gov/23info/bts_web/Bill.aspx?SessionType=R&BillID=44407. Accessed April 10, 2025.

¹⁸ Covvey J, Bratberg J. Actions speak louder than words: Taking a stand for reproductive health care and gender-affirming care. *J Am Pharm Assoc* 2024; 64(1):174-178. PMID: 38309786.

¹⁹ American College of Physicians. Attacks on Gender-Affirming and Transgender Health Care. 2024. <https://www.acponline.org/advocacy/state-health-policy/attacks-on-gender-affirming-and-transgender-health-care>. Accessed April 14, 2025.

²⁰ Manian M. The ripple effect of *Dobbs* on health care beyond wanted abortion. *SMU L Rev* 2023; 76(1): 77-104. doi: 10.25172/smulr.76.1.9.

²¹ Calacal C. Kansas City declares itself a "safe haven" for gender-affirming health care as Missouri restricts access. 2023. <https://www.kcur.org/news/2023-05-11/kansas-city-transgender-safe-haven-gender-affirming-care-missouri-laws>. Accessed April 10, 2025.

²² Shorman J BJ. After failed veto override, gender-affirming care for trans youth remains legal in Kansas. 2024. <https://www.kansascity.com/news/politics-government/article288108015.html>. Accessed April 10, 2025.

²³ King S. Kansas and Missouri bans may spur families to travel far out of state for gender-affirming care. 2024. <https://thebeaconnews.org/stories/2024/04/05/kansas-and-missouri-bans-may-spur-families-to-travel-far-for-gender-affirming-care/>. Accessed April 10, 2025.

²⁴ Stephenson-Famy A, Sonn T, Baecher-Lind L, et al. The *Dobbs* decision and undergraduate medical education: The unintended consequences and strategies to optimize reproductive health and a competent workforce for the future. *Acad Med* 2023; 98(4):431-435. PMID: 36347017.

²⁵ Guttmacher Institute. Interactive Map: US Abortion Policies and Access After Roe. 2025. <https://states.guttmacher.org/policies>. Accessed April 12, 2025.

Keywords: *abortions, legal, gender-affirming care; gynecology; sexual and gender minorities*