DOI: 10.1111/1475-6773.14108

COMMENTARY

Chronic Conditions and Women's Reproductive Health

HSR Health Services Research

Dobbs and disability: Implications of abortion restrictions for people with chronic health conditions

Asha Hassan MPH[1] | Lindsey Yates PhD, MPH[2] | Anna K. Hing PhD, MPH[1] | Alanna E. Hirz MSPH[3] | Rachel Hardeman PhD, MPH[1]

[1]Center for Antiracism Research for Health Equity, University of Minnesota School of Public Health, Minneapolis, Minnesota, USA

[2]Center of Excellence, Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina, USA

[3]Fielding School of Public Health, University of California, Los Angeles, California, USA

Correspondence
Asha Hassan, Center for Antiracism Research for Health Equity, University of Minnesota School of Public Health, 2001 Plymouth Ave N Suite 106 Minneapolis, MN 55411, USA.
Email: hassa209@umn.edu

The United States has a long history of undermining the reproductive autonomy of people with chronic conditions. This includes people with disabilities that are seen or unseen, and related or not related to health.[1] The Dobbs decision, a June 2022 Supreme Court ruling which reversed the long-held constitutional right to an abortion, carries tremendous impact on all people. However, people managing chronic health conditions are particularly at risk of harm by the constellation of abortion bans and restrictions emerging across the United States. For example, people with disabilities experience disproportionate exposure to sexual violence, higher rates of unwanted pregnancy, and are at greater risk of maternal and infant mortality and morbidity.[2–4]

Before Dobbs, comprehensive and medically accurate pregnancy-options counseling, inclusive of abortion, was standard of care, but the shifting legal landscape has greatly limited choice for both patients and providers. When examining states with the highest prevalence of chronic health conditions,[5] it is concerning that these are also among the states with some of the most severe abortion restrictions.[6] For people with chronic health conditions, reproductive autonomy is rarely prioritized in state policy, health care institutions or clinical practice; therefore, health services researchers invested in making quality care attainable for this population must weigh the implications of a present and future health care system where abortion is no longer an option.

This commentary examines the intersecting and compounding issues of ableism, racism, and sexism in producing reproductive health challenges for people with chronic health conditions in a post-Dobbs United States. We, the authors, define chronic health conditions as long term and persistent health challenges that require medical treatment or routine accommodation and recognize that although many chronic health conditions are disabilities, not all disabilities are chronic health conditions. Furthermore, people with chronic health conditions, like all people, deserve reproductive justice—"the human right to maintain personal bodily autonomy, have children, not have children, and parent the children they have in safe and sustainable communities".[7] Health services research as a discipline has a role to play in supporting these rights and in interrogating the systems which diminish them.

1 | ACKNOWLEDGING THE EXPERIENCES OF PEOPLE WITH CHRONIC HEALTH CONDITIONS IN REPRODUCTIVE HEALTH CARE

During much of the 20th century, state-sanctioned forced sterilization commonly targeted people with disabilities, including those with chronic health conditions.[1] This legacy of eugenic policy continues to show up today.[8] Preconception care and medication management in the context of potential pregnancy has, at times, been problematic or even coercive. Dehlendorf et al. discuss this troublesome standard in the approach of preconception care: "the focus of pre-pregnancy health on people's bodies primarily with regard to their reproductive

capacity, rather than considering people's health as having intrinsic value in and of itself, is inconsistent with Reproductive Justice's grounding in human rights and focus on bodily autonomy."[9] Ableism directly shapes the experiences of people with chronic health conditions as they navigate reproductive health care by assigning value to more able-bodies, while simultaneously pathologizing differently-abled bodies, making them "less than."

Ableism is entangled in all aspects of reproductive care if bodies only carry value when they can bear equally healthy offspring. Biases impact provider and societal perceptions about reproduction for people with chronic health conditions: It is often believed that either their health is too compromised to carry a pregnancy to term, or that due to their chronic health condition, they are not sexually active and thus, they are not provided with comprehensive reproductive health education.[10] Both assumptions are harmful, diminishing reproductive autonomy by failing to offer reproductive health services that emphasize choice and by withholding appropriate support for people with chronic health conditions who do want to become pregnant.[10] In extreme, though not uncommon, cases, reproductive providers may even discourage pregnancy, appealing to the objective "suffering" experienced by those with chronic health conditions as reason to prevent similar suffering in future offspring.[10]

Perceptions grounded in ableism, such as the belief that disease and disability is the fault of the individual rather than heavily influenced by structural inequities, assigns social stigma and shame to people with chronic health conditions or disabilities, which carries on into pregnancy. With this stigma comes unjust doubts about the abilities of people with chronic health conditions to adequately care for their children. Stigma about having a perceived "unhealthy" pregnancy or "unconventional" parenting is a fixture in reproductive health care culture, driving victim-blaming and reproducing hierarchies of health. All people regardless of ability or identity must have control over their reproductive health and as of present, health care systems and policymakers have not adequately insured such for people with chronic health conditions.

2 | ALL CHRONIC HEALTH CONDITIONS MAKE PREGNANCY INTENTION AND DECISION-MAKING MORE COMPLEX

Even with appropriate and affirming preconception care, the precarious nature of pregnancy itself may necessitate a person with a chronic health condition to reconsider the wantedness of their pregnancy. Health is not a fixed status and abortion care as an intervention allows people with chronic health conditions to take control of their bodies even when events do not go to plan. Scholars often discuss pregnancy intention at time of conception or discovery and not as an evolving feeling throughout pregnancy gestation[11]; however, this interpretation insufficiently captures the complexity and nuance of pregnancy decision making for people with chronic health conditions. As expressed by the American College of Obstetrics and Gynecology, "pregnancy imposes significant physiological changes on a person's body. These changes can exacerbate underlying or preexisting conditions, like renal or cardiac disease, and can severely compromise health or even cause death."[12] Pregnancy can be disabling for many people, but people with chronic health conditions must consider pregnancy as a potential *further* disabling event.

For people managing chronic health conditions, how treatment and medication management is delivered can change significantly while pregnant. Since many medications commonly prescribed to treat chronic health conditions are not tested on pregnant people, these patients are frequently transitioned to less-effective, pregnancy-compatible medications that may provide inadequate disease management.[13] This issue of clinical trial exclusion of pregnant people, particularly for drugs that treat chronic health conditions, compromises pregnancy decision making. This is especially unjust given that women and people who can become pregnant are disproportionately likely to have a chronic diagnosis.[5]

Separately, some essential medications used to manage chronic health conditions may also be classified as teratogenic (linked to congenital malformations) or abortifacients (miscarriage causing). Given that half of all pregnancies in the United States are unplanned,[14] it is not inconceivable for someone who is prescribed a teratogenic medicine to learn they are pregnant after the fact, resulting in higher risk of fetal anomalies. One study suggests 1 in 16 pregnancies in the United States is exposed to teratogenic medications.[15] These patients, like all patients, should receive comprehensive pregnancy options counseling and have their decision to carry to term or have an abortion affirmed by their provider and in legal statute.

Since the overturning of the once-constitutional right to an abortion, access to life-saving, teratogenic drugs has been limited. For example, people with lupus are often prescribed methotrexate, a teratogenic drug and known abortifacient. Due to unfounded concerns that patients may use prescribed methotrexate to terminate a pregnancy, legal risk-averse health care organizations have created barriers that effectively harm patients and hinder access to continuous life-saving treatment.[16] At the same time, prescribing providers are forced to balance the ethical dilemma of prescribing a medication known to cause fetal anomalies in circumstances where patients cannot legally access an abortion.[16] Enforcing abortion bans and restrictions carry many consequences, including adversely affecting management of chronic health conditions like lupus.[17]

The current landscape of abortion restrictions also complicates other pregnancy decisions for people with chronic health conditions who rely on assisted reproductive technologies (ART) to conceive.[18,19] ART are fertility treatments that involve handling the egg or embryo outside of a birthing person's body.[20] These methods, which include in vitro fertilization, result in approximately 2% of live births in the United States.[20] For some people with chronic health conditions, ART is critical to ensuring that they are able to have the families they want. Some chronic health conditions like polycystic ovarian syndrome and autoimmune disorders affect individuals' reproductive health, making it difficult for them to conceive without additional medical intervention.[21] As a result, these individuals may rely on ART to become pregnant. Women and birthing people with lupus also use ART because

they are unable to stop medications that are incompatible with pregnancy due to the severity of their disease.[10] With the Dobbs ruling, techniques used in ART, such as selective reduction or discarding of embryos, may be prohibited as courts consider whether embryos have certain rights.[18,19] With unclear legislative support for ART, people living with certain chronic health conditions may have to give up the possibility of using ART to conceive and have biological children.

3 | RECOGNIZING THE COMPOUNDING EFFECTS OF RACISM AND ABLEISM FOR RACIALIZED PEOPLE LIVING WITH CHRONIC HEALTH CONDITIONS

Access to abortion services are particularly important for people who have multiple oppressed identities, such as people from racialized communities who are living with chronic health conditions. The relationship between race, chronic health conditions, and abortion is layered, with multiple, overlapping effects. First, many chronic health conditions disproportionately affect racialized people. Racial and ethnic inequities in chronic health conditions are not solely related to health behaviors and genetics, but these outcomes are rooted in systems of oppression, including structural racism. Structural racism is defined as "normalization and legitimization of an array of dynamics—historical, cultural, institutional and interpersonal—that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color".[22] Structural racism shapes when, where, and how people interact with various systems that impact their health and well-being. This includes their interactions with public health and health care systems, as well as their exposure to healthy food, water, and air, all resources that influence a person's likelihood of experiencing or better managing chronic health conditions. Chronic health issues have been linked to indicators of structural racism including racial residential segregation[23–27] and experiences of racial discrimination.[28,29]

Second, racial inequities in the diagnosis and treatment of chronic health conditions put people who are racialized at greater risk of having chronic health conditions that may be worsened by pregnancy. Some racialized populations are more likely to be undiagnosed for certain chronic health conditions such as diabetes,[30] endometriosis,[31] and cancer.[32,33] There is also evidence that racialized people do not receive the best available treatments for their chronic health conditions.[34] Multiple examples of treatment inequities exist in the literature. For example, Black patients with diabetes are less likely to be prescribed the highest quality diabetes medication.[35] Black women diagnosed with endometriosis are less likely to have minimally invasive gynecological surgery.[36] Black and Hispanic women are less likely to receive guideline-concordant care for gynecologic and breast cancers.[37] Even after accounting for differences in overall health, severity of disease, access to care, and other related factors, racial inequities in diagnosis and treatment remain. Because racialized people are at greater risk of being undiagnosed and receiving suboptimal clinical treatments, they may be at greater risk of adverse pregnancy outcomes. In addition to eliminating these inequities, racialized people with chronic health conditions should have access to timely abortion services to reduce the potentially debilitating effects of becoming pregnant while having an undiagnosed or untreated chronic health condition.

Third, racialized people have higher rates of chronic health conditions, and are more likely to experience adverse pregnancy health outcomes. Black and Indigenous women and birthing people are 2- to 3-times more likely to experience pregnancy-related mortality compared to White women and birthing people.[38] There is strong evidence that chronic health conditions are associated with higher rates of adverse pregnancy health outcomes,[39] and that Black and Indigenous birthing people disproportionately experience severe maternal outcomes in part because of having more comorbid conditions.[40,41] Like the inequity in chronic health conditions, the root cause of the inequity in maternal health outcomes is structural racism. Lack of access to abortion services for people with chronic health conditions is more troubling when we consider place. For instance, Black people are concentrated in the southern United States.[42] Many southern states have some of the strongest abortion restrictions[6] and highest rates of chronic health conditions.[5] For racialized people, the lack of access to abortion services, combined with the high prevalence of chronic health conditions and the increased risk of adverse pregnancy outcomes, could lead to drastic increases in racial and ethnic inequities in maternal deaths. A recent study estimates that abortion bans will result in a 39% increase in maternal deaths for Black people.[43]

Because of racial inequities in the prevalence of chronic health conditions and inequities in the diagnosis and treatment of chronic health conditions it is important that racialized women and birthing people have access to a range of reproductive health care services, including access to abortion. These services provide them with the autonomy to make decisions for their well-being and health.

4 | CONCLUSION

People with chronic health conditions in a post-Dobbs reality will face extraordinary challenges when accessing reproductive health care due to the complex and unjust intersections of ableism, racism and sexism. As health services researchers, we have an obligation to understand how changes in policy can create and exacerbate health inequities, such as the impact of abortion restrictions on people with chronic health conditions. People who live with chronic health conditions must fight daily for the right to make decisions regarding their reproductive health. We, too, must decide to fight for their right to choose.

FUNDING INFORMATION

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID

Asha Hassan https://orcid.org/0000-0003-0097-3075
Rachel Hardeman https://orcid.org/0000-0003-3913-5933

REFERENCES

1. Nourse V. Buck v. Bell: a constitutional tragedy from a lost world. *Pepp L Rev*. 2011;39:101.
2. Harrell E. Crime against Persons with Disabilities, 2009-2014-Statistical Tables. 2016. https://bjs.ojp.gov/content/pub/pdf/capd0914st.pdf.
3. Horner-Johnson W, Dissanayake M, Wu JP, Caughey AB, Darney BG. Pregnancy intendedness by maternal disability status and type in the United States. *Perspect Sex Reprod Health*. 2020;52(1):31-38.
4. Tarasoff LA, Ravindran S, Malik H, Salaeva D, Brown HK. Maternal disability and risk for pregnancy, delivery, and postpartum complications: a systematic review and meta-analysis. *Am J Obstet Gynecol*. 2020;222(1):27.e1-27.e32.
5. Newman D, Tong M, Levine E, Kishore S. Prevalence of multiple chronic conditions by US state and territory, 2017. *PLoS One*. 2020; 15(5):e0232346.
6. Kaiser Family Foundation. Abortion in the US Dashboard 2022. Accessed October 31, 2022. https://www.kff.org/womens-health-policy/dashboard/abortion-in-the-u-s-dashboard/.
7. Ross LJ, Brownlee SL, Diallo DD, Rodriquez L, Roundtable L. The "SisterSong Collective": women of color, reproductive health and human rights. *Am J Health Stud*. 2001;17:79-88.
8. Kozhimannil KB, Hassan A, Hardeman RR. Abortion access as a racial justice issue. *New Engl J Med*. 2022;387:1537-1539.
9. Dehlendorf C, Akers AY, Borrero S, et al. Evolving the preconception health framework: a call for reproductive and sexual health equity. *Obstet Gynecol*. 2021;137(2):234-239.
10. Hirz AE. *Psychosocial Factors Contributing to Pregnancy Decisions among Women with Lupus: A Qualitative Study. [Unpublished Doctoral Dissertation]*. University of California, Los Angeles; 2022.
11. Potter JE, Stevenson AJ, Coleman-Minahan K, et al. Challenging unintended pregnancy as an indicator of reproductive autonomy. *Contraception*. 2019;100(1):1-4.
12. The American College of Obstetrics and Gynecology. Abortion Can be Medically Necessary 2019. Accessed October 31, 2022. https://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary.
13. Shields KE, Lyerly AD. Exclusion of pregnant women from industry-sponsored clinical trials. *Obstet Gynecol*. 2013;122(5):1077-1081.
14. Guttmacher Institute. Unintended Pregnancy in the United States 2019. Accessed October 31, 2022. https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.
15. Sarayani A, Albogami Y, Thai TN, et al. Prenatal exposure to teratogenic medications in the era of risk evaluation and mitigation strategies. *Am J Obstet Gynecol*. 2022;227:263.e1-263.e38.
16. Rubin R. Threats to evidence-based care with teratogenic medications in states with abortion restrictions. *JAMA*. 2022;328(17):1671-1673.
17. Mahase E. US anti-abortion laws may restrict access to vital drug for autoimmune diseases, patient groups warn. *BMJ*. 2022;378:o1677.
18. Cohen IG, Daar J, Adashi EY. What overturning Roe v Wade may mean for assisted reproductive technologies in the US. *JAMA*. 2022; 328(1):15-16.
19. Daar J. Assisted reproductive technologies and abortion. 2015. The Oxford Handbook of U.S. Health Law. Oxford University Press.
20. Centers for Disease Control and Prevention; US Dept of Health and Human Services. 2019 Assisted Reproductive Technology Fertility Clinic and National Summary Report 2021. Accessed October 31, 2022. https://www.cdc.gov/art/reports/2019/pdf/2019-Report-ART-Fertility-Clinic-National-Summary-h.pdf.
21. Collée J, Mawet M, Tebache L, Nisolle M, Brichant G. Polycystic ovarian syndrome and infertility: overview and insights of the putative treatments. *Gynecol Endocrinol*. 2021;37(10):869-874.
22. Lawrence K, Terry K. Structural Racism. In: Chronic Disparity: Strong and Pervasive Evidence of Racial Inequalities POVERTY OUTCOMES for the National Conference on Race and Public Policy 2004. Accessed October 31, 2022. https://www.intergroupresources.com/rc/Definitions%20of%20Racism.pdf.
23. Woo H, Brigham EP, Allbright K, et al. Racial segregation and respiratory outcomes among urban black residents with and at risk of chronic obstructive pulmonary disease. *Am J Respir Crit Care Med*. 2021;204(5):536-545.
24. Plascak JJ, Beyer K, Xu X, Stroup AM, Jacob G, Llanos AA. Association between residence in historically redlined districts indicative of structural racism and racial and ethnic disparities in breast cancer outcomes. *JAMA Netw Open*. 2022;5(7):e2220908.
25. Kershaw KN, Albrecht SS. Racial/ethnic residential segregation and cardiovascular disease risk. *Curr Cardiovasc Risk Rep*. 2015;9(3):1-12.
26. Nardone A, Casey JA, Morello-Frosch R, Mujahid M, Balmes JR, Thakur N. Associations between historical residential redlining and current age-adjusted rates of emergency department visits due to asthma across eight cities in California: an ecological study. *Lancet Planet Health*. 2020;4(1):e24-e31.
27. Nardone A, Chiang J, Corburn J. Historic redlining and urban health today in US cities. *Environ Just*. 2020;13(4):109-119.
28. Simons RL, Lei M-K, Klopack E, Zhang Y, Gibbons FX, Beach SR. Racial discrimination, inflammation, and chronic illness among African American women at midlife: support for the weathering perspective. *J Racial Ethn Health Disparities*. 2021;8(2):339-349.
29. Chae DH, Martz CD, Fuller-Rowell TE, et al. Racial discrimination, disease activity, and organ damage: the Black Women's Experiences Living with Lupus (BeWELL) study. *Am J Epidemiol*. 2019;188(8): 1434-1443.
30. Britton LE, Hussey JM, Crandell JL, Berry DC, Brooks JL, Bryant AG. Racial/ethnic disparities in diabetes diagnosis and glycemic control among women of reproductive age. *J Womens Health*. 2018;27(10): 1271-1277.
31. Bougie O, Yap MI, Sikora L, Flaxman T, Singh S. Influence of race/ethnicity on prevalence and presentation of endometriosis: a systematic review and meta-analysis. *BJOG*. 2019;126(9):1104-1115.
32. Miller-Kleinhenz JM, Collin LJ, Seidel R, et al. Racial disparities in diagnostic delay among women with breast cancer. *J Am Coll Radiol*. 2021;18(10):1384-1393.
33. Doll KM, Snyder CR, Ford CL. Endometrial cancer disparities: a race-conscious critique of the literature. *Am J Obstet Gynecol*. 2018;218(5): 474-482.e2.
34. Morales ME, Yong RJ. Racial and ethnic disparities in the treatment of chronic pain. *Pain Med*. 2021;22(1):75-90.
35. Elhussein A, Anderson A, Bancks MP, et al. Racial/ethnic and socioeconomic disparities in the use of newer diabetes medications in the Look AHEAD study. *Lancet Region Health-Am*. 2022;6:100111.
36. Barnes WA, Carter-Brooks CM, Wu CZ, Acosta DA, Vargas MV. Racial and ethnic disparities in access to minimally invasive gynecologic surgery for benign pathology. *Curr Opin Obstet Gynecol*. 2021; 33(4):279-287.
37. Chen L, Li CI. Racial disparities in breast cancer diagnosis and treatment by hormone receptor and HER2 status. *Cancer Epidemiol Biomarkers Prev*. 2015;24(11):1666-1672.
38. Centers for Disease Control and Prevention; US Dept of Health and Human Services. Pregnancy Mortality Surveillance System 2022. Accessed October 31, 2022. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductivehealth%2Fmaternalinfanthealth%2Fpregnancy-mortality-surveillance-system.htm#race-ethnicity.
39. Admon LK, Winkelman TN, Heisler M, Dalton VK. Obstetric outcomes and delivery-related health care utilization and costs among

pregnant women with multiple chronic conditions. *Prev Chronic Dis*. 2018;15:E21.
40. Howell EA, Egorova NN, Balbierz A, Zeitlin J, Hebert PL. Site of delivery contribution to black-white severe maternal morbidity disparity. *Am J Obstet Gynecol*. 2016;215(2):143-152.
41. Kozhimannil KB, Interrante JD, Tofte AN, Admon LK. Severe maternal morbidity and mortality among indigenous women in the United States. *Obstet Gynecol*. 2020;135(2):294-300.
42. USA Facts. How the Black Population in the US Changed in the Last Census 2022. Accessed October 31, 2022. https://usafacts.org/articles/how-black-population-changed-in-the-last-census/.
43. Stevenson AJ, Root L, Menken J. The maternal mortality consequences of losing abortion access. 2022. SocArXiv. 10.31235/osf.io/7g29k.

How to cite this article: Hassan A, Yates L, Hing AK, Hirz AE, Hardeman R. Dobbs and disability: Implications of abortion restrictions for people with chronic health conditions. *Health Serv Res*. 2023;58(1):197-201. doi:10.1111/1475-6773.14108