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The Impact of *Dobbs* on Rheumatology Practice

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Abstract: Soon after the Supreme Court issued Dobbs v. Jackson Women's Health Organization*—a case that overturned the right to abortion—roughly a third of the country enacted a total or near-total abortion ban. Women's healthcare has suffered in a variety of ways as a result. This chapter considers an underappreciated harm of abortion bans: their impact on rheumatology practice. It considers three chilling effects that have resulted from state abortion bans: (1) a hesitation to prescribe rheumatology medications that can cause abortion, like methotrexate; (2) a hesitation to prescribe rheumatology medications with teratogenicity (i.e., those that can cause fetal anomaly), and (3) a hesitation to refer patients to abortion providers out of state. Though liability for these actions is unlikely, the high penalties of abortion bans coupled with aggressive, antiabortion prosecutors, have created a culture of fear that has intruded into the practice of medicine, harming patients far beyond reproductive healthcare.*

In June 2022, the Supreme Court issued *Dobbs v. Jackson Women's Health Organization*, which overturned the fifty-year-old precedent that created the federal right to pre-viability abortion: *Roe v. Wade*. In *Dobbs*, the Court returned abortion law to the states, and within a few months, nearly a third of the country banned abortion from the earliest moments of pregnancy.[i] Exceptions to these bans are rare, narrow, and vague.[ii]

The effects of *Dobbs* on reproductive healthcare are extensive and well documented, as I've explored in prior work.[iv] But this chapter examines an underappreciated harm of *Dobbs*: it's impact on rheumatology practice. Rheumatic disease is much more common in women than men, and common rheumatology medications can cause miscarriages or fetal anomalies.[xiv] When pregnancy does occur in this population, the patients are more likely to need abortions for medical reasons.[xiv] The chapter covers three harmful chilling effects of the *Dobbs* decision on rheumatology: (1) a hesitation to prescribe rhemotology medications that can cause abortion, like methotrexate, due to concerns that it could fall within an abortion ban; (2) a hesitation to prescribe rheumatology medications with teratogenicity due to liability concerns if a child is born with an anomaly because the pregnant patient lacked access to abortion; and (3) a hesitation to refer rheumatology patients to an abortion provider, even one who operates legally out of state—due to fears of aiding and abetting an abortion.

Though none of these activities will likely manifest into real legal consequences, even low-risk activities will alter physician practice when the penalties include decades in prison, the loss of a medical license, and exorbitant fees.[iv] These high penalties are compounded by aggressive antiabortion activists and prosecutors who have created a culture of fear. These chilling effects demonstrate how abortion bans intrude into the practice of medicine well beyond reproductive healthcare in unexpected and harmful ways.

I. Prescribing Potential Abortifacients

Every medication that can be used for abortion also has others uses. For instance, the two most common abortion medications—mifepristone and misoprostol—are also the gold standard for miscarriage care.[iii] As pertinent to this chapter, rheumatologists regularly prescribe a drug for

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rheumatoid arthritis (RA), methotrexate, that can be an abortifacient at high doses. Methotrexate is also commonly prescribed to remove an ectopic pregnancy, which can be categorized as an abortion under some state abortion definitions.[iv]

Immediately after *Dobbs*, female patients reported difficulties accessing methotrexate.[v] Some reported that their rheumatologists were refusing to prescribe the medication without birth control or sterilization.[v] Providers worried that if their patient became pregnant while taking the drug, and the drug caused a miscarriage, they could be liable under an abortion ban for terminating a pregnancy. Other patients reported that pharmacists were refusing to dispense their prescribed medications.[v] Pharmacists often lack information about why a drug is prescribed, and they therefore feared that if the drug was being prescribed for ectopic pregnancy or abortion, they could be liable under an abortion ban.

These concerns, especially in the initial chaos after *Dobbs*, are understandable. State abortion definitions are intentionally broad.[iv] Though state definitions vary, Texas's definition is fairly representative: "'Abortion' means the act of using or prescribing an instrument, a drug, a medicine, or any other substance, device, or means with the intent to cause the death of an unborn child . . . ."[2][vi] Though rheumatologists and pharmacists are not prescribing or dispensing methotrexate with the *intent* to terminate a pregnancy, even if that is the result, intent can be circumstantial and inferred.[vii] Could a prosecutor, jury, or judge infer an illegal intent from a rheumatologist prescribing methotrexate without checking to see if their patient was pregnant first? It is highly unlikely, but not impossible to imagine.

Nevertheless, when rheumatologists refuse to prescribe medically necessary medications, or condition their prescribing on birth control, their patients suffer. Though there are other possible treatments for RA beside methotrexate, they are not recommended as the gold standard for moderate to severe RA.[viii] Alternatives are either very expensive, like biologics; cheap but less effective, like hydroxychloroquine; or cheap with long-term side effects, like prednisone.[viii] Thus, without methotrexate, patients who cannot afford expensive biologics are forced to use less effective or higher risk products, harming their long-term health. And even when patients *can* afford more expensive biologics, they should not have to spend unnecessary money when a cheaper alternative manages their RA. Forcing non-ideal, alternative medications is also sex discriminatory: only female patients of reproductive age are being asked to make these choices.[ix] And when providers resort to mandating birth control or sterilization before prescribing medically necessary medications, there are serious concerns about reproductive coercion, particularly for this community. This country has a long, ugly history with coercing sterilization or birth control in disabled populations—a practice that is now illegal in many states.[x]

As time has gone on, some concerns surrounding prescribing methotrexate have dissipated. The Biden Administration issued a guidance document to over 60,000 U.S. pharmacies explaining that it violated federal law to deny patients abortifacients, like methotrexate, for legal uses.[ix] And many pharmacies incorporated protocols that asked for the intended use of a prescribed drug to calm

[2] Texas's law also requires a known pregnancy and excludes ectopic pregnancy treatment—text I omitted because it was not necessarily representative. States with "known pregnancy" requirements provide more reassurance to rheumatologists that their prescribing abortifacients or teratogens would not fall within an abortion ban *unless* they knew a patient was pregnant.

pharmacist fears about inadvertently dispensing a medication intended for abortion. Some states modified their laws to specifically exclude ectopic pregnancy from the definition of abortion, lessoning fears for methotrexate in particular.[iv] Other state abortion definitions and bans exclude accidental abortions or require the termination of a *known* pregnancy.[iv]

Nevertheless, rheumatologist fears have not fully disappeared. In a November 2022 survey, rheumatologists in states with abortion bans were more likely to report that they planned to alter their prescribing of methotrexate after *Dobbs* (13.0% v. 5.3%) and that their patients had encountered challenges filing their methotrexate prescriptions (23.2% v. 11.8%).[xi] Around the same time, a survey of patients described that 1 in 17 patients had trouble refilling a methotrexate prescription.[xii] In November 2023, group of Congresspeople wrote a letter to the Secretary of HHS noting that patients continue to struggle accessing methotrexate and requesting action.[xiii]

II. Chilling Effect on Prescribing Teratogens

Another area of anxiety for rheumatologists relates to the prescribing of teratogens—medications that can cause fetal anomalies if taken during pregnancy. A variety of rheumatology drugs are teratogenic and therefore not recommended in pregnancy. But it is inevitable that some patients will become pregnant while taking them. Between 2006-2017,[xiv] one in sixteen pregnancies were exposed to a teratogenic or potentially teratogenic drug, and those numbers would likely increase if limited to pregnancies in women with rheumatic diseases, which are often treated with teratogens. In some sense, the availability of abortion has historically provided a failsafe when a teratogen exposure led to a severe fetal anomaly.

Many states with abortion bans lack an exception for fetal anomaly, and when one exists, it only applies narrowly to uniformly fatal anomalies, leaving many pregnant patients unprotected.[iv] Though some patients may be able to get an abortion out of state, others will not be able to afford it or to manage the logistics of interstate travel with limited notice and support. There is also evidence that abortion bans are increasing the number of babies born with anomalies,[xv,xvi] and increasing infant mortality as a result.[xvii] This confirms pre-*Dobbs* research showing that abortion restrictions increase infant mortality.[xviii]

In these instances, providers might be worried about medical malpractice liability if a patient gives birth to a child that developed an anomaly due to a prescribed medication. Certainly, there is the risk of liability if a provider knew a patient was pregnant and continued to prescribe a teratogen when safe alternatives existed.[xix] But if the medication was prescribed without knowledge of a pregnancy or when no safe alternatives existed, it is much less likely that a provider would be found liable. Liability would be judged on whether the standard of care required, for instance, contraceptive counseling before prescribing or regular pregnancy testing—and that standard of care was not followed.

Fears about medical malpractice risks have chilled patient access to teratogens. For instance, the same survey described above, rheumatologists in states with abortion bans reported a greater likelihood that they would alter their prescribing practices for a common teratogen, mycophenolate.[xii] Dermatologists face a similar dilemma, and some are calling for new dermatology guidelines to change the standard of care related to prescribing teratogens in states with abortion bans.[xx]

As mentioned above, when pregnancy capable patients are unable to get medically necessary medications, their health suffers. This is true when a medication is avoided due to teratogenicity too. And when physicians alter their prescribing practices for one sex only, regardless of pregnancy status, it is sex discriminatory. A risk averse rheumatologist could mitigate medical malpractice risks by providing contraceptive counseling before prescribing teratogens.[xxi] Contraceptive counseling does not condition prescribing on contraceptives, but rather educates patients and allows them to make the best reproductive choices for themselves.

III. Chilling Effect on Abortion Referrals

Just like the average American population, some rheumatology patients will become pregnant and need abortion care. This could be because the pregnancy was unintended, the pregnancy was exposed to a teratogen, the fetus has an anomaly, or the patient's health cannot support the pregnancy. The proportion of patients seeking care for medically indicated reasons will likely be higher in patients with rheumatic disease—not only are they more likely to be exposed to teratogens, as discussed above, but their disease may make pregnancy riskier.[xv]

As a result, rheumatologists may be in the position of needing to counsel a patient on the possibility of abortion care. In states with abortion bans, not only are in-state options unavailable, but providers may be concerned that a referral out of state could make them an accomplice to a crime. In Texas, for instance, a civil abortion statute known as SB8 creates civil liability for anyone who "aids and abets" an abortion; there is also a pre-*Roe* law on the books creating criminal liability for anyone "furnishing the means for procuring an abortion."[xxii] Abortion funds in Texas ceased operations for a period of time after the Attorney General made statements suggesting he was open to prosecuting those who helped Texans leave the state for abortion.[xxiii] The Attorney General in Alabama declared that Alabama's abortion laws made it illegal to assist or otherwise facilitate someone getting an out-of-state abortion.[xxiv] Idaho and Tennessee have also created a new crime, abortion trafficking, to apply to anyone who helps a minor leave the state for an abortion without parental consent.[xxv] Laws like these make people, including physicians, nervous to help others seek abortion out of state.

When patients aren't properly counseled on the possibility for abortion or referred for care, they might continue a risky pregnancy, continue a nonviable and psychologically painful pregnancy, or attempt an abortion in an unsafe way. All of these possibilities can negatively impact a person's health. The famous Turnaway Study demonstrated that people who are denied abortions are more likely to report poor physical health than those who obtain them.[xxvi] Presumably, these risks increase if a pregnancy is complicated by underlying maternal or fetal disease.

Thus far, no state has tried to prosecute a healthcare provider for an out-of-state abortion referral. It is especially unlikely that they would do so if an abortion was sought for medical reasons. Moreover, courts in Alabama and Texas have both found that states cannot restrict people from leaving the state for abortion, so even if such a prosecution were attempted, it would be unlikely to succeed.[xxvii] But the chilling effect remains.

IV. Conclusion

Dobbs has chilled rheumatology practice in three distinct ways: the prescribing of rheumatology medications that could cause abortion, the prescribing of rheumatology medications that could cause fetal anomaly, and the referral of patients for abortion care. It's unlikely that any of these actions would lead to legal action, but the steep penalties associated with abortion bans and the zeal of antiabortion prosecutors have created a culture of fear that has harmed patients and intruded in the practice of medicine well beyond reproductive health. Given the low legal risks and the critical harms to patient care, there is a strong argument that rheumatologists should follow the standard of care without changing their prescribing or referral practices. But until the Supreme Court overturns the stain of *Dobbs*, there is no zero risk activity when healthcare can impact a pregnancy outcome.

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