Physicians for Human Rights

Cascading Harms:

How Abortion Bans Lead to Discriminatory Care Across Medical Specialties

Physicians for Human Rights Research Brief

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Acknowledgements

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Cover: A patient sits and waits during her intravenous chemotherapy treatment at Maryland Oncology Hematology in Frederick, Md.

Photo by Ricky Carioti/The Washington Post via Getty Images

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Glossary

- **Chilling Effect:** The "chilling effect" refers to a phenomenon where individuals or groups refrain from engaging in an action or expression for fear of running afoul of a law or regulation. Chilling effects generally occur when a law is either too broad or too vague. Individuals steer far clear from the reaches of the law for fear of retaliation, prosecution, or punitive governmental action.
- **Chronic Disease:** Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.
- **Cushing Syndrome:** Also known as hypercortisolism, Cushing syndrome is a rare hormonal condition caused by prolonged exposure to high levels of cortisol. This can result from the body producing too much cortisol (Cushing's disease) or from taking corticosteroid medications for other conditions. Symptoms include high blood pressure, diabetes, weight gain, muscle weakness, and bruising.
- **Dilation and Curettage (D&C):** A procedure in which the cervix is opened (dilated) and a thin instrument is inserted into the uterus to remove tissue from inside the uterus (curettage). It is used for both diagnostic and therapeutic purposes, including for first-trimester abortion or after a miscarriage to remove all pregnancy tissue.
- **Ectopic Pregnancy:** A pregnancy in a place other than the uterus, usually in a fallopian tube.
- **Estrogen Receptor-Positive Cancer:** Estrogen receptor-positive breast cancer happens when high levels of estrogen in breast cancer cells help cancer grow and spread. Patients with this type of cancer are more impacted by hormonal changes associated with pregnancy and hormonal birth control.
- **Family Medicine:** A medical specialty within primary care that provides continuing and comprehensive health care for the individual and family across all ages, genders, diseases, and parts of the body, including obstetric care.
- **Hypertensive Disorders of Pregnancy:** Hypertensive disorders of pregnancy (HDPs) are a group of conditions characterized by high blood pressure during pregnancy, and they can pose significant risks to both the mother and the baby. These disorders include chronic hypertension, gestational hypertension, preeclampsia, and eclampsia. HDPs are a leading cause of maternal and perinatal morbidity and mortality.
- **Maternal-Fetal Medicine (MFM) Specialist:** Also known as a perinatologist, an obstetrician-gynecologist with additional training in caring for pregnant patients with high-risk pregnancies.
- **Maternal Morbidity:** Any health condition attributed to and/or complicating pregnancy, and childbirth that has a negative impact on the woman's well-being and/or functioning. As opposed to maternal mortality, which refers to deaths associated with pregnancy and birth, morbidity refers to harm to living patients.
- **Medication Abortion:** The use of medications to induce abortion. The World Health Organization endorses two regimens: one is the combination of mifepristone and misoprostol and the other uses misoprostol alone.
- **Medical Exception:** A medical exception to an abortion ban allows for the procedure to be performed when the pregnancy poses a serious threat to the pregnant person's life or health. Exceptions to state abortion bans generally fall into four general categories: (i) to prevent the death of the pregnant person, (ii) to preserve the health of the pregnant person, (iii) when the pregnancy is the result of rape or incest, and (iv) when the embryo or fetus has lethal anomalies incompatible with life.
- **Methotrexate:** Methotrexate is the preferred treatment for ectopic pregnancies. Originally developed as a chemotherapy, methotrexate is used to treat a wide range of solid and blood cancers including breast cancer, lymphoma, osteosarcoma, leukemia, lung cancer, and others. In lower doses, the drug is also used as an immune system suppressant and considered first line treatment for conditions including rheumatoid arthritis, psoriatic arthritis, juvenile idiopathic arthritis, and other inflammatory arthidites; Crohn's disease; Irritable Bowel Disorder; Atopic Dermatitis; vasculitis; multiple sclerosis; Lupus; sarcoidosis, and more. Due to its versatility, methotrexate is listed on the World Health Organization's Model List of Essential Medicines.
- **Mifepristone (Mifeprex/Korlym):** Mifepristone is a progesterone blocker that was approved in 2000 by the U.S. Food and Drug Administration for use in medical termination of pregnancy and is typically used in a two-drug regimen with misoprostol. It is also the preferred treatment for management of early pregnancy loss, endometriosis, and uterine fibroids. On its own, mifepristone is also used to treat Cushing's syndrome under the brand name Korlym, as well as for use as a low-dose emergency contraceptive.

- **Misoprostol:** Misoprostol is a synthetic prostaglandin E1 analogue that is used off-label for a variety of indications in the practice of obstetrics and gynecology, including medication abortion, medical management of miscarriage, induction of labor, cervical ripening before surgical procedures, and the treatment of postpartum hemorrhage. Alongside mifepristone, it is part of the two-drug regimen approved to provide medication abortions in the United States. Due to its wide-ranging applications in reproductive health, misoprostol is on the World Health Organization's Model List of Essential Medicines.
- **Neoadjuvant Chemotherapy:** Neoadjuvant therapy aims to shrink cancerous tumors before surgery. It is a treatment for many kinds of cancer. Chemotherapy, hormone therapy, and radiation therapy are common types of neoadjuvant therapy. Treatment may last weeks, months, or up to a year before surgery. Most people have surgery within a month after completing treatment.
- **Obstetrics-Gynecology (OB-GYN):** The medical specialty that encompasses the two subspecialties of obstetrics (care of pregnant patients) and gynecology which focus on reproductive health and pregnancy.
- **Preterm Premature Rupture of Membranes (PPROM):** A condition where the pregnant person's amniotic sac (bag of water) breaks prior to 37 weeks' gestation and prior to the onset of labor. Delivery occurs within one week of PPROM in 50 percent of patients.
- **Pulmonary Hypertension (PH):** Pulmonary hypertension is high blood pressure in your pulmonary arteries, which carry oxygen-poor blood from your heart to your lungs. Without treatment, PH can result in heart failure, pulmonary damage, or death.
- **Qualitative Research:** A type of research that gathers and analyzes nonnumerical data in order to gain an understanding of individuals' social reality, including understanding their perceptions of their experiences, attitudes, beliefs, and motivations.
- **Risk Evaluation and Mitigation Strategy (REMS) Protocol:** A Risk Evaluation and Mitigation Strategy Protocol is a drug safety program that the U.S. Food and Drug Administration can require for a certain medication with serious safety concerns to help ensure the benefits of the medication outweigh its risks. REMS use risk minimization tools to reinforce behaviors and actions that support the safe use of that medication. A REMS can be required pre-approval or post-approval if new safety information is identified.
- **Rheumatoid Arthritis (RA):** Rheumatoid arthritis is a chronic inflammatory disorder which causes the body's immune system to mistakenly attack the lining of the joints – called the synovium – causing inflammation and pain and potentially leading to joint damage and other health problems. As an autoimmune condition, the inflammation (swelling) that comes with RA can also affect other body parts, including the eyes, skin, heart, nerves, blood, or lungs.
- **Self-Managed Abortion:** Where a pregnant person performs their own abortion outside the formal health care system.
- **Shared Decision-Making:** A collaborative process where health care providers and patients work together to make informed decisions about tests, treatments, and care plans, considering both medical evidence and the patient's personal values, goals, and circumstances. It is a core component of patient-centered care, empowering patients to actively participate in their health care by understanding their options and their potential benefits and risks.
- **Spontaneous Abortion:** Also called a miscarriage, it is the loss of a pregnancy before 20 weeks' gestation.
- **Standard of Care:** Treatment that is accepted by medical experts as the most appropriate for a certain type of disease in a particular setting and is widely used by health care professionals. Also called best practice, standard medical care, best available therapy, and standard therapy.
- **Teratogen:** A teratogen is any agent that causes an abnormality following fetal exposure during pregnancy. These abnormalities can range from minor to significant, including causing increased risks for pregnant women. For example, fetal exposure to the acne drug Accutane of the anti-seizure medication Dilantin and Depakote can result in anencephaly, a fatal condition where the fetal brain does not develop, leading to open cavities in the head, which can increase the risk of maternal infection and postpartum hemorrhage.

Executive Summary

Since the U.S. Supreme Court ruled to overturn the federal constitutional right to abortion in *Dobbs v. Jackson* in June 2022, 28 states have introduced legislation banning or curtailing access to abortion care.[1] Most of this legislation includes criminal or civil penalties on health care providers who provide abortion care. Physicians for Human Rights (PHR) and partners have conducted research with health care providers in Oklahoma, Idaho, Louisiana, and Florida to document the multiple ways that state abortion bans have harmed the health of pregnant patients.[2] In this research, providers repeatedly emphasized the cascading impact of abortion bans on other forms of care and the need for peer clinicians from multiple specialties to work together to address restrictions that impede quality of health care.

To further investigate the impact of abortion bans on health care beyond reproductive health care, PHR conducted 33 semi-structured interviews with physicians from reproductive and non-reproductive health specialties across 20 states in three different policy environments: states with abortion bans before 12 weeks, states with abortion bans after 12 weeks, and states with abortion protections. PHR's research team spoke with physicians providing reproductive health care (specialties included obstetrics-gynecology, family medicine, and emergency medicine) to understand the continued and changing impacts of abortion bans on reproductive health care beyond abortion provision three years post-*Dobbs*. Our research team also interviewed physicians from non-reproductive health specialties – such as rheumatology, dermatology, pulmonology/critical care medicine, oncology, hematology, neurology, and cardiology – who regularly prescribe teratogenic medications, treat patients with health complications that are contraindicated for continuing pregnancy, or treat patients who develop medical conditions (e.g., cancer) for which immediate treatment would necessitate abortion care.

Our research highlights how abortion bans and restrictions create cascading effects that extend far beyond reproductive health care, compromising the quality and effectiveness of medical care across reproductive and non-reproductive specialties. As one participant in a state with abortion protections stated:

> "It's really, really, really hard to document all of the ways that these laws are harming and frankly killing women. And so when we get the report that these are the number of women who died because of restricted access to [abortion] care, that number is 100 percent going to be an underestimate. We are not going to include in that number the women who had pulmonary hypertension and their doctor didn't talk to them about abortion as an option. We're not even going to know about the women who wanted abortion but couldn't put together the resources to get out of state to get that abortion. There are so many women that it is going to be impossible for us to consistently count how many are going to be harmed, that are women who are going to have a complication that isn't going to be addressed until it's too late and they lose their ovary or they lose their uterus and they lose their ability to have children forever. That's another thing that's going to be so hard for us to count and say, 'This is the impact of this law'."
> *Participant 25*

These restrictions have hindered the ability of providers in diverse medical fields to follow evidence-based practices and standards of care, creating a pervasive chilling effect that results in substandard care and discriminatory treatment for reproductive-age women and pregnant patients.

Physicians highlighted:

- Delays in care for patients who experienced complications from acute or chronic medical conditions during pregnancy.
- Delays and denials of abortion care in cases of worsening acute and chronic medical conditions during pregnancy.
- Changes in prescribing teratogenic medications to reproductive-age patients due to a fear that patients might become pregnant and be unable to access abortion care, with particular impacts on individuals from marginalized communities and lower socioeconomic statuses.

- Physician concerns about including abortion care as a possible option when counseling patients in the face of severe comorbid medical conditions in pregnancy.
- Difficulty with pharmacies dispensing medications associated with pregnancy termination, such as mifepristone and misoprostol.
- Continued fear of providing abortion care under confusing exceptions and severe criminal and civil penalties in state-level abortion bans.

The striking similarity of these impacts across both reproductive and non-reproductive specialties highlights the urgent need for joint action across medical specialties to prevent further restrictions, including on medications used for abortion. The findings add to a strong and growing body of evidence of the chilling effect of abortion bans on the provision of high-quality, evidence-based health care and their adverse impact on pregnant and reproductive-age patients.[3] As an obstetrician-gynecologist in a state with an abortion ban before 12 weeks shared:

> "I had a patient the other day who came to me at 15 weeks and had chronic kidney disease. And at the start of her pregnancy her creatinine was 4 [normal range is generally up to about 1.1 mg/dL for women depending on lab and muscle mass], which is not a good predictor of a healthy and uneventful pregnancy. And by the time she had gotten to us at 15 weeks, her creatinine was [at a dangerously high level] .... But if you just were to look at her and talk to her, you would say, 'Oh, you're stable, you look healthy.' The problem here is that many people are construing threat to maternal life as actually seeing a sick person in front of them, a physically ill-appearing sick person, and kind of just disregarding all of our training and evidence-based education to know that a rising creatinine, although someone might not physically look ill, is an extremely concerning sign in early pregnancy. And one that without a doubt will become worse as the pregnancy progresses .... And what we are doing is sitting and waiting almost for irreversible damage to occur before we do something and offer them [abortion care]."
> *Participant 3*

At their core, these restrictions – both current abortion bans and proposed measures to further restrict mifepristone and misoprostol access by the U.S. Food and Drug Administration and state governments – are attacks on science, health care, and medical and individual autonomy. As physicians described, the failure to provide patients with the full range of options for treatment, including the option for abortion care, harms treatment practices for a wide variety of conditions and results in discriminatory care for patients.

These shared and widespread impacts of abortion restrictions highlighted in this research reinforce the need for physicians and other clinicians across specialties to engage in joint advocacy to ensure that additional rollbacks, such as restrictions on mifepristone and misoprostol, do not go into effect. These restrictions do not just harm reproductive health; they undermine the fundamental principles of medicine by restricting clinical autonomy, limiting physicians' ability to counsel patients effectively, and preventing them from offering the most effective treatments. Health care professionals have an obligation to stand against policies that interfere with their duty of care and deny patients the right to comprehensive medical care to help ensure that patients can make the best decisions for their health and lives.

These shared and widespread impacts of abortion restrictions highlighted in this research reinforce the need for physicians and other clinicians across specialties to engage in joint advocacy to ensure that additional rollbacks, such as restrictions on mifepristone and misoprostol, do not go into effect.

Based on these findings, Physicians for Human Rights recommends the following:

To the U.S. Government and Congress:

- Enact and implement national laws and policies that ensure rights and remove barriers to abortion care and maternal health care.
- Ensure that all people can access comprehensive reproductive health care with dignity, free from discrimination and criminalization, regardless of where they live.
- The U.S. Food and Drug Administration (FDA) must refrain from further restrictions on the medications mifepristone and misoprostol given rigorous evidence of their safety.
- Continue and reaffirm the longstanding interpretation that the Comstock Act does not apply to the mailing of medication or supplies for legal abortion.
- Monitor the impact of abortion bans on the provision of reproductive and other health care and on health inequities, including by employing U.S. Congressional authority to investigate discrimination in programs and services funded by the U.S. Department of Health and Human Services.
- Support legislation that prohibits clinicians' civil or criminal liability, disbarment, loss of license, or other retribution or reprimanding measures where clinicians provide life- or health-preserving abortion care in line with medical standards.

To State Governments and Legislatures:

- Repeal state-level abortion bans as well as all other restrictive laws and regulations that effectively obstruct access to abortion. This includes enacting legislation that:
  - Decriminalizes abortion and removes professional, civil, and criminal penalties for health care workers who provide abortion care to patients.
  - Repeals laws that could be used to prosecute or penalize people for having an abortion, including a self-managed abortion, assisting another person to access abortion care, or for pregnancy outcomes.
  - Removes all medically unnecessary requirements for provision of abortion care.
  - Establishes shield laws to protect patient access to abortion and protect health care providers.

To Health Care Providers and Institutions:

- Speak out against laws criminalizing abortion or otherwise restricting access to abortion, including by raising awareness of the harms caused to patients and health care systems and ensuring clinicians are not prohibited by their medical institutions from speaking out against such laws.
- Assist clinicians in navigating abortion bans and restrictions and providing patients with the proper standard of care, including by providing them with accurate and up-to-date legal guidance as well as guaranteed and timely legal support for abortion-related investigations or legal proceedings.
- Continue to support clinicians and medical students of all specialties to attend trainings on abortion and other reproductive health care, including clinical training and ethical guidance.

To State and National Medical Associations:

- Vigorously advocate for the repeal of abortion bans and restrictions and continue to speak out against the range of injuries – criminal, civil, and moral – caused by abortion bans and restrictions.

Introduction and Background

Since the U.S. Supreme Court ruled to overturn the federal constitutional right to abortion in *Dobbs v. Jackson* on June 24, 2022, 28 states have introduced legislation banning or curtailing access to abortion care.[4] Most of this legislation includes criminal or civil penalties on health care. Physicians for Human Rights (PHR) and partners' previous research with health care providers in Oklahoma, Idaho, Louisiana, and Florida documented multiple ways that state abortion bans have harmed the health of pregnant patients.[5] Participants in these studies repeatedly emphasized the cascading impact of abortion bans on other forms of care and the need for peer clinicians from multiple specialties to work together to address restrictions that impede quality of health care.

This new research from PHR further investigates the impact of abortion bans on health care beyond reproductive health care; the findings add to a strong and growing body of evidence of the chilling effect of abortion bans on the provision of high-quality, evidence-based health care and their adverse impact on pregnant and reproductive-age patients.[6] Documented accounts of patients – including girls as young as eight years old – being denied access to chronic disease medication, chemotherapy, and other treatment options because of their potential for pregnancy exemplify how real and perceived fears of abortion bans erode medical choice and quality of care for reproductive-age women.[7] In some cases, patients opted to undergo elective hysterectomies in order to be able to use highly effective medical treatments that are teratogenic.[i][8] As of September 2022, more than 21 percent of the roughly 4,000 pregnant women diagnosed with cancer in the United States annually do not have the option of pregnancy termination in their home state, leading to increased financial, logistical, and emotional burdens on patients who cannot continue their pregnancies.[9] Yet, as obstetrician-gynecologist and reproductive rights advocate Caitlin Bernard, MD, noted, "While some cases are deemed newsworthy, these daily injuries and death are not even counted, much less made public. Nobody will ever know how many women have been harmed or died because of abortion bans preventing appropriate medical care."[10] This brief adds to that body of research by underscoring how these harms persist in reproductive health medical specialties three years post-*Dobbs* and extends this work to examine how abortion bans are impairing the care provided by physicians in non-reproductive medical specialties to reproductive-age women and pregnant patients.[ii]

From March to July 2025, PHR researchers conducted 33 semi-structured interviews with physicians in 20 states from a variety of specialties, including cardiologists, oncologists, hematologists, critical care pulmonologists, dermatologists, gastroenterologists, rheumatologists, and reproductive health care providers including obstetrician-gynecologists and emergency and family medicine physicians. Our research –which focused on three different policy environments: states with laws protecting the right to abortion care, states with abortion bans at or after 12 weeks, and states with abortion bans before 12 weeks – has confirmed ongoing chilling effects from restrictive laws on health care in states with abortion and gestational age bans post-*Dobbs*.

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i *Teratogenic* refers to something that can cause or increase the risk of birth defects in a developing fetus or embryo. These defects can range from physical malformations to functional abnormalities and even issues with growth and development. Essentially, a teratogen is any agent that disrupts normal fetal development during pregnancy.

ii Not all pregnancy-capable people identify as women. However, for the purposes of this report, we will use the term "reproductive-age women" to discuss discriminatory care by gender and the term "patient" when referring to individuals who are pregnant.

To systematically examine ongoing impacts of current restrictive abortion laws and efforts to curtail access to mifepristone and misoprostol on care provided to reproductive-age women and pregnant patients by reproductive and non-reproductive medical specialists, PHR's research centered on three key research questions:

- How do abortion bans and restrictions continue to affect medical practice in reproductive and non-reproductive medical fields for pregnant and reproductive-age patients?
- How are medications used for abortion (mifepristone and misoprostol) and treatment of ectopic pregnancy (methotrexate) used in reproductive and non-reproductive physicians' practice of medicine, and what are their concerns about continued access or potential restrictions on these medications?
- How, if at all, have reproductive-age women and pregnant patients' health and human rights been affected by any impact on care identified through the two questions above?

The impact of abortion bans on broader health care for reproductive-age women and pregnant patients is vital to document. The prevalence of chronic and complex medical comorbidities among people of reproductive age continues to increase in the United States.[11] As of 2019, approximately one in three women of reproductive age had at least one chronic condition that could compromise their health or lead to adverse outcomes during pregnancy – and since then, that number has continued to increase.[12] Many women with chronic medical conditions are also on teratogenic medications for treatment that could cause severe maternal and fetal harm should pregnancy occur while on these medications.[13]

The examination room in reproductive health care clinic in Jacksonville, Florida
Photo by Joe Raedle/Getty Images

In addition, patients may develop medical conditions during pregnancy that will cause adverse health outcomes if pregnancy continues. For example, of the four million pregnancies that occur annually in the United States, between 40,000 and 160,000 of these pregnant women develop cardiovascular disease and roughly 4,000 to 6,000 pregnant women develop cancer.[14] Hypertensive disorders of pregnancy affect one in 16 pregnancies[15] The U.S. Centers for Disease Control and Prevention and the National Institutes of Health also highlight a number of conditions that could increase the risk of complications during pregnancy.[16] While complications might result in the need for emergency medical interventions such as abortion care, ambiguities in state criminal abortion laws deter providers from providing such care where the patient's condition is not immediately life-threatening.[17] These delays in treatment have already resulted in a documented increase in maternal morbidity.[18] Delays may further result in longer-term morbidity for patients who develop chronic conditions from unaddressed acute medical issues during pregnancy.[19] Additionally, patients with chronic health conditions or who are taking certain medications may have reduced options for contraception due to impacts on the effectiveness of hormonal contraception, and some studies have found increased risks of unintended pregnancy associated with chronic health conditions.[20]

Finally, state and national efforts underway to restrict medications associated with abortion care – mifepristone and misoprostol – also have adverse impacts on broader medical practice for both reproductive and non-reproductive health care. Such restrictions not only affect multiple aspects of reproductive health care, but likely also affect multiple medical specialties that rely on these medications for treatment of non-reproductive medical conditions. Despite state-level abortion bans, medication abortion in the United States grew from 53 percent of all abortions in 2020 to 63 percent in 2023.[21] The growth of telehealth provision of medication abortion is a major driver of this growth – seen after the U.S. Food and Drug Administration (FDA) removal of the Risk Evaluation and Mitigation Strategy (REMS) requiring in-person dispensing of mifepristone – as well as the existence of shield laws to protect physicians prescribing medication abortion to patients in states without access to abortion care.[22] In response to the growth of medication abortion, states such as Louisiana have sought to restrict access by reclassifying mifepristone and misoprostol as controlled substances, and other states have also put forward similar legislation.[23] Furthermore, there are a variety of efforts underway at the national level to further restrict the use of mifepristone and misoprostol, including legislation to ban the import of these drugs into the United States and reinstate the REMS protocol for these drugs and an FDA review of mifepristone, without clarity around what is being reviewed and despite strong peer-reviewed evidence establishing the safety of mifepristone over the last 25 years. Finally, there is ongoing concern that the existing U.S. Department of Justice Office of Legal Counsel guidance on non-application of the Comstock Act to the mailing of medications used for legal abortion[iii] could be rescinded and the Comstock Act[iv] enforced, making the mailing of mifepristone, misoprostol, and potentially other instruments used in abortion and reproductive health care illegal nationally.[24]

These and other measures seek to curtail access to medications used for medication abortion both in states with abortion bans and those that now protect the right to abortion care.[25] Such restrictions would affect multiple aspects of reproductive health care and treatment of non-reproductive medical conditions. Some media accounts and research articles suggest that this is the case.[26]

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iii The 2022 memo from the U.S. Department of Justice Office of Legal Counsel explained its longstanding position that the law applied only to unlawful abortion and given the myriad lawful uses of common abortifacients, the mailing of medications, alone, was insufficient basis to prove unlawful intent.

iv The Comstock Act is an obscure federal obscenity statute from 1873 criminalizing the use of the post office to mail material of an "obscene, lewd, [or] lascivious" nature which holds a "vulgar or indecent character." The law also prohibits "any article or thing designed or intended for the prevention of conception or the procuring of abortion, nor any article or thing intended or adapted for any indecent or immoral use or nature," unless that item is obtained via a "prescription of a physician in good standing, in good faith" (Lines 12-14).

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Medical Uses of Mifepristone, Misoprostol, and Methotrexate

Mifepristone, misoprostol, and methotrexate are on the World Health Organization's list of essential medications,[27] and have decades of data proving they are safe and effective.[28] The FDA approved mifepristone in 2000 as Mifeprex for the medical termination of intrauterine pregnancy, to be used in a regimen with misoprostol.[29] Mifepristone was also approved by the FDA in 2012 under the brand name Korlym for treatment of Cushing syndrome.[30] While these are the only indications of mifepristone that are FDA approved, the mifepristone/misoprostol regimen is also used for miscarriage management.[31] There are other investigational uses of mifepristone in the United States and other countries that could be approved as new drug applications, including treatment for mental health and neurological conditions such as depression, dementia, post-traumatic stress disorder, Gulf War syndrome, delirium, suicide, psychosis, catatonia, and cognitive deterioration; cancers – particularly breast cancer; and other conditions such as endometriosis, uterine fibroids, non-hormonal birth control, and emergency contraception.[32] Scientists, including those with whom PHR spoke, involved in clinical trials for other uses of mifepristone have also expressed concerns about how the political climate and further restrictions on mifepristone could impact the future of these studies.[33]

Misoprostol is currently FDA approved for treating gastric ulcers induced by nonsteroidal anti-inflammatory drugs.[34] However, it is commonly used internationally as a single-drug medication abortion regimen,[35] and in the United States in obstetrics to support cervical ripening, induce labor, stanch postpartum hemorrhage, and manage other conditions related to abnormal bleeding such as fibroids.[36] A recent study of patient claims data in states that have introduced legislation to make mifepristone and misoprostol controlled substances found that "about half of outpatient claims for misoprostol in Texas and Missouri Medicaid, and a third in Kentucky and Louisiana were used to manage miscarriages. About one in five were used for other pregnancy-related reasons, such as induction of labor or to manage pregnancy-related hemorrhages in Texas, Missouri, and Louisiana."[37] Of the non-abortion claims for mifepristone, the vast majority of patients had a miscarriage diagnosis.

Methotrexate is an immune modulator medication that interferes with DNA replication, thus slowing down replication of cells. Methotrexate is not generally used for termination of intrauterine pregnancies, although it has been studied for this use in early pregnancy combined with misoprostol.[38] However, due to its use in treatment for ectopic pregnancies, there have been national reports of pharmacy denials of methotrexate and physicians uncertain if they can provide early treatment for ectopic pregnancies using methotrexate.[v39] Methotrexate is considered a teratogenic medication and has many non-reproductive health uses including treatment for cancers such as central nervous system lymphoma; rheumatoid or psoriatic arthritis; autoimmune conditions such as myositis, mixed connective tissue disease, or scleroderma; inflammatory bowel diseases such as Crohn's disease and ulcerative colitis to prevent inflammation and flares, or scleritis; and eczema.[40] In one national analysis of prescription claims data, among those who were not pregnant, more than half (55 percent) of reproductive-age women with a claim for a methotrexate prescription had a diagnosis code for rheumatoid arthritis at some point during the year. Nearly one-third (33 percent) had a diagnosis for another autoimmune disease and just over one in five (18 percent) had a cancer diagnosis at some point in the year.[41]

v In some states ectopic pregnancy is considered as a medical exception to abortion bans, while in other states these exceptions are not made or are not clear. (Source: https://www.kff.org/womens-health-policy/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/).

Research Methodology

From March to July 2025, Physicians for Human Rights' (PHR) conducted outreach to health care providers in the team's professional networks to identify physicians in both reproductive health and non-reproductive health medical specialties who care for reproductive-age women. These contacts facilitated outreach to physicians in three different policy environments: states with abortion bans before 12 weeks, states with abortion bans at or after 12 weeks, and states with abortion protections. PHR's research team then used snowball sampling, an established sampling strategy for research on hard-to-reach populations or sensitive topics, which has been used to conduct qualitative research in comparable studies. PHR conducted additional targeted outreach for representation across state policy contexts and medical specialties (Table 1).

PHR's research team conducted a total of 33 semi-structured interviews. The team spoke with 16 physicians providing reproductive health care (specialties included obstetrics-gynecology, family medicine, and emergency medicine) to understand the continued and changing impacts of abortion bans on reproductive health care beyond abortion provision three years post-Dobbs. The team also interviewed 17 physicians from non-reproductive health specialties who regularly prescribe teratogenic medications or treat patients with health complications that are contraindicated for continuing pregnancy. These specialties included: rheumatology, dermatology, pulmonology/critical care medicine, oncology, hematology, neurology, and cardiology. In addition, PHR's research team spoke with several endocrinologists about prescribing Korlym (mifepristone) for Cushing syndrome, as well as researchers involved in clinical trials[42] and the compassionate use program[43] about other uses of mifepristone. Because some physicians in states with abortion bans feared that they might be identified should their state be named alongside their specialty, states are characterized by one of the three policy contexts rather than specifically named. Classification of states was determined based on status assigned in the Guttmacher Institute's U.S. State Legislation Map.[44] (See Table 1)

Table 1: Participant Geographies and State Classification

States with abortion bans before 12 weeks: States with extremely hostile environments with enacted legislation that overwhelmingly bans abortion, including gestational bans before 12 weeks, and may include civil or criminal penalties for physicians or others who assist in procuring or providing abortion services and/or medication.	• Alabama • Florida • Georgia • Idaho • Indiana • Iowa • Louisiana • South Carolina • Texas
States with abortion bans after 12 weeks: States that have enacted mixed legislation that restricts access to abortion, including gestational bans at or after 12 weeks, and targeted regulation of abortion providers (TRAP)[vi] laws, though patients and providers retain some access and/or protections.	• Arizona • Kansas • North Carolina • Virginia • Wyoming
States with abortion protections: States that have enacted protections for patients and providers.	• California • Massachusetts • Michigan • Minnesota • Maryland • Washington

vi TRAP laws are laws that are enacted to place additional restrictions on abortion clinics and providers, beyond what is necessary to ensure patient safety, with the effect of shuttering clinics and making care more challenging. (Source: https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers).

Physicians consented to 30- to 45-minute confidential interviews. Interview guides were developed based on the research team's expertise and conversations with partner organizations. Transcripts were deidentified and cleaned by interviewers, and data was stored on a password-protected server and only accessed by the research team. Study recruitment ended when the data reached concept saturation, the point at which no new themes emerged from additional interviews. Thematic analysis was used to identify experiences across interviews. Three interviewers read transcripts of the clinician interviews and identified key themes emerging from the data (inductive analysis) and based on the research questions (deductive analysis) to develop a codebook. Four members of the research team double coded the data. Illustrative quotes were selected based on key themes.[vii] PHR's Ethics Review Board approved the study with exempt status.

A doctor with the Department of Obstetrics and Gynecology at the University of New Mexico discusses the procedure for getting a medication abortion to her patient as her child plays on the ground at a clinic in Albuquerque, New Mexico.

Photo: Gina Ferazzi / Los Angeles Times via Getty Images

vii Quotations have been edited for clarity and concision.

> "It's really, really, really hard to document all of the ways that these laws are harming and frankly killing women. And so when we get the report that these are the number of women who died because of restricted access to [abortion] care, that number is 100 percent going to be an underestimate. We are not going to include in that number the women who had pulmonary hypertension and their doctor didn't talk to them about abortion as an option. We're not even going to know about the women who wanted abortion but couldn't put together the resources to get out of state to get that abortion. There are so many women that it is going to be impossible for us to consistently count how many are going to be harmed, that are women who are going to have a complication that isn't going to be addressed until it's too late and they lose their ovary or they lose their uterus and they lose their ability to have children forever. That's another thing that's going to be so hard for us to count and say, this is the impact of this law."
> *Participant 25*

Restrictive Abortion Laws Continue to Adversely Affect Care for Pregnant Patients, Causing Harm

In discussing the ongoing impacts of abortion bans on broader health care, physicians outlined how fear of criminalization for providing abortion care continues to result in delays in care and worsening maternal health outcomes. Reproductive health physicians in states with abortion bans described being overwhelmed with transfers of pregnant patients from other health systems in their states and by increased numbers of pregnant patients facing obstetric complications presenting at their emergency departments. As one obstetrician-gynecologist (OB-GYN) from a state with an abortion ban before 12 weeks recounted:

> "I'm actually seeing a lot of these patients come into our emergency rooms asking for abortion care at later gestational ages with worsening maternal condition because they've been waiting, and [having] pending appointments and haven't been seen. So, it's really not an ideal kind of situation as the provider, because it's a more complicated procedure at that moment."
> *Participant 3*

The same OB-GYN gave an example of a recent pregnant patient with chronic kidney disease (CKD), whose kidney condition had progressively deteriorated while being sent to different facilities due to reluctance to provide abortion care:

> "I had a patient the other day who came to me at 15 weeks and had chronic kidney disease. And at the start of her pregnancy her creatinine was 4, which is not a good predictor of a healthy and uneventful pregnancy. And by the time she had gotten to us at 15 weeks, her creatinine was [at a dangerously high level]. And that's a perfect example of someone who kind of was bounced around from clinic to clinic, obviously knowing that a rising creatinine is concerning. But if you just were to look at her and talk to her, you would say, 'Oh, you're stable, you look healthy.'"
> *Participant 3*

This OB-GYN explained how pregnant patients often appear healthy, even while lab and other measures show increasingly dangerous medical conditions, until health harms become severe, irreversible, or life-threatening:

> "The problem here is that many people are construing 'threat to maternal life' as actually seeing a sick person in front of them, and kind of just disregarding all of our training and evidence-based education to know that a rising creatinine, although someone might not physically look ill, is an extremely concerning sign in early pregnancy. And one that without a doubt will become worse as the pregnancy progresses. If there's one

> organ that is extremely vulnerable to the demands and the changes of pregnancy and cannot compensate, it is the kidney. And what we are doing is sitting and waiting almost for irreversible damage to occur before we do something and offer them [abortion care]."
> *Participant 3*

A recent simulation study estimated that in a cohort of 31,243 patients with CKD who were unable to receive a desired abortion because of abortion bans, 27 percent of these patients would progress in CKD staging, with three percent progressing to end-stage renal disease (ESRD). Alternately, living in a state with abortion access resulted in just 11 percent of patients progressing in CKD staging, with only 0.001 percent progressing to ESRD – due to the baseline progression of the disease.[45] These examples highlight how patients with chronic health conditions who do not receive abortion care experience increased maternal morbidity.

An OB-GYN in a state with an abortion ban before 12 weeks recounted that many physicians in all specialties were leaving their state due to abortion bans combined with other restrictive laws, such as those against gender-affirming care. They explained that not only had this exodus of physicians from the state created even more "maternity care deserts" where there were no reproductive health care providers, but also the departure of medical specialists like gynecologist-oncologists had placed additional burdens on those physicians who remained in the state. The OB-GYN described having to provide medical care to their patients outside their scope of practice because of this lack of specialists:

> "So, all my cancer patients, what ends up happening is if they can't leave, drive or whatever, they wait forever to get into the one person in the metro area or they drive two and a half hours to the [academic practice] to be seen. And then what happens is they do their surgery, but then they can't go back there. So, they end up [here]. I'm doing all of the follow up cancer care, but I'm not an oncologist. And it's fine, I'll do it. But I am like, 'Will you please give me super detailed instructions as to like, exactly what you want me to do?' Because it's actually, like, scary because I don't do that. Like, I will, right? [Because] what is the option? This patient is saying they will not drive two and a half hours. Fine. So they'll either not get care or I'll do the best that I can. So yeah, I'll just do the best that I can."
> *Participant 6*

Abortion Bans Cause Delays in Emergency Care for Pregnant Patients Across Specialties

Physicians across specialties emphasized the importance of being able to take immediate action when pregnant patients face medical emergencies. Interviewed physicians described three categories in which delays in necessary termination of pregnancies would seriously jeopardize the health of pregnant patients: (i) ectopic pregnancies, especially if there was still fetal cardiac activity; (ii) pre-viable premature rupture of membranes where sepsis had not yet occurred; and (iii) patients with chronic or acute non-pregnancy-related medical emergencies.

An emergency medicine physician in a state with an abortion ban before 12 weeks recalled multiple cases that exemplified the harm of criminalization leading to delays in care:

> "The majority of people we see are not dying, but when somebody is coming in front of us and they are dying, we have to be able to think on our toes and make split second decisions. And the last thing that we need is to have to stop and consider a law …. For instance, one patient, her beta HCG was like 8,000, which would indicate that this is probably an ectopic pregnancy. But instead [of receiving treatment], the patient was sent home because they couldn't see anything and so was told to come back in a couple days to get repeat blood work. Well, 12 hours later, the patient ended up having a ton of bleeding and pain at home and came in and she had a ruptured ectopic and was completely unstable."
> *Participant 31*

They described several cases of patients experiencing health harms from delays caused by uncertainty about whether a pregnant patient's health condition met legal criteria to offer abortion care. As one example:

> "It was like in the middle of the night ... and this woman comes in and she's bleeding, and she [was] somewhere in the first trimester. So, it was an incomplete abortion or incomplete miscarriage, but the fetus still had a heartbeat. And so, we called the OB-GYN on call, who ... wanted to consult with the legal team before coming down to help. At the moment that I called, that was okay, the patient was stable. Their heart rate was a little bit high, maybe like 105, but her blood pressure was fine .... She was bleeding, but it was not like pouring out. But then like a half hour goes by and I call back and I'm like, 'Hey, what's going on? Like, I need you to come down here and take care of this patient. The bleeding is getting heavier, the blood pressure starting to drop, heart rate's starting to go up.' And then by the time they got down, the patient was very unstable. Ultimately, the patient got the [abortion] that she needed, but by then there were complications with it. Ultimately, she ended up getting a hysterectomy. And now this was her first and unfortunately her last pregnancy. This did not need to happen."
> *Participant 31*

Another OB-GYN in a state with an abortion ban before 12 weeks noted how the constellation of abortion bans and chilling effect on providing abortion care continues to result in delays in care and increased patient complications:

> "I know of a patient who was on the border [between states with early gestational age limits], who went to the other state to get IVF [in vitro fertilization], came back home to have a baby, and had a medical complication. That hospital administrator told her we couldn't take care of you in [her state with a six-week ban]. She went back to where she got IVF, which was also a state with a [later gestational-age abortion] restriction and she was too far along, so then she had to go to a third state. And then by the time she got there she was septic. So, this is very unfortunate care all around and completely could have been avoided if she had [received the needed abortion care] in her own state."
> *Participant 6*

The same chilling effect resulting in delays in care that reproductive health care physicians reported were also experienced by other specialists when caring for pregnant patients. A pulmonologist/critical care medicine physician in a state with abortion protections described how uncertainty about care for critically ill pregnant patients created by restrictive abortion laws in other states has had a chilling effect on practice even in their state:

> "Longstanding medical practice has always been that you optimize care for the person in front of you. Your patient is a person, the fetus is not a person, and so you save the person first. And so, we now have to go through with each new group of learners, each new group of nurses, we bring the OB-GYNs to the bedside to make sure we have the conversation about in the event of a life-threatening emergency, how do we optimize this? People need a fair amount of reassuring that they can practice good medicine and won't get in trouble for it, even here in a state where [abortion] is fully legal, just because no one's quite sure."
> *Participant 21*

The perceived need to institute additional training for health care practitioners even in abortion protective states shows the ripple effects that bans have on the practice of medicine. The critical care pulmonologist further explained the danger of even slight delays in acting in the face of a medical emergency:

> "The nightmare scenario is the case if a pregnant patient in the hospital for some medical condition codes [experiences a cardiac arrest]. [If that happens], you immediately deliver the fetus, even if the fetus is not viable. If you're trying to bring [the patient] back from the dead, you call OB-GYN right away. Like you open the abdomen immediately just like you would any other abdominal catastrophe and take the fetus out. That's a situation where even 10 minutes of screwing around trying to figure out 'Can we, should we, do we need to ask anyone if we can legally do this?' could be the difference between return of normal brain

> function or not for the patient. In these incredibly time sensitive moments where we're thinking about intubation or we're thinking about cardiac arrest resuscitation, how could it influence things by just making people stop and think? We do so much training so we can act immediately, almost automatically, and that is the right thing to do. We are trained that we can't stop to think, you just do the right thing then."
> *Participant 21*

The other critical care physicians we interviewed echoed these sentiments. They highlighted both how the practice of their specialty requires them to make quick decisions under pressure and ways that abortion bans cause unnecessary and life-threatening delays in care provision. This concern is especially salient as 75 percent of maternal deaths occur in critical care hospital settings.[46]

Abortion Bans Impact Care for Pregnant Women with Acute or Chronic Medical Conditions, Including Cancer

Many specialists outside of reproductive health care discussed treating patients with chronic medical conditions that might not meet the exceptions under state abortion bans.[viii] Physicians across specialties provided examples of serious medical conditions they treat that are not immediately life-threatening to a pregnant woman that they question whether these conditions would fall under many states' laws permitting abortion only where necessary to prevent the patient's death or substantial and irreversible impairment of a major bodily function.

In some of these cases, treatment for the medical condition required use of teratogenic medication. In a webinar organized by the American Society of Clinical Oncology, gynecologic oncologist Monica Vetter, MD, shared the story of a pregnant patient with a cervical mass who was denied an abortion by the hospital board because her cancer was not advanced enough, but was also denied effective chemotherapy to treat the mass because of her pregnancy. As she described, "So after we obtained this [cancer] diagnosis – again because of confusion and what was felt to be gray area in the law – it was determined that this patient was not eligible for a termination to pursue a standard oncologic treatment based on the Kentucky law at that time. And it was felt by the legal team that the definition of blood loss that she was having was not a life-threatening bleeding. So based on this, I did speak to her about transferring her to a state where evacuation of the uterus was possible. However, given a number of socioeconomic factors, my patient was not able to pursue this. So ultimately, we had to decide on what we were going to do for her cancer treatment and the setting of this pregnancy. We eventually proceeded with what's called neoadjuvant chemotherapy, which is chemotherapy that is administered to a patient prior to their definitive or their needed final cancer treatment. One of the challenging things for me as a cancer physician is that the decisions that I make for my patient and my recommendations for my patients should be based on evidence and research. I always want to follow standard of care in order to give my patients the best, again, oncologic outcome. But for this patient, standard of care was not an option for her."[47]

In an example from PHR's interview, a neurologist from a state with abortion protections described cases of central nervous system neoplasms that require teratogenic medications for treatment. While not immediately life-threatening, such cancers if not immediately treated would likely cause long-term health harm or premature mortality (Participant 17).

Several oncologists and hematologists provided PHR with numerous examples of serious cancers they treat that would not meet some state abortion bans' exceptions of being immediately life-threatening to the pregnant woman. As one oncologist in a state with an abortion ban after 12 weeks explained:

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viii Some state court decisions have clarified that medical conditions need not be immediately life-threatening under abortion ban exceptions if they ultimately increase the risk of death. *Oklahoma Call for Reproductive Justice v. Drummond*. (Supreme Court of Oklahoma 2023). (Source: https://statecourtreport.org/sites/default/files/fastcase/converted/Okla.%20Call%20for%20Reprod.%20Justice%20v.%20Drummond%2C%20Okla.%20120543.pdf)

> "In the case of, say, acute myelogenous leukemia, that would be considered an immediate life-threatening condition. That would probably be one of the only cancer diagnoses that would fly in these states that have outlawed abortion for everything except immediate risk to the mother. Because if they had breast cancer, I, as an oncologist, cannot prove that a woman will live only if they get treatment now and die by postponing it six months. And so many oncologists are therefore afraid to even discuss the potential benefit to the mother of getting an abortion. [In my hospital] physicians are afraid to even offer abortion as an option."
> *Participant 20*

In a 2024 survey of 1,254 medical oncology fellows,[ix] 33 percent reported that abortion restrictions affected their ability to deliver at least one aspect of quality care, including 22 percent reporting limited availability or delays in receiving medication, and 28 percent reported poorer job satisfaction.[48] For all nine measured aspects of quality care, reported ability to deliver each of these was strongly associated with working in a state without abortion restrictions ($p<0.001$). For example, 37 percent of fellows in abortion-restricted states reported reduced patient trust and relationship quality compared to 20 percent among those in states adjacent to bans and 18 percent among those in and adjacent to legal states ($p<0.001$).[49]

Physicians also described that the standard of care if a pregnant patient requires a teratogenic medication for treatment of an acute or worsening medical condition is to offer the option of abortion. To illustrate their standard practice, an oncologist in a state with an abortion ban before 12 weeks described the case of a recent patient who was diagnosed with an aggressive form of breast cancer in the first trimester of her desired pregnancy:

> "She had stage 3 estrogen receptor-positive and HER2 amplified cancer. This cancer has molecular markers that suggest that treatment would be wildly more successful with two targeted agents like Herceptin and Perzutamab that are not safe to give during pregnancy. Giving any chemotherapy at that point is not really safe. Sometimes you can get creative and offer other solutions to a patient like maybe surgery first to get them to the second trimester. That would not have been acceptable for this patient because I still wouldn't have been able to give her the most effective therapy I could. And for patients with ER positive and HER2 amplified cancer, when I can successfully give targeted therapy, I can eradicate the cancer in a complete response with neoadjuvant chemotherapy 80 percent of the time. And so, it's very effective therapy. If I'm not able to give that effective therapy, then I'm much less effective at curing the disease."
> *Participant 28*

The oncologist recounted that they recommended pregnancy termination and the patient elected to have an abortion in order to be able to undergo chemotherapy without delay:

> "And so that's an example where I would not have been able to deliver effective therapy in a timely way [if abortion were not an option]. She had a great response to therapy. We are already in discussions about how long she will have to wait before she attempts pregnancy again, because again, it was a very desired pregnancy. But I think that her chances of curing her breast cancer would have been substantially diminished if I were not able to deliver effective therapy. And so that was an informed discussion between me and the patient and that was how we both jointly decided to handle it. But I think her chances of being alive for her current children and for having other children in the future are very high because [we] were able to manage it that way. I feel like that offered the best outcome for the patient and her family."
> *Participant 28*

That oncologist said that while they were able to coordinate with an OB-GYN to provide this patient care, colleagues in rural parts of the state lacked the resources to provide this care due to the closure of abortion clinics and lack of termination services and more often had to send patients out of state.

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ix Thirty-four percent trained in states with abortion bans, 44 percent in states adjacent to states with bans, and 22 percent in and adjacent to states where abortion is legal.

An OB-GYN practicing in a state with an abortion ban after 12 weeks shared how fear of prosecution is leading to an influx of patients who had been denied abortion despite having cancer:

> "In [redacted state], we can still take care of patients with cancer who need an abortion [before the gestational limit], but we have seen referrals from other states because their doctors refuse to, or it doesn't fall in the parameters of their laws. It is something that absolutely happens. There are definitely situations that I've seen on more than one occasion where a patient [who came here for abortion care] was told in her home state that her pregnancy did not pose enough of a threat to her life, regardless of her cancer diagnosis and regardless of needing to delay the appropriate treatment for cancer. She should continue the pregnancy and then deal with the cancer diagnosis per their recommendations."
> *Participant 4*

Physicians across medical specialties described similar concerns about abortion care not being included as an option for pregnant women on or requiring teratogenic medications, which would result in health harms to patients and serious fetal birth defects. A general hematologist practicing in a state with abortion protections gave examples of patients who became pregnant while on highly teratogenic medications such as hydroxyurea for sickle cell disease or warfarin for anticoagulation, which might not fall under state abortion exceptions (Participant 22).

Non-reproductive Health Physicians Fear Legal Repercussions If Their Patients Receive Abortions – Even Though This Is Outside of Their Area of Practice

Much media coverage to date has focused on reproductive health physicians' fears of legal retaliation, such as that threatened by Texas Attorney General Ken Paxton toward OB-GYNs referring patients out of state for abortion care.[50] However, physicians in other specialties practicing in states with abortion bans also expressed fear of possible legal prosecution they might face for referring patients in need of abortion care. One oncologist in a state with an abortion ban before 12 weeks expressed their and their colleagues' fears of being prosecuted for referring patients to other states for abortion care:

> "Now we are seeing ourselves having to refer patients who need more immediate treatments that [are teratogenic or might themselves cause an abortion]. And so then we are the ones recommending the abortion. We're even putting our own staff at risk. And there are concerns about then putting additional burden on these patients that are already stressed by a cancer diagnosis or a cancer recurrence diagnosis and having to send them to another state where they can have the full array of treatment options. And then of course there's also the chilling effect of physicians not knowing what they can even say to patients anymore, which is really sad."
> *Participant 29*

Another oncologist who practiced in a state with an abortion ban after 12 weeks echoed fears about the threat of prosecution:

> "[We are experiencing] a lot of fear about threats of lawsuits if we try to help the patient cross the state line, you know, to get an abortion. We have a [professional oncology association] member in [redacted state with abortion ban] who's very vocal about this …. She's been threatened with lawsuits if she tries to facilitate [referring patients out of state]. She's feeling all alone."
> *Participant 26*

A pulmonologist in a state with abortion protections described conversations they had with colleagues in a neighboring abortion ban state who expressed fear of prosecution if they discuss termination of pregnancies with their patients with severe chronic conditions who become pregnant:

"In some instances, clinicians are interpreting [the laws] as, 'I can't talk to this patient about termination.' And that was something we heard from specialists in pulmonary hypertension. In other instances, we had critical care docs who told us that critically ill women showed up in my intensive care unit (ICU) who had these congenital heart problems or other conditions that had made pregnancy really unsafe for them. They hadn't been able to access abortion. And now they're critically ill in my ICU and I'm trying to just keep them alive. So, you have multiple pathways through which pulmonary and critical care doctors who don't think [that] abortion bans are going to affect them [are] being affected and they're being affected in ways that [are] really hard for us to measure."
Participant 25

One cardiologist in a state with an abortion ban before 12 weeks explained that preconception counseling for patients with chronic conditions such as pulmonary hypertension or severe cardiomyopathies for which pregnancy was not recommended now must include further warnings about legal treatment options should pregnancy occur:

"I've now had to add that since the laws have changed in our state, your options regarding termination are more limited than they used to be. I never used to talk about that before. I used to sometimes bring up that if there was a pregnancy and they were critically ill, that termination would be something we might recommend. But now I have this last piece that I say, which is, 'You would have limited options in this state. You might have to travel to another state.'"
Participant 34

Physicians Fear Legal Repercussions and Health Harms to Transferred Patients

A pulmonologist in a state with abortion protections described receiving patients who required abortion care due to their medical conditions from nearby states with abortion bans and the fear that comes with potential legal attacks from that state:

"Obviously when they're transferred to our state, our state's law is governing .... Although questions about whether those states will adopt Texas-like sort of vindictive components remain open."

They described some of the medical conditions of patients who had been transferred to their hospital for abortion care from other states:

"We have a very large pulmonary hypertension practice, [with patients] who end up in the ICU all the time [very] sick. And they are clearly patients who have to take medications that are teratogenic to manage their pulmonary hypertension. Standard counseling would be to approach pregnancy very carefully and with a lot of thoughtfulness ... I know my pulmonary hypertension colleagues in states with abortion bans have been concerned about pregnancy and then the women feeling they do not have the option to have an abortion…. Even in the best case, many patients with pulmonary hypertension die during pregnancy or at delivery. The rates are very high. Some women want to take that risk, and that is their decision, and you support that. But how awful to feel that you have no choice. I can't imagine that, but it is a fear. You know, a third group are transplant patients because the meds necessary to make transplant work are medications that fetuses should not be exposed to. And those patients need those medications. They should not get pregnant and should be given the option of abortion if they do."
Participant 21

An oncologist in a state with an abortion ban after 12 weeks further confirmed that she and her colleagues were referring pregnant patients out of state for abortion so they could undergo cancer treatment:

"And so that person would have to get counseled and go out of state, which is often very difficult as you know, for low income and other people who have a lot of barriers to going out of state. And they have to deal with all these while they have metastatic cancer."
Participant 26

Even when it is possible to transfer patients to another state for needed abortion care, physicians described concerns about health harms pregnant women faced from delays in care. As one OB-GYN in a state with an abortion ban before 12 weeks recounted:

"I think most people err on the side of not providing the care and referring them to someone else in the hopes that someone else can take care of them. And the downside of that is obviously when abortion is in the conversation, timely care is extremely important. And what happens to many of these patients is they're kind of bounced around, referred from one site to another site. It may be blatantly clear that abortion is ... important for the patient's health. But still, providers are kind of saying, 'I'm not sure what I can and can't do. You need to go someplace else or talk with someone else.' And what we're seeing at our doors here at the hospital is patients with later gestational ages, patients who are sicker."
Participant 3

Abortion bans often use non-medical language that can make them difficult to interpret, with some facilities interpreting the laws more restrictively and others more open to authorizing abortion care.[51] This experience was confirmed by several physicians who noted that interpretation of the abortion laws tended to vary by health care facility. One oncologist in a state with an abortion ban before 12 weeks explained that even in cases where their institution authorized an abortion, there still have been significant delays because of limited availability of services within their state. They recounted that several times in the past few years when a pregnant patient with cancer could not receive services within the state, they had to inform them of options outside of the state. They explained:

"Because of the concern around pregnancy termination and the repercussions and personal liability of pregnancy termination, the availability of termination services has become much more restrictive, more limited, or not available. There are fewer people and sites that are doing it because of the restrictions of the law .... In some rural areas of the state, those services are largely unavailable. And that has created a deficit in appropriate women's health services across the state."
Participant 29

Abortion Bans Impact Prescribing Standard of Care With Teratogenic Medications

Physicians Fear Prescribing Teratogenic Medications to Reproductive-Age Women, Even If They Are Not Intending to Become Pregnant

For women of reproductive age who suffer from chronic conditions such as sickle cell anemia, autoimmune or seizure disorders, or rheumatoid, psoriatic, or other inflammatory arthritides, often the most effective treatments include prescription of teratogenic or potentially teratogenic medications that cause or increase the risk of severe harms to a developing fetus or embryo and to the health of the pregnant patient. For example, these medications are often the best choice to enable patients with rheumatological conditions to be able to live without severe pain and progressive joint destruction and those with seizure disorder to live seizure-free, as well as to prevent progression of disease for patients with many conditions. It is the standard of care for physicians to discuss thoroughly with reproductive-age women who are prescribed teratogenic medications that they must stop these medications if they seek to become pregnant and that they must take effective, preferably long-acting contraception methods if they are sexually active.

Many neurological diseases also disproportionately affect women during their reproductive years, and many of the most effective medications for conditions such as multiple sclerosis, seizure disorder, migraine prevention, and a range of neuro-immunological disorders are highly teratogenic. A 2022 *Journal of the American Medical Association* perspective piece noted that while in neurology teratogenic drugs should only be prescribed when it is possible for women to plan pregnancies and prevent fetal exposure, it may not always be feasible to control the timing of teratogenic medication in the short-term treatment of certain disorders, such as medically refractory status epilepticus, infectious and autoimmune encephalitis, or vasculitis.[52]

For example, as of 2023, approximately 45 percent of reproductive-age women with rheumatoid arthritis (RA) and 30 percent of reproductive-age women with systemic lupus erythematosus are prescribed at least one teratogenic medication, such as the first-line medications[x] methotrexate or mycophenolate mofetil/mycophenolic acid.[53] Concerningly, physicians in multiple specialties practicing in states with restrictive abortion laws reported changes in their prescribing practices of highly effective, yet teratogenic medications, to reproductive-age women. One rheumatologist in a state with an abortion ban after 12 weeks noted the critical importance of highly teratogenic cytotoxic medications for treatment of many autoimmune diseases, which disproportionately affect women of reproductive age.[54] Yet, if taken during pregnancy, these medications may cause severe harms to the fetus and to maternal health. Thus, the rheumatologist reported that in light of the abortion ban in their state, they and their colleagues were becoming increasingly hesitant and more "defensive" about prescribing teratogenic medications to reproductive-age women. They reported that if they had any doubts about whether a patient was "*able to reliably take contraception*," they were not prescribing or might not "*even offer [teratogenic medications] as a treatment option*" (Participant 30).

With decreased access to in-state abortion care, most interviewed physicians in abortion ban states noted that they were spending much more time trying to ensure that their reproductive-age patients were on reliable contraception before prescribing teratogenic medications due to concerns about patients potentially becoming pregnant and having no options to access abortion care. They also shared that they now need to emphasize warnings to patients that they may not have in-state abortion care options should they become pregnant on the prescribed teratogenic medication. As one oncologist in a state with an abortion ban after 12 weeks noted:

> "I am spending more time discussing pregnancy prevention with my women patients of reproductive age [who are undergoing chemotherapy treatment] …. I tell them that chemo is a teratogen and [if they should become pregnant] it will be hard to take care of a pregnancy under the circumstances, so it is critically important that they not get pregnant."
> *Participant 26*

These accounts are consistent with a 2023 national survey of rheumatologists that found that 13 percent of rheumatologists in abortion-restricted states reported having changed or planning to change their prescribing of methotrexate and nine percent having changed or planning to change their prescribing of mycophenolate post-Dobbs, compared to only five percent and one percent, respectively, of rheumatologists practicing in abortion-protected states.[55] Another rheumatologist in a state with an abortion ban before 12 weeks expressed concern that due to potentially unconscious biases on the part of physicians, fear of women patients on teratogenic medications becoming pregnant might disproportionately harm low-income and socially marginalized women who physicians may perceive to be "*less adherent*" in taking effective contraception (Participant 33).

This was also true in other specialties. Interviewed physicians across specialties emphasized that standard of care when a patient becomes pregnant while on a teratogenic medication should be to involve a Maternal Fetal Medicine (MFM) specialist; conduct additional testing as indicated; and engage in shared decision-making about whether to continue or terminate the pregnancy, weighing the pros and cons of each possible action, with the patient and, if appropriate, her partner and family. After that, it would always be the patient's decision whether to continue or terminate the pregnancy. As one neurologist in a state with abortion protections explained:

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x "First-line medications" are the initial and preferred drugs or treatments used for a specific condition based on their proven effectiveness and safety profile.

> "Valproic acid is pretty highly teratogenic. [And] phenytoin is another big one that is teratogenic. The standard of care if someone is accidentally pregnant, and I have been prescribing them, say, valproic acid [which can cause fetal damage in the first trimester], would be to have a very serious conversation, and I say, 'There's a lot of risks. Very serious neural tube defects in your baby. Like, this is what those things can look like.' I would send them urgently to an obstetrician to discuss testing and the possibility of abortion if teratogenic effects are found …. In such a situation, it would not be standard of care if we failed to discuss options including abortion."
> *Participant 27*

They expressed their concern that fear of prescribing teratogenic medications due to abortion bans could lead to lower standards of care depending on the state laws where a patient lives:

> "We're going to have to see a separate set of national guidelines for abortion ban states than other states. And I think that is kind of an alarming process as the idea of prescribing a different standard of care in one place versus another within the same country, which ostensibly has the same resources, like, what is that training going to look like when people are going to medical school?"
> *Participant 27*

Some Physicians Are Prescribing Less Effective Non-Teratogenic Medications

Physicians described how in states with abortion bans, fear that their reproductive-age patients may become pregnant has resulted in less effective non-teratogenic medications being prescribed instead of more effective teratogenic medications. One interviewed neurologist in a state with abortion protections reported that:

> "I have colleagues in states where abortion care access is restricted who are afraid of being on the hook [for] prescribing the better therapies for their patients because they're afraid that should the patient become pregnant, there could be an issue, they could be sued, et cetera. Or they might be faced with a situation where a woman should be offered the option of termination if they are on highly teratogenic medications, which for some conditions are by far the most effective medications. And so what people do is they actually prescribe medications that are considered more safe in pregnancy and that are absolutely not as effective."
> *Participant 17*

The neurologist expressed concern that as a result, reproductive-age women were not being offered as effective treatment as men with the same medical conditions:

> "And so the way it hurts the patients is they are not getting standard of care. And so they're … getting like the worst old drugs that do not work as well. And so the difference is a better drug that prevents new brain injury from their neurological condition, a less effective drug prevents that much less. And so what we see is patients who are put on these really inadequate, inappropriate therapies because people are afraid of the possible pregnancy, which raises the question of abortion that physicians in abortion ban states do not want to deal with …. And so we're in a situation where we can prevent long-term neurological injury, disability, keep people well, including during some of the most stressful times in their lives. And neurologists choose to not do that because of these restrictive reproductive access laws."
> *Participant 17*

Similarly, in dermatology, teratogenic medications such as doxycycline and methotrexate are commonly prescribed for inflammatory skin disorders. Among these, isotretinoin (Accutane) is both highly teratogenic and the most effective medication for treating cystic and other severe forms of acne. To minimize the risk of fetal exposure to isotretinoin leading to severe birth defects, there is a federal safety program the iPLEDGE Risk Evaluation and Mitigation Strategy (REMS) that monitors the prescribing and dispensing of isotretinoin. Despite such precautions, an interviewed dermatologist in a state with an abortion ban before 12 weeks explained for patients who become pregnant on isotretinoin, even if pregnancy is caught within the six-week gestational limit in their state:

> "We have very little time to make any decision. And health care access in general is a huge challenge [here], there is very poor reproductive health care access in general, especially in more rural parts of the state, but especially poor family planning care access. And so, if one were to get detected for pregnancy within that one-month period, you really have just two weeks to make decisions given the six-week abortion ban. And so it really makes dermatologists really scared about the potential of having to make those decisions here …. And in the past based on data, people have usually chosen abortions or terminations to avoid the risk of significant fetal defects or even spontaneous abortions – it's a very individualized decision, but before it would be completely up to the patient not the state."
> *Participant 23*

As a result of their state's restrictive abortion laws, the dermatologist explained:

> "I know a lot of dermatologists here now who don't prescribe Accutane to reproductive-age women [because of] the potential risk of needing an abortion that it carries. I am seeing a lot of these patients who have been turned away. These additional restrictions surrounding reproductive health care definitely makes [Accutane] harder and harder to access."
> *Participant 23*

They also described that this concern about possible pregnancy led to discriminatory care between reproductive-age men and women:

> "The same dermatologists who won't prescribe it for reproductive-age women will prescribe it to men. This happens all the time. I mean, they feel ethically justified, justifying or rationalizing that there is a harm to the fetus that doesn't exist with someone who doesn't have a pregnancy potential. So, there isn't that inherent risk that's associated with that for someone who doesn't have pregnancy potential. But yeah, it's a completely built in disparity …. Men in general have a much easier time accessing care than women …. And people with bad cystic acne, the kind that leaves permanent scarring, disfigurement, Accutane is the only medication that is really effective, so it makes you feel bad if they can't get access to it."
> *Participant 23*

The increased reluctance of physicians to prescribe teratogenic medications to reproductive-age women due to abortion bans thus may result in two forms of discriminatory care. In the first, reproductive-age women receive less effective medications compared to men. In the second, patients who health care providers perceive to be "less reliable" in terms of contraceptive adherence, possibly due to socioeconomic status, mental health conditions, or race, may not be prescribed the most effective medications if they are teratogenic.

Restrictions on Medications Used for Abortion Will Cause Further Harm for Reproductive and Non-reproductive Health Care Specialties

Problems Filling Prescriptions for Medications Associated with Pregnancy Termination (Mifepristone, Misoprostol, and Methotrexate)

To date, no state has laws in effect prohibiting prescriptions of mifepristone, misoprostol, and methotrexate for their U.S. Food and Drug Administration (FDA) approved or off-label uses.[xi] Yet, many interviewed physicians recounted cases in which their patients faced difficulties in filling a prescription for mifepristone, misoprostol, or methotrexate due to their association with abortion care. An OB-GYN in a state with an abortion ban before 12 weeks recounted their experiences:

xi Wyoming has enacted a law banning medication abortion, but the law is being blocked by a state court. (Source: https://www.bbc.com/news/world-us-canada-64998920).

> "When it comes to patient care, I have had a lot of problems with outpatient pharmacies, both for gynecological patients and pregnant patients. I had a patient who was prescribed misoprostol for her missed abortion … had no heart tones and could not get the medication. The pharmacist told her if she didn't leave, she was going to call the cops on her. I recently, not even a month ago, prescribed Cytotec or misoprostol for a patient who was getting an IUD [intra-uterine device]. [Cytotec] helps soften the cervix so the insertion is less painful. And they didn't dispense it to her. I had a 70-year-old woman, I was doing a D&C [dilation and curettage] for post-menopausal bleeding. Again, the pharmacy wouldn't dispense the medication."
> *Participant 19*

In Louisiana, after mifepristone and misoprostol were classified as controlled substances,[56] interviewed physicians in the state described difficulties their patients faced finding pharmacists that carried misoprostol. As one OB-GYN explained:

> "A lot of pharmacies are like, this is too much of a hassle. We're not going to carry this anymore. So finding misoprostol has been a challenge even in a big city like New Orleans."
> *Participant 1*

Although pharmacies are able to dispense mifepristone and misoprostol and two large pharmacy chains announced that they would dispense mifepristone following the FDA REMS change,[57] this is often not happening in states with abortion bans. Another OB-GYN in a state with an abortion ban after 12 weeks said:

> "I've seen that despite the fact that it is legal now to prescribe mifepristone and have it be dispensed from a pharmacy, that is just not happening [here]. I also have seen some large chains still refuse to fill misoprostol, even for things like a postmenopausal woman needing a dose of misoprostol to get an endometrial biopsy …. A lot of the mom and pop, like smaller pharmacies around the state are refusing to stock or supply anything – misoprostol and certainly not mifepristone."
> *Participant 4*

We spoke with several endocrinologists who had not experienced any impact on availability of mifepristone to treat Cushing syndrome, a disorder caused by excessive production or administration of glucocorticoid hormones.[xii] However, as we have seen with pharmacy denials of methotrexate and misoprostol, this may or may not continue to be the case with future restrictions.

Physicians Are Concerned about Future Harms From Restrictions on Medications Associated With Abortion

With the expanded use of medication abortion, there is concern that state and national legislation will increasingly be used to target the medications commonly used in medication abortion – mifepristone and misoprostol – and because of its use in abortion care for ectopic pregnancies, methotrexate. The effect of these restrictions would be felt across reproductive and non-reproductive health specialties. Interviewed physicians in reproductive health care fields reiterated the importance of mifepristone and misoprostol as the best treatments for miscarriage management, methotrexate as the standard treatment for ectopic pregnancies, and misoprostol to induce cervical softening before a cervical procedure and to treat postpartum uterine hemorrhages. One OB-GYN in a state with an abortion ban before 12 weeks described the consequences of restricting access to these medications:

> "We already have a crisis in maternal morbidity and mortality that we've been trying to work on for how long now? 10 years almost. So we would see then a complete, almost reversal of all that work. Mainly morbidity and mortality in our state comes from hemorrhage and hypertension. When we then remove misoprostol, one of the resources that we know is safe and effective to treat a woman that may have other comorbidities

xii This is due to the differing drug brand and dosage of mifepristone used for the treatment of Cushing syndrome.

to stop their bleeding, then we're going to see an increase in those numbers. [This is also true for] methotrexate [which] is the safe and effective way that is nonsurgical that we can treat an ectopic pregnancy and also decrease the risk factors that can come for this patient."
Participant 19

Physicians across non-reproductive health specialties outlined crucial concerns about restrictions on medications used in abortion care. Many physicians we spoke with used methotrexate[xiii] in treating multiple debilitating medical conditions, as one interviewed MFM specialist who practiced in both states with abortion bans before and after 12 weeks noted, restrictions on access to methotrexate "*impacts entire populations of health, not just abortion care for pregnancy-capable patients*" (Participant 10).

A gastroenterologist in a state with an abortion ban after 12 weeks elaborated on the importance of methotrexate:

"We use methotrexate usually in combination with some of our biologic medications like infliximab in order to optimize biologic medication levels and also to prevent antibody formation. And this is imperative in patients who have pretty severe inflammatory bowel disease or have complications for their inflammatory bowel disease – things such as perianal Crohn's disease with fistula. It's also used for patients that have comorbid inflammatory arthritis or other skin conditions, which is also quality of life and can lead to further joint damage, erosive joint disease, leading to significant debility and disability."
Participant 12

This gastroenterologist highlighted the potential harms to patients if methotrexate was included or perceived to be included in abortion restrictions designed to prohibit the mailing of medications associated with abortion care:

"If it becomes challenging to mail medications to our patients, whether from a specialty pharmacy or even just like good old CVS mailing service, it could become potentially dangerous to their health. If you don't use methotrexate and you only use these medications by themselves, there is risk of failure of the medications and you can't just restart them. Once you've formed antibodies, that medication goes completely out the window and you have to use other lines of medications, which once you're on your second line of medication, it's historically not as good as your first line of medication for inflammatory bowel disease. So really that first out the gate combination therapy is oftentimes our best bet for treating these diseases that have significant impact on the quality of life of patients."
Participant 12

Interviewed physicians described that many of their patients, especially those in rural areas or with disabilities that limited their ability to travel to access care, relied on mailed prescriptions. As one rheumatologist in a state with an abortion ban before 12 weeks said:

"I think if you're limiting mailing of these medications, again, it could differentially affect people that have access to care problems in rural areas that may not have pharmacies that dispense it, or if they have physical disabilities that limit their ability to travel to a pharmacy regularly to pick up their medication, that could also negatively impact people's quality of life and the care that they receive. And we have enough trouble sometimes with regular follow up with patients to see us in clinic. I mean, some of my patients travel hours to get there and then luckily they're able to get their medications mailed to them through their pharmacy or specialty pharmacy. But so that could be a problem I could envision if [mailing of methotrexate] was impaired in some way."
Participant 33

The rheumatologist described the health harms patients may experience if their supply of medications is interrupted:

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xiii Methotrexate is an immune modulator medication that interferes with DNA replication, thus slowing down replication of cells.

> "If someone is on a stable regimen and they're on stable methotrexate dosage and they're doing great and they're in remission, and then their medication use is interrupted and they're not able to access methotrexate or their biologic medicine, and then they flare. And it can be really difficult to get their flare under control. A flare in RA [rheumatoid arthritis] is joint inflammation, swelling. They may miss work because they can't bend their fingers and write or type on a computer or walk sometimes. If it's lupus, a flare may be a flare in their kidneys, and they may have to be hospitalized for that and given additional cytotoxic meds to get their flare under control and steroids."
> *Participant 33*

Other specialists expressed the additional concern that many of their patients already had difficulty accessing clinic-based care. They provided examples of how further limitations on their ability to access medication abortion could be harmful to their health. A neurologist in a state with abortion protections described an example of a pregnant patient on teratogenic medications who wanted abortion care but whose gestational limit was beyond the clinical window for medication abortion:

> "I mean I had a patient who [unintentionally] got pregnant even though she was supposed to be on contraception … and was still taking teratogenic medications during pregnancy. She made a decision to medically terminate and she was no longer in a window where she could have a medication abortion. And so she had to do procedural termination. And it was a huge stress for her. In a lot of our neurological diseases, stress actually triggers attacks. So stress is a big trigger in migraines, a big trigger in MS, a big trigger in seizures, et cetera. And [she now faced] the stress of having to go and do a termination procedure … the patient was suffering quite directly in that respect. And that of course puts her disease management at risk …. Procedural abortions can be more difficult for people than an early medication abortion. And it would be terrible if more people did not have the option of medication abortion."
> *Participant 17*

Legal and Medical Ethical Analysis

The findings presented in this research brief provide significant evidence of how state-level abortion bans are contributing to delays and denials of health care across a range of fields of medicine for pregnant patients and women of reproductive age in the United States. Clinicians across geographies and specialties repeatedly underscored the impossibility of prioritizing evidence-based patient care and the many harms this untenable situation has caused both in states with bans and states where patients ultimately end up seeking care.

The end result of these state-level abortion bans has been deepening discrimination in access to quality and timely medical care for women and pregnant patients. Our findings paint a clear picture of how state-level abortion bans have resulted in delays and denials of care and substandard treatment for pregnant patients and women and girls of reproductive age in fields ranging from oncology to hematology to dermatology that have caused serious physical and mental health harm. These disparities in treatment are further deepened for people facing multiple and intersecting forms of discrimination, including those belonging to marginalized races and lower socioeconomic groups. These findings affirm what has been recognized by the World Health Organization: the criminalization and penalization of abortion care – even with an exception for medical necessity – is fundamentally inconsistent with human rights and evidence-based, ethical, and patient-centered health care.[58]

Human Rights

The United States has signed and ratified several human rights treaties that obligate the government to ensure individuals' rights to life, equality, freedom from torture and ill-treatment, and privacy, among others[59] These treaties establish human rights obligations for all levels of government – federal, state, and local. While the federal government is ultimately responsible for reporting to human rights treaty monitoring bodies on how the United States is meeting those obligations, state and local governments play a critical role in ensuring that the United States fulfills its international human rights commitments.

The evidence from this study confirms that state-level abortion bans are resulting in violations of human rights not only for pregnant patients, but also for women of reproductive age who physicians consider could become pregnant. For example, physicians report that pregnant patients who need abortions for medical reasons – including complications arising from the use of teratogenic medications – face barriers in accessing such care, resulting in real risks to their lives and health. Under the right to life enshrined in the International Covenant on Civil and Political Rights (ICCPR), which the United States has signed and ratified, the United Nations (UN) Human Rights Committee has recognized that states parties' "restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering that violates article 7 of the Covenant, discriminate against them or arbitrarily interfere with their privacy."[60] Similarly, both the UN Human Rights Committee and the UN Committee against Torture, which monitors the Convention against Torture – which the United States has also signed and ratified, have assessed restrictive abortion laws and recognized denial of abortion-related services as a form of torture or other ill-treatment, including in situations where pregnant patients cannot access abortion in cases of fatal fetal impairments or sexual violence due to the foreseeable, preventable risk of pain and suffering.[61] The UN Human Rights Committee has called for the reform of criminal abortion bans, including through constitutional reform if necessary, in two such cases.[62] States parties to the ICCPR are required to ensure that abortion restrictions do not interfere with women's privacy and "protect women from arbitrary and preventable losses of life related to pregnancy and childbirth;" the failure to do so is considered discrimination in violation of Articles 2, 3, and 26 of the treaty.[63]

Human rights law is clear; laws that subject pregnant patients and women of reproductive age to substandard medical care and endanger their health and survival constitute discrimination and must be remedied.[64] Yet, the findings of this report confirm that abortion bans are resulting in pregnant patients with cancer, blood disorders, and other health conditions being denied the health care that would be offered to non-pregnant patients because of criminal abortion bans. Similarly, women of reproductive age are also being denied access to certain treatments due to abortion bans that men of reproductive age would receive, constituting differential treatment

on the basis of sex. Human rights bodies have repeatedly recognized that abortion restrictions that compel women to carry pregnancies to term despite risks to their life and health reflect discriminatory gender stereotypes "that protection of the foetus should prevail over the health of the mother" and violate the right to equality and non-discrimination.[65]

In its first review of the United States post-Dobbs, the UN Human Rights Committee urged the United States to "put an end to the criminalization of abortion by repealing laws that criminalize abortion, including laws that apply criminal sanctions to women and girls who undergo abortion, to health service providers who assist women and girls to undergo abortion and to persons who assist women and girls to procure an abortion, and consider harmonizing its legal and policy framework with the World Health Organization's Abortion Care Guideline (2022)."[66] Similarly, noting the particular impact of abortion bans on women and girls of color, the UN Committee on the Elimination of Racial Discrimination expressed deep concern about intersecting forms of discrimination based on gender, race, ethnicity, and migration status and recommended that the United States "take further steps to eliminate racial disparities in the field of sexual and reproductive health and rights."[67]

Medical Ethics

It is not only patients who are harmed, but also the health care providers who are threatened with civil and criminal punishment for providing patients with essential health care. Abortion bans prevent physicians from all specialties from adhering to the four core principles enshrined in their professional codes of ethics:[68]

- Beneficence, or the duty to provide beneficial care to patients;
- Nonmaleficence, or the duty to "do no harm" to patients;
- Respect for patient autonomy; and
- Justice or fair distribution of benefits and burdens.

Codes of ethics further affirm physicians' duty to protect patients' human rights. The World Medical Association International Code of Medical Ethics states physicians' obligation to pledge not to use "medical knowledge to violate human rights and civil liberties, even under threat."[69]

Abortion bans further undermine physicians' ethical duty to provide comprehensive, accurate, and evidence-based information on all treatment options available to patients.[70] Many physicians reported that the prospect or fear of civil and criminal consequences prevented them from providing information or referrals for abortion services, prescribing the best treatment option, and delayed care to pregnant patients.

Ongoing legal and policy actions to restrict access to abortion

In May 2025, Senator Josh Hawley of Missouri introduced a bill to ban the import of mifepristone (Mifeprex/Korlym) into the United States, reinstate the 2011 FDA REMS protocol requiring in-person prescribing by a certified clinician, and create a federal tort allowing patients to sue pharmacies and physicians if they experienced "bodily harm or harm to mental health" associated with the prescription of Mifeprex.[71][xiv] One week later on May 14, 2025, U.S. Secretary of Health and Human Services Robert F. Kennedy, Jr. testified before Congress that he had ordered the FDA to begin a review of mifepristone, without clarity around what is being reviewed and despite strong peer-reviewed evidence establishing the safety of mifepristone over the last 25 years.[72] Finally, there is ongoing concern that the existing U.S. Department of Justice (DOJ) Office of Legal Counsel (OLC) guidance on non-application of the Comstock Act to the mailing of medications used for legal abortion[xv] could be rescinded and the Comstock Act[xvi] enforced, making the mailing of mifepristone, misoprostol, and potentially other instruments used in abortion and reproductive health care illegal nationally.[73] While the OLC memo remains in place, senior DOJ officials in the Trump administration –including Vice President JD Vance – have previously indicated their interest in rescinding the guidance.[74]

Health care workers and advocates rally outside of the U.S. Supreme Court ahead of a trial related to EMTALA (Emergency Medical Treatment and Labor Act), which requires hospitals to stabilize patients experiencing medical emergencies, including patients with pregnancy complications.

Photo: Physicians for Human Rights

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xiv The bill was introduced in response to claims made by a conservative think tank, the Ethics and Public Policy Center, that alleged, unsupported by raw data and conducted using deeply flawed methodology, that mifepristone was responsible for a greater proportion of adverse events than previously reported.

xv The 2022 memo from the DOJ OLC explained its longstanding position that the law applied only to unlawful abortion and given the myriad lawful uses of common abortifacients, the mailing of medications, alone, was insufficient basis to prove unlawful intent.

xvi The Comstock Act is an obscure federal obscenity statute from 1873 criminalizing the use of the post office to mail material of an "obscene, lewd, [or] lascivious" nature which holds a "vulgar or indecent character." The law also prohibits "any article or thing designed or intended for the prevention of conception or the procuring of abortion, nor any article or thing intended or adapted for any indecent or immoral use or nature," unless that item is obtained via a "prescription of a physician in good standing, in good faith" (Lines 12-14).

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Conclusion

Our research highlights how abortion bans and restrictions create cascading effects that extend far beyond reproductive health care, compromising the quality and effectiveness of medical care across reproductive and non-reproductive specialties. These restrictions have hindered providers in diverse medical fields from following evidence-based practices and standards of care, creating a pervasive chilling effect that results in substandard care and discriminatory treatment for reproductive-age women and pregnant patients.

Physicians we interviewed highlighted delays in care for patients who experienced complications from acute or chronic medical conditions during pregnancy, a chilling effect on prescribing teratogenic medications to reproductive-age patients due to a fear that patients might become pregnant and be unable to access abortion care; difficulty with pharmacies dispensing medications associated with abortion and treatment of ectopic pregnancy such as methotrexate, mifepristone, and misoprostol; and continued fear of providing abortion care under confusing exceptions in state-level abortion bans. The striking similarity of these impacts across both reproductive and non-reproductive specialties highlights the urgent need for joint action across medical specialties to prevent further restrictions, including on medications used for abortion.

At their core, these restrictions – both current abortion bans and those proposed on reversing the U.S. Food and Drug Administration's Risk Evaluation and Mitigation Strategy safety data on mifepristone or classifying mifepristone and misoprostol as controlled substances – are attacks on science, health care, and medical and individual autonomy. As physicians described, the failure to provide patients with the full range of options for treatment, including the option for abortion care, harms treatment practices for a wide variety of conditions. These far-reaching impacts that are not grounded in evidence-based medical science create differential treatment and harm patients and providers in states that criminalize abortion provision and in those that protect abortion access. When patients experiencing complications or increased risks must be referred out of state, this also impacts care provision in states with protected abortion access as physicians in those states may see these patients later in pregnancy and with additional maternal health complications. Abortion care is a crucial part of comprehensive health care access. We see this in the many examples of patients who need to access abortion care to ensure continued treatment for chronic conditions, conditions that can be complicated by pregnancy, and new conditions diagnosed during pregnancy shared by physicians we interviewed.

This chilling effect results in equity and discrimination concerns as teratogenic medications may be first-line treatment regimens for many conditions such as rheumatoid arthritis, and – particularly in the case of methotrexate – may be the most affordable treatment option for patient care.

> These shared and widespread impacts of abortion restrictions highlighted in this research reinforce the need for physicians across specialties to engage in joint advocacy to ensure that additional rollbacks, like restrictions on mifepristone and misoprostol, do not go into effect.

A rheumatologist in a state with an abortion ban before 12 weeks expressed frustration that physicians in their state have to feel afraid to provide needed abortion care when they deemed it medically necessary:

> "I think what people don't realize with these bans is that it's very easy to sit in your office as a man in Capitol Hill and make these laws saying we're protecting unborn children. But what they don't understand is that pregnancy itself is a big stress on the body. And for some women, this is life-threatening and they may have families already and they may not have the resources to seek care .... And so I think when [politicians] make these exceptions about, oh, it's okay if the mother's life is in danger. What we've seen in [redacted state]

> is that often doctors are so scared to provide the abortion care a woman might need, and that [failure to provide abortion care] can result in, you know, horrible morbidity for the woman. And I think that's such a shame. And yet, at the same time, I need my medical license because I am hundreds of thousands of dollars in debt. And so I understand those doctors saying we need input from our hospital legal team, but it's just, you know, I think if those same senators up in Capitol Hill had a heart attack, they would want their doctor to intervene without question. But, yeah, we're not sitting around waiting to see if we can legally give you treatment for your heart attack. You know, it's just sad. It's very sad."
> *Participant 32*

These shared and widespread impacts of abortion restrictions highlighted in this research reinforce the need for physicians across specialties to engage in joint advocacy to ensure that additional rollbacks, like restrictions on mifepristone and misoprostol, do not go into effect. These restrictions do not just harm reproductive health, they undermine the fundamental principles of medicine by restricting clinical autonomy, limiting physicians' ability to counsel patients effectively, and preventing them from offering the most effective treatments. Health care professionals have an obligation to stand against policies that interfere with the duty of care and deny patients their right to comprehensive medical care to help ensure that patients can make the best decisions for their health and lives.

People in Florida hold up signs during a reproductive rights rally on the second anniversary of the Supreme Court ruling to overturn Roe v. Wade.

Photo by Marco Bello / AFP

Recommendations

To the U.S. Government and Congress:

- Enact and implement national laws and policies that ensure rights and remove barriers to abortion care and maternal health care.
- Ensure that all people can access comprehensive reproductive health care with dignity, free from discrimination and criminalization, regardless of where they live.
- The U.S. Food and Drug Administration (FDA) must refrain from further restrictions on the medications mifepristone and misoprostol given rigorous evidence of their safety.
- Continue and reaffirm the longstanding interpretation that the Comstock Act does not apply to the mailing of medication or supplies for legal abortion.
- Monitor the impact of abortion bans on the provision of reproductive health care and on health inequities, including by employing U.S. Congressional authority to investigate discrimination in programs and services funded by the U.S. Department of Health and Human Services.
- Support legislation that prohibits clinicians' civil or criminal liability, disbarment, loss of license, or other retribution or reprimanding measures where clinicians provide life- or health-preserving abortion care in line with medical standards.

To State Governments and Legislatures:

- Repeal state-level abortion bans as well as all other restrictive laws and regulations that effectively obstruct access to abortion. This includes enacting legislation that:
  - Decriminalizes abortion and removes professional, civil, and criminal penalties for health care workers who provide abortion care to patients.
  - Repeals laws that could be used to prosecute or penalize people for having an abortion, including a self-managed abortion, assisting another person to access abortion care, or for pregnancy outcomes.
  - Removes all medically unnecessary requirements for provision of abortion care.
  - Establishes shield laws to protect patient access to abortion and protect health care providers.

To Health Care Providers and Institutions:

- Speak out against laws criminalizing abortion or otherwise restricting access to abortion, including by raising awareness of the harms caused to patients and health care systems and ensuring clinicians are not prohibited by their medical institutions from speaking out against such laws.
- Assist clinicians in navigating abortion bans and restrictions and providing patients with the proper standard of care, including by providing them with accurate and up-to-date legal guidance as well as guaranteed and timely legal support for abortion-related investigations or legal proceedings.
- Continue to support clinicians and medical students of all specialties to attend trainings on abortion and other reproductive health care, including clinical training and ethical guidance.

To State and National Medical Associations:

- Vigorously advocate for the repeal of abortion bans and restrictions and continue to speak out against the range of injuries – criminal, civil, and moral – caused by abortion bans and restrictions.

Endnotes

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61 See, e.g., Comm. against Torture, Concluding observations on the second periodic report of Ireland, U.N. Doc. CAT/C/IRL/CO/2 (2017); Comm. against Torture, Concluding observations on the seventh periodic report of Poland, U.N. Doc. CAT/C/POL/CO/7 (2019); Comm. against Torture, General comment No. 2: Implementation of article 2 by States parties, U.N. Doc. CAT/C/GC/2 (2008); Mellet v. Ireland, Human Rts. Comm., Commc'n No. 2324/2013, U.N. Doc. CCPR/C/116/D/2324/2013 (2016); Whelan v. Ireland, Human Rts Comm., Commc'n No. 2425/2014, U.N. Doc. CCPR/ C/119/D/2425/2014 (2017); K.L. v. Peru, Human Rts Comm., Commc'n No. 1153/2003, ¶6.3, U.N. Doc. CCPR/C/85/D/1153/2003.

62 Mellet v. Ireland, Human Rts. Comm., Commc'n No. 2324/2013, U.N. Doc. CCPR/C/116/D/2324/2013 (2016); Whelan v. Ireland, Human Rts Comm., Commc'n No. 2425/2014, U.N. Doc. CCPR/ C/119/D/2425/2014 (2017).

63 Human Rts. Comm., General comment No. 36 Art. 6: right to life, ¶8, U.N. Doc. CCPR/C/GC/36 (2018) [hereinafter Human Rts. Comm., General comment No. 36].

64 HRC Mellet v. Ireland. Communication No. 2324/2013 Geneva: United Nations Human Rights Committee; 2016, Appendix II, paras. 7, 10, 12. *The right to sex and gender equality and non-discrimination obligates States to ensure that State regulations, including with respect to access to health services, accommodate the fundamental biological differences between men and women in reproduction and do not directly or indirectly discriminate on the basis of sex. They thus require States to protect on an equal basis, in law and in practice, the unique needs of each sex.*

10. Gender equality requires that pregnant women in State custody receive appropriate care, obligates States to afford access to safe abortion services to women who have become pregnant as a result of rape, and obligates them to ensure that women are able to access information necessary for equal enjoyment of their rights.

12. Women's unique reproductive biology traditionally has been one of the primary grounds for de jure and de facto discrimination against women. This is true when women are treated differently from men based on stereotyped assumptions about their biology and social roles, such as the claim that women are less able to take full time or demanding jobs than men.

65 L.C. v. Peru, supra, para. 8.15 (finding violations of CEDAW articles 5 and 12); see also, HRC Mellet v. Ireland. Communication No. 2324/2013 Geneva: United Nations Human Rights Committee; 2016, Appendix II, paras. 7, 10, 12.

66 WHO. Abortion Care Guideline. March 8, 2022. https://www.who.int/publications/i/item/9789240039483. The Abortion Care Guideline is based on an evaluation of public health evidence and human rights standards. This guideline provides the first-ever definition of "decriminalization" in the context of abortion by a UN agency or human rights mechanism: "Decriminalization means removing abortion from all penal/criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors." It notes that "decriminalization would ensure that anyone who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care" and that "decriminalization of abortion does not make women, girls or other pregnant persons vulnerable to forced or coerced abortion. Forced or coerced abortion would constitute serious assault as these are non-consensual interventions." Accordingly, the Guideline recommends: 1) the full decriminalization of abortion and the absence of laws and other regulations that restrict abortion (at §2.2.1, pp. 24-25); 2) that abortion be available on the request of the woman, girl, or other pregnant person (at §2.2.2, pp. 26–29); 3) the absence of gestational age limits (at §2.2.1, pp. 24–25), mandatory waiting periods for abortion (at §3.3.1, pp. 41–42), and third-party authorization requirements (at §3.3.2, pp. 42–44); 4) the option of self-management of medical abortion in whole or in part at gestational ages of less than 12 weeks (at §3.6.2, p. 98); and 5) that regulations on who can provide and manage abortion are consistent with WHO guidance (at §3.3.8, p. 59).

67 United Nations, International Convention on the Elimination of All Forms of Racial Discrimination, Committee on the Elimination of Racial Discrimination, Concluding observations on the combined tenth to twelfth reports of the United States of America. CERD/C/USA/CO/10-12, 21 September 2022. Para 56.

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