

# From Training to Practice: Physician Labor Market Entry, Geographic Mobility, and Reproductive Health Policy

Diaz-Campo & Pineda-Torres (2026)

Paper presentation and discussion

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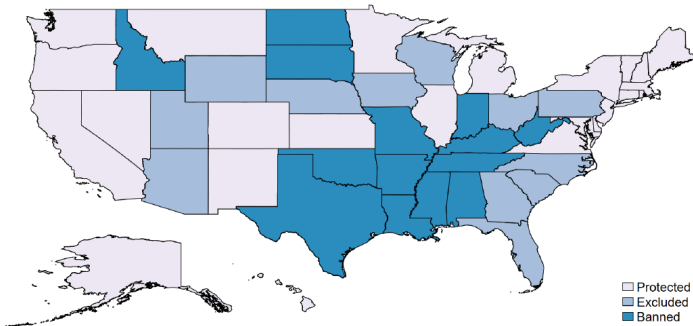
## **Part I: The Paper**

**How do highly trained workers respond when regulation changes the returns to their skills after the human-capital investment is sunk?**

- Physicians have already chosen medicine, medical school, core specialty, and residency location
- What remains adjustable at the exit from training:
  - Whether to enter clinical practice now or train further
  - Whether a confirmed position materializes
  - Where that position is, and at what **compensation**
- Shock: *Dobbs* (June 24, 2022) — the largest reproductive-policy change in 50 years

**Sign is ambiguous ex ante:** legal risk and constrained scope of practice push one way; higher births and demand for reproductive care (Dench, Pineda-Torres & Myers 2024) push the other.

# Setting: The Post-Dobbs Policy Landscape

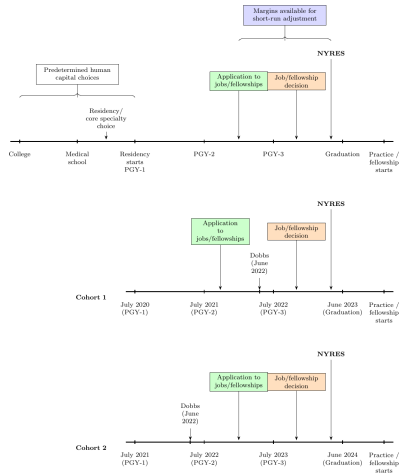


Three-way classification following Dench, Pineda-Torres & Myers (2024):

- **Ban** — 14 states with near-total bans before Nov 2024
- **Protective** — 25 states with constitutional or statutory protection
- **Excluded** — 12 states with gestational bans or highly restrictive regimes

Sample ends in 2024, before ND and MO bans were struck down.

# Setting: Timing of Career Decisions Relative to Dobbs



Cohort 1 (June 2023 grads) entered PGY-3 right after *Dobbs*; Cohort 2 (June 2024) entered PGY-2 around *Dobbs*, so more of the application *and* acceptance window is post-treatment.

## Data: New York Resident Exit Survey (NYRES)

- Administered annually since 1998 by CHWS at SUNY Albany to residents and fellows **at training completion**
- Survey waves 2017–2024 (no 2020 wave, COVID); 18,675 respondents
- The distinctive feature is the timing. Most workforce data measure the *stock* of practicing physicians. NYRES observes the transition itself:
  - Intended primary activity after graduation
  - Whether a clinical position is confirmed
  - Location of that position
  - Expected base salary (in 13 brackets)
- New York: 11% of U.S. ACGME programs, 12% of residents on duty; 100 residents per 100k population vs. 37 in California

## Descriptives: Pre- vs. Post-Dobbs

|                           | 2017–2022 | 2023–2024 |
|---------------------------|-----------|-----------|
| Received any job offer    | 0.860     | 0.919     |
| Enter clinical practice   | 0.515     | 0.539     |
| Delay clinical practice   | 0.485     | 0.461     |
| New job located in NYS    | 0.492     | 0.524     |
| Base salary $\geq$ \$375k | 0.101     | 0.232     |
| Female                    | 0.478     | 0.484     |
| Native born               | 0.579     | 0.637     |
| Fellows (vs. residents)   | 0.315     | 0.304     |

- Composition is broadly stable across specialties and demographics
- Entry rises, offers rise, salaries rise sharply — *in levels*, the post period looks like a strong market

## Reduced Form I: Clinical-Practice Entry

|                            | LPM                         | Logit                       |
|----------------------------|-----------------------------|-----------------------------|
| Fellow                     | 0.319***<br>(0.012)         | 1.367***<br>(0.055)         |
| Educ. debt (\$100k)        | 0.012***<br>(0.002)         | 0.054***<br>(0.010)         |
| Post- <i>Dobbs</i>         | 0.056***<br>(0.010)         | 0.264***<br>(0.048)         |
| <b>Repro. Spec. × Post</b> | <b>-0.073***</b><br>(0.017) | <b>-0.340***</b><br>(0.076) |
| Observations               | 18,675                      | 18,675                      |

Reproductive-care group: family medicine, general internal medicine, general pediatrics, emergency medicine, OB-GYN general and subspecialties.

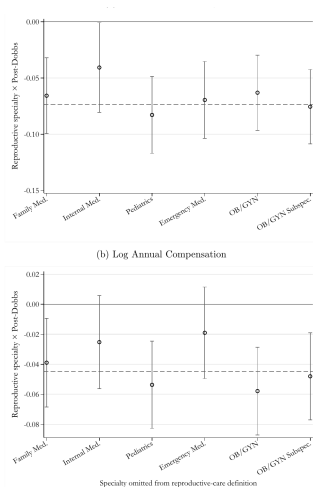
- Controls: 12 specialty groups, fellow status, educational debt
- **7.3 pp differential decline** against a base rate of ~50%
- Debt raises immediate entry — consistent with repayment pressure
- Authors are explicit: these are *patterns to be explained*, not causal effects

## Reduced Form II: Expected Compensation

| Dep. var: log salary | (1)                         | (2)                         |
|----------------------|-----------------------------|-----------------------------|
| Female               | -0.094***<br>(0.008)        | -0.088***<br>(0.008)        |
| OB-GYN (general)     | 0.135***                    | 0.120***                    |
| OB-GYN (subspec.)    | 0.447***                    | 0.434***                    |
| Surgery (subspec.)   | 0.347***                    | 0.330***                    |
| Facility based       | 0.337***                    | 0.327***                    |
| <b>Repro. × Post</b> | <b>-0.048***</b><br>(0.015) | <b>-0.045***</b><br>(0.015) |
| US: Protected        |                             | -0.109***                   |
| Outside US           |                             | -0.306***                   |
| Observations         | 7,875                       | 7,865                       |

- ~5% relative decline in expected salary for reproductive-care specialties
- **Unchanged when destination is controlled for** — so it is not simple geographic reallocation
- Ban states are the omitted destination category: protective states pay ~11% less

# Reduced Form III: Leave-One-Out Robustness



Notes: Each point reports the coefficient on the interaction between the reproductive-care specialty indicator and the post-Dobbs indicator from a specification that excludes the specialty indicated on the horizontal axis

- Each point drops one specialty from the treatment definition
- Entry (panel a): stable, negative everywhere
- Compensation (panel b): negative everywhere, but loses precision when general IM or EM is dropped

# Why the Reduced Form Is Not Enough

- ① **Equilibrium outcomes, not mechanisms.** A decline in entry could come from compensation, employment probability, geographic prospects, or any mix. Regressions cannot separate them.
- ② **Not causal.** *Dobbs* was national. Every reproductive-care physician in the country was exposed. There is no clean untreated comparison group.
- ③ **No counterfactuals.** The regressions describe what happened, but they cannot say what a no-*Dobbs* world looks like, or reweight the channels.

⇒ **Structural model of occupational choice, employment, location, and pay**

## Model I: Occupational Choice

Physician  $i$ , specialty  $s$ , graduating year  $t$  chooses  $d_{ist} \in \{0, 1\}$  — enter the clinical job market, or not.

$$V_{ist}^{PC} = X_{ist}^O \beta^O + EV_{ist}^{PC} + \varepsilon_{ist}^{PC}$$

- $X^O$ : constant, specialty indicators, fellowship status, educational debt
- $EV^{PC}$ : expected utility of participating, integrating over job realization, location, and pay
- Outside option normalized to zero; T1EV shocks  $\Rightarrow$  logit

$$P(d_{ist} = 1) = \Lambda(X_{ist}^O \beta^O + EV_{ist}^{PC})$$

Key timing assumption: the entry decision is made *before* the job, location, and wage are realized. Physicians act on expectations.

## Model II: Labor-Market Outcomes and Compensation

**Destinations** — multinomial logit over  $y_{ist} \in \{0, \dots, 5\}$ :

0: no confirmed job    1: excluded state    2: New York    3: protective    4: ban    5: outside U.S.

$X^L$ : citizenship, high-school location, medical-school location, specialty, post-*Dobbs* interactions. Outcome 0 normalized.

**Compensation** — Mincerian, with interval censoring (13 salary brackets):

$$\log(w_{ist}) = X_{ist}^W \beta^W + \eta_{ist}, \quad \eta \sim N(0, \sigma_\eta^2)$$

$X^W$ : age, gender, degree, fellow, year FE, realized location, reproductive-care indicator, post-*Dobbs* interactions.

Compensation is observed **only** for physicians with confirmed positions  $\Rightarrow$  selection handled jointly.

## Model III: Bringing It Together

$$EV_{ist}^{PC} = P(y \neq 0) \left[ \alpha_{job} + \alpha_{wage} \mathbb{E}[\log w_{ist}] + \alpha_{home} \sum_I P(I \mid y \neq 0) \mathbb{I}[HS = NY] \mathbb{I}[I = 2] \right]$$

with  $\mathbb{E}[\log w_{ist}] = \sum_{I=1}^5 P(y = I \mid y \neq 0) \cdot \mathbb{E}_{\eta}[\log w \mid y = I]$

Three ingredients enter the entry decision:

- 1 Probability of securing any confirmed clinical position
- 2 Expected pay, integrated over the destination distribution
- 3 Home-state attachment (a NY premium for physicians who went to high school in NY)

Estimated jointly by maximum likelihood on repeated cross-sections, 2017–2024.

- **Timing:** choice precedes realization, so entry is disciplined by expectations
- **Compensation:** log-normal latent wage + bracket responses identify mean and variance; selection handled à la Heckman through the joint likelihood
- **Exclusion restrictions:**
  - Disaggregated specialty and educational debt → choice equation only
  - High-school/medical-school location and citizenship → destination equation only
- **Repro × post interactions:** identified DiD-style from differential post-2022 changes for reproductive specialists
- Why the cross-equation structure (previous slide) is essential: entry alone would identify only a composite of  $\alpha_{job}$  and  $\alpha_{wage}\mathbb{E}[\log w]$

## Results I: Occupational-Choice Parameters

| Parameter              | Est.    | S.E.    |
|------------------------|---------|---------|
| Constant               | 1.759   | (0.626) |
| Fellow                 | 1.395   | (0.057) |
| Internal Med (general) | -1.740  | (0.095) |
| OB-GYN (general)       | -0.615  | (0.125) |
| Surgery (general)      | -3.130  | (0.146) |
| Educ. debt (\$100k)    | 0.053   | (0.011) |
| $\alpha_{job}$         | -12.786 | (2.354) |
| $\alpha_{home}$ (NY)   | 0.160   | (0.057) |
| $\alpha_{wage}$        | 0.976   | (0.165) |

- $\alpha_{wage} > 0$  and precise  $\rightarrow$  expected pay matters for entry
- $\alpha_{home} > 0 \rightarrow$  New York ties persist even conditional on expected pay
- Surgical and facility-based specialties strongly prefer further training
- $\alpha_{job}$  not interpretable alone, enters only jointly through  $EV^{PC}$

## Results II: Compensation Equation

| Parameter                  | Est.          | S.E.    |
|----------------------------|---------------|---------|
| Age                        | 0.037         | (0.008) |
| Female                     | -0.142        | (0.008) |
| DO degree                  | -0.009        | (0.011) |
| Fellow                     | 0.052         | (0.008) |
| US: Excluded               | -0.015        | (0.018) |
| US: Protected              | -0.137        | (0.015) |
| Outside US                 | -0.283        | (0.035) |
| Year 2022                  | 0.132         | (0.014) |
| Year 2023                  | 0.289         | (0.018) |
| Year 2024                  | 0.347         | (0.018) |
| Repro. care specialty      | -0.111        | (0.009) |
| <b>Repro. × Post-Dobbs</b> | <b>-0.109</b> | (0.018) |
| $\sigma_\eta$              | 0.324         | (0.004) |

- Standard concave age profile, large gender gap
- Ban states are the omitted category → protective states pay ~14% less
- Strong nominal year trend: +21.5 log points from 2022 to 2024
- Reproductive-care pay falls 10.9 log points relative to others after *Dobbs*

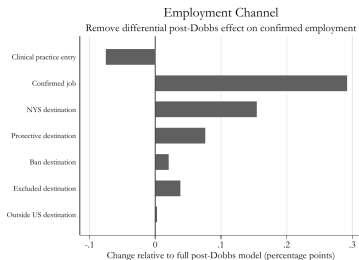
## Results III: Model Fit

|                          | Overall |       | Repro Pre- <i>Dobbs</i> |       | Repro Post- <i>Dobbs</i> |       |
|--------------------------|---------|-------|-------------------------|-------|--------------------------|-------|
|                          | Data    | Model | Data                    | Model | Data                     | Model |
| $P(PC = 1)$              | 0.498   | 0.503 | 0.543                   | 0.540 | 0.553                    | 0.573 |
| $P(Job = 1 \mid PC = 1)$ | 0.901   | 0.902 | 0.897                   | 0.896 | 0.929                    | 0.928 |
| $P(NYS)$                 | 0.517   | 0.492 | 0.501                   | 0.477 | 0.545                    | 0.527 |
| $P(Protective)$          | 0.268   | 0.283 | 0.272                   | 0.286 | 0.248                    | 0.259 |
| $P(Ban)$                 | 0.071   | 0.074 | 0.079                   | 0.083 | 0.069                    | 0.072 |
| $P(Excluded)$            | 0.129   | 0.136 | 0.134                   | 0.141 | 0.122                    | 0.128 |
| $P(Outside\ US)$         | 0.016   | 0.015 | 0.014                   | 0.013 | 0.016                    | 0.015 |

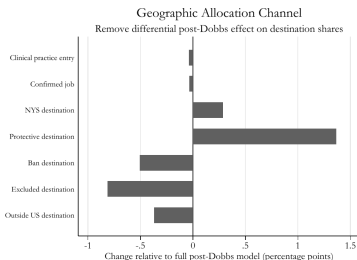
- Occupational transitions and geographic allocation fit well
- Compensation brackets (Panel C, omitted here) are smoother in the model than in the data, but that's expected, given the log-normality

# Counterfactual I: Channel Decomposition

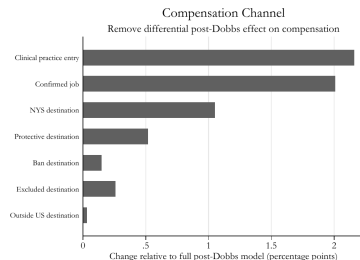
Sequentially zero out the differential post-*Dobbs* effect one component at a time, holding the rest at post-*Dobbs* values.



**Employment:** entry moves  $<0.1$  pp



**Geography:** *where*, not *whether*

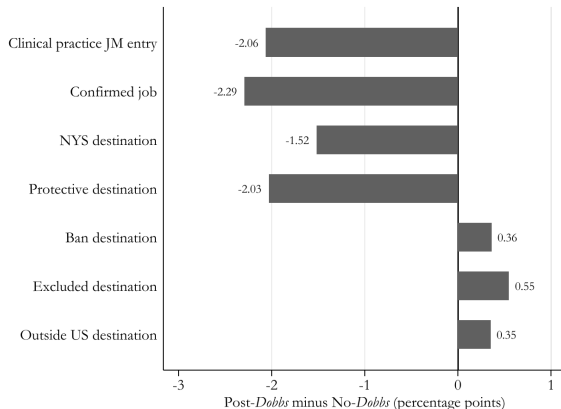


**Compensation:** entry +2.2 pp

**Expected pay is an order of magnitude more important than the other two channels.**

# Counterfactual II: No-Dobbs Economy

Figure 7: Estimated Effect of *Dobbs* on Physicians in Reproductive-Care Specialties



Set all repro  $\times$  post interactions to zero in the destination and compensation equations.

- Entry: **-2.06 pp** ( $\approx 4.0\%$ )
- Confirmed job: **-2.29 pp** ( $\approx 2.5\%$ )
- New York: -1.52 pp
- Protective: -2.03 pp
- Ban/excluded/ abroad: modest increases

How I'm reading this: with lower expected earnings overall, the relatively high nominal pay in ban states pulls some physicians toward less protective environments.

## What the Paper Concludes

- ① *Dobbs* reduced immediate clinical-practice entry among reproductive-care physicians by ~2 pp ( $\approx 4\%$ )
- ② The dominant channel is **expected compensation**, not employment probability or geography
- ③ Workforce shifts *away* from New York and other protective states
- ④ Reproductive-health policy affects physician careers through **economic returns**, not only through direct practice restrictions
- ⑤ Caveat the authors flag: a decline in *immediate* entry need not be a permanent supply reduction — it may be delay into fellowship

## **Part II: Discussion**

## This is a very valuable paper!

- **Great Data.** NYRES observes physicians at the exact decision node. The literature is stuck comparing *stocks*; this measures the *flow*.
- Between the residency-application literature and the practicing-physician literature is a genuine gap, and the sunk-human-capital framing is a compelling way to motivate it.
- **The structural approach is well-motivated.** With a national shock and no clean control group, a model that maps expectations into choices is valuable.
- The authors say plainly that the reduced form is descriptive and list three reasons it cannot carry the argument.

**My comments are about how much weight the headline number can carry.**

### **A. Who is in the treatment group?**

A definitional question that flows through everything else.

### **B. The reduced form (Section 4).**

Specification, sample selection, measurement, and inference.

### **C. The structural model (Sections 5–8).**

What identifies the key parameter, what the model allows for, and what the counterfactuals do and do not show.

As always, free disposal.

## A1. What “Reproductive-Care Specialty” Actually Contains

| Specialty                   | Share        |
|-----------------------------|--------------|
| Internal medicine (general) | 19.3%        |
| Pediatrics (general)        | 7.6%         |
| Emergency medicine          | 5.2%         |
| Family medicine             | 4.5%         |
| OB-GYN (general)            | 3.1%         |
| OB-GYN (subspecialty)       | 0.9%         |
| <b>Total treated</b>        | <b>40.6%</b> |

- The treated group is **40% of the sample**, dominated by general internal medicine
- The specialty with unambiguous exposure (OB-GYN) is **4%**
- General pediatrics is treated; it is hard to argue pediatricians provide reproductive care
- The control group is surgery, radiology, anesthesiology, pathology, psychiatry

**Maura:** the “treatment” is close to *primary care and emergency medicine*, and the “control” is close to *procedural and hospital-based specialties*. Any shock that hits those two groups differently will show up as a Dobbs effect.

## A2. Does this Matter?

**2022–2024 was not a totally neutral period for these specialties.**

- Emergency medicine had a contraction
- Procedural and facility-based specialties had strong compensation growth
- Primary care compensation compressed relative to both

For the comparison group, log salary rises:

2022: +0.132     $\longrightarrow$     2023: +0.289     $\longrightarrow$     2024: +0.347    (+21.5 log points in two years)

**Maura:** the key coefficient of  $-0.109$  says the treated group got about *half the raise* the control group got. That is what a specialty-market divergence looks like. It is also what a Dobbs effect looks like. How do we separate them?

### A3. The Treated Group are Generalists

**Maura:** The treatment group is the generalists, and your outcome variable is whether people stopped being generalists. “Practice now vs. train more” is a question that is only *live* for the treated group.

Suppose the generalist-subspecialist pay gap widened after 2022 (estimates say yes):

| Table 4 compensation premia                 | Coefficient |
|---------------------------------------------|-------------|
| OB-GYN (subspecialty)                       | +0.447      |
| Surgery (subspecialty)                      | +0.347      |
| Facility based                              | +0.337      |
| Pediatrics (general)                        | −0.230      |
| Year effects, comparison group, 2022 → 2024 | +0.215      |

**That single mechanism predicts both of the paper’s findings:**

- **Compensation:** the treated group’s relative pay falls.
- **Entry:** generalist-track residents shift toward fellowship, because the return to subspecializing rose.

## A3 cont. Might the Groups Differ, With No Dobbs Content

- ① **“Reproductive care” is partly proxying for “resident.”** Fellows are 30% of the sample and are almost entirely in the control group. So repro  $\times$  post is partly **resident**  $\times$  **post**. Maybe include a fellow  $\times$  post interaction.
- ② **Program length  $\rightarrow$  cohort composition?** NYRES surveys at completion, and cohorts are graduation years. So the treated group's post-Dobbs cohorts selected their specialty in different years than controls.
  - Since OB-GYN is four year, if the effect shows up for them alone, this likely not big deal.
  - Can you run on residents only, so everyone faces same choice set?
  - Can you compare treatment and control programs of same length?
  - Maybe add fellow  $\times$  post.

## A. Additional Ideas

- 1 **An event study by graduating cohort.** You have eight cohorts. Plot repro  $\times$  year for 2017–2024, for entry and for log salary. Not sure what the pre-trends look like.
- 2 **Leave-one-in, not leave-one-out.** Dropping one specialty from a group dominated by general IM cannot move much. Maybe estimate the interaction **separately by specialty**. If it is monotone in plausible exposure — OB-GYN largest, general peds near zero, that would be super compelling.
- 3 **A placebo treatment group** matched on “primary-care-ness” but without reproductive exposure.
- 4 **Specialty-specific trends**, or benchmark against an external compensation series to absorb the secular divergence.

## B1. Composition Moved, and Table 3 Doesn't Absorb It

|                                      | 2017–2022 | 2023–2024    |
|--------------------------------------|-----------|--------------|
| Native born                          | 0.579     | <b>0.637</b> |
| Naturalized / permanent resident     | 0.267     | 0.228        |
| Medical school outside the U.S.      | 0.373     | <b>0.298</b> |
| Medical school in another U.S. state | 0.327     | 0.404        |

- The paper attributes this to immigration policy, not to Dobbs (citing Lo Sasso 2021 on the 2009 regulations)
- General internal medicine is the largest treated specialty *and* is disproportionately IMG-staffed
- So a compositional shift driven by visa policy loads differentially onto the treated group
- Does Table 3 have demographic or citizenship controls to absorb it?

**Maura:** the composition of *who answers the survey in a treated specialty* changed at the same time as Dobbs, for an unrelated reason.

## B2. “Entry Fell” Is a Relative Statement About a Rising Level

| $P(\text{enter practice})$ | Pre   | Post  |
|----------------------------|-------|-------|
| All specialties            | 0.515 | 0.539 |
| Reproductive care          | 0.543 | 0.553 |

Post-Dobbs main effect in the LPM: +0.056

- Reproductive-care entry **rose** by about a point in levels
- The negative result is entirely relative to a *larger* rise elsewhere
- “Dobbs reduced immediate labor-market entry by 4%” will be read by most people as a level decline

**And the outside option is overwhelmingly fellowship.** So the finding may be:

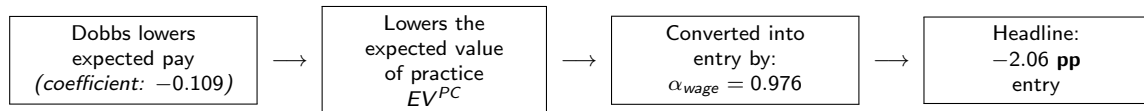
**“Dobbs induced more subspecialization among reproductive-care physicians”**

...which is a substantively different (possibly more interesting) claim than a workforce reduction.

It also has a very different policy implication: *delay* is not *exit*.

# C0. What the Model Does, in One Slide

## The chain the paper builds:



## So four questions organize everything that follows:

- 1 Is  $-0.109$  **credible**?
- 2 Is  $\alpha_{wage}$  **well identified**? Where does the model *learn* how much physicians respond to pay?
- 3 Are there channels ruled out by construction?
- 4 What does  $-0.109$  **really mean**? Is a falling wage a *supply* response or a *demand* shift?

## C1. Entry Equation Controls

- $X^O$  contains: a constant, 12 specialty dummies, fellowship status, educational debt.
- It does not contain: year effects, a post-Dobbs dummy, demographics.
- But the wage equation has strong year effects.
- $\mathbb{E}[\log w]$  rises roughly 35 log points over 2017–2024 (21.5 log points in 2022–2024).
- And entry also trends up: 51.5%  $\rightarrow$  53.9%.

**Maura:** The two series both trend upward. What in the model breaks the correlation? Miht  $\alpha_{wage}$  be fit off that time trend rather than off genuine cross-sectional variation.

**Also:** Is compensation deflated? Does the model treats post-2021 *inflation* as a real increase in the return to practice?

## C2. Questions about Key Parameters

- The key  $\alpha$  terms enter utility as a sum:  $\alpha_{job} + \alpha_{wage} \cdot \mathbb{E}[\log w]$ 
  - Has their possible collinearity been explored?
  - The values look a little like  $\alpha_{job}$  is a negative intercept canceling out the wage term, and this matters for counterfactual.
- The motivation in Section 1: abortion restrictions “increase legal uncertainty, constrain the services physicians can provide, and raise the **nonpecuniary costs of practice.**”
  - But the utility function only has one location-specific term: **New York home bias**
  - There is **no ban-state disamenity**. No legal-risk term. No scope-of-practice term.
  - So the headline mechanism can only express itself by loading onto **wages** or **destination probabilities**

**Maura:** “compensation is the dominant channel” is partly *definitional*. Something like an  $\alpha_{ban} \times \text{post}$  term would compete with  $\alpha_{wage}$  for the same variation.

### C3. Could the Supply Response be (partly) a Demand Shift?

The paper requires two things at the same time:

- 1 To read the wage decline as something physicians *respond to*, the wage must be **exogenous** from the physician's perspective
- 2 To read the quantity outcomes as physician *choices*, demand must be slack enough that anyone who wants a job gets one

**Do these pull against each other?** If demand were horizontal at the going wage (physician shortage) then **wages would not move at all.**

**No demand model.** The compensation process  $\log w = X^w \beta^w + \eta$  is a reduced-form object taken as given. There are no employers, no vacancies, no market clearing.

**Maura:** Can the paper explore *why* compensation fell for reproductive-care physicians.

## C3 cont. Price-Quantity Diagnostic

Supply shifts and demand shifts leave **opposite signatures** in prices and quantities:

|                                                         | Relative quantity | Relative price |
|---------------------------------------------------------|-------------------|----------------|
| <b>Supply story</b> (physicians avoid the field)        | falls             | <b>rises</b>   |
| <b>Demand story</b> (employers want fewer, or pay less) | falls             | <b>falls</b>   |

**What the paper finds, relative to control specialties:**

- Entry: -7.3 pp (quantity **down**)
- Expected compensation: -4.5% to -10.9% (price **down**)
- Confirmed-job probability: no significant differential change

**Maura:** Quantity down, price down is the demand signature, rather than supply.

**Caveat:** entry is itself a choice, so quantity is partly supply-determined; and composition or top-coding could be moving the measured wage. This is a diagnostic, not a proof.

## C4. Potential Rival Explanation: Waiting for Uncertainty to Resolve

**The decision is static and one-shot. The outside option is a constant.**

But the natural economics of “regulatory uncertainty causes delayed entry” is a **real option**: wait for the policy environment to resolve before committing to a location and a contract.

That predicts *exactly* the observed pattern (more fellowship, delayed entry, concentrated in exposed specialties) **with no compensation channel at all**.

**Two specific points the model rules out:**

- ① **The outside option's value does not depend on wages.** But fellowship is an *investment* whose payoff is a future wage (the paper estimates fellows earn 5 log points more).
  - A rise in the wage level raises the return to **both** alternatives, so the net effect on entry is ambiguous. The model says it is unambiguously positive.
- ② **Utility is linear in  $\mathbb{E}[\log w]$ , so variance is irrelevant.**  $\sigma_\eta = 0.324$  is substantial.
  - A Dobbs-induced increase in compensation *uncertainty* is at least as plausible as a mean shift. A risk-averse physician facing higher variance delays.

**Maura:** let  $\sigma_\eta$  vary by repro-care  $\times$  post.

## Suggested Extensions/Additions/Etc.

- 1 **An event study by graduating cohort**, 2017–2024, for entry and for log salary. There is currently no pre-trend evidence anywhere in the paper.
- 2 **Year fixed effects in the occupational choice equation**, and **real** rather than nominal compensation, and report  $\alpha_{wage}$  both ways.
- 3 **A ban-state disamenity term** interacted with post-Dobbs, so the paper's own stated mechanism competes rather than being assumed away.
- 4 **Separate supply from demand**:  $\text{repro} \times \text{post} \times \text{destination}$  in the wage equation, plus the offer-count variable if NYRES records it.

- 5 **Leave-one-in by specialty**, with OB-GYN reported on its own
- 6 **What the non-entrants actually do**: the LPM run on all six activity categories
- 7 **Counterfactuals by subgroup** (OB-GYN alone; ban-state ties; residents vs. fellows), and at least one **forward-looking policy experiment**

- **The setting and data are excellent** and the career stage is genuinely understudied. I expect this to be a well-cited paper.
- **The structural apparatus is appropriate** to a national shock with no clean control group, and the cross-equation logic is clearly laid out.
- **My central concern is that the paper's conclusion is close to what its assumptions require.** The treatment group coincides with a specialty-market divergence; the wage response is identified without time controls; and compensation is the only mechanism given a parameter.
- **My concerns are “easily” fixable** Event study, time controls, a disamenity term, ...

**Maura:** I think this paper sincerely matters (not as easy for me to say with some of my IO colleagues...),

I truly enjoyed reading it and can't wait for the next iteration!

Thank You

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