

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

SEPTEMBER 3, 2026

Telehealth Access to Mifepristone — Evaluating Reproductive-Coercion Arguments

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June 24, 2026, marked the fourth anniversary of the *Dobbs v. Jackson Women's Health Organization* decision that overturned the constitutional right to abortion in the United States. Since then, the number of abortions has slightly increased,[1] a trend driven primarily by medication abortions, including in states with abortion bans. In response, antiabortion legal organizations and state attorneys general have brought several lawsuits challenging the safety of mifepristone — one of the two drugs in the medication-abortion regimen. In 2023, the Food and Drug Administration (FDA) adjusted its Risk Evaluation and Mitigation Strategy (REMS) for mifepristone to permit telehealth-based dispensing. Recent litigation has sought to reverse that change and reinstate the in-person dispensing requirement for mifepristone.

In addition to claiming that mifepristone is inherently unsafe — a claim that has been repeatedly refuted by studies conducted over decades[2] — antiabortion advocates have asserted that prescribing must occur in person to prevent reproductive coercion, specifically forced abortions. Given the increased prominence of the reproductive-coercion argument, it is important to assess its validity for driving policymaking. We contend that halting telehealth access to mifepristone would harm, not help, people who have experienced reproductive coercion or intimate partner violence (IPV).

In 2025, Louisiana Attorney General Liz Murrill sued the FDA, seeking a reversal of the REMS provision permitting telehealth access to mifepristone. Louisiana claimed that the drug harms women because of adverse effects, which had cost the state $92,000 in Medicaid bills, and that telehealth access to mifepristone frustrates its ability to enforce its abortion ban. The lawsuit, *Louisiana v. FDA*, was also brought on behalf of Rosalie Markezich, a Louisiana woman who says that her estranged partner was able to fraudulently obtain mifepristone by mail from a California clinician and then forced her to take it against her will to end her pregnancy. In May 2026, the U.S. Supreme Court temporarily paused an order by the Fifth Circuit Court of Appeals in *Louisiana v. FDA* that would have frozen telehealth access to mifepristone nationwide. The Trump administration filed a brief asking the lower

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court to pause all proceedings in the case while the FDA conducts its own review of the REMS for mifepristone. It did not participate in the appeal to the Supreme Court by Danco Laboratories and GenBioPro — two manufacturers of mifepristone challenging the nationwide injunction of the REMS imposed by the Fifth Circuit. The case is now back before the Fifth Circuit for further litigation of the appeal.

States with laws that permit greater access to contraception, abortion, and family-planning services tend to have lower pregnancy-associated homicide rates, including among younger Black and Hispanic women, than other states.

Bringing the lawsuit on behalf of Markezich allows Murrill to put a face to the alleged harms associated with permitting telehealth access to mifepristone. In addition to filing the lawsuit, Murrill testified in January 2026 before the U.S. Senate Committee on Health, Education, Labor, and Pensions, where she cited reproductive coercion as a significant problem resulting from telehealth access to mifepristone. Because mifepristone has been well studied and has a strong safety profile, the reproductive-coercion argument may be an important factor in this debate.

Reproductive coercion is defined as behavior that interferes with autonomous reproductive decision making, including sabotage of birth control, pregnancy coercion, or manipulation of pregnancy outcomes.[3] Up to 16% of women seeking routine reproductive health care report experiencing reproductive coercion, and nearly one third of people experiencing reproductive coercion report also experiencing IPV.[3] Reproductive coercion is consistently linked to unintended pregnancies, rape-related pregnancies, sexually transmitted infections (STIs), severe psychological or emotional trauma, and pregnancy-associated homicide.[3,4]

Reproductive coercion may involve either forced pregnancy or forced abortion, although research shows that forced pregnancy is more common.[3] Women in abusive relationships report seeking abortions in order to escape abuse.[3] When reproductive health care options are restricted, abusers may leverage pregnancy and forced parenthood to tether partners to a violent or coercive relationship.[3] Discreet access to medication abortion, particularly telehealth access, which allows patients to receive medication by mail, therefore offers a vital escape route for pregnant people in abusive relationships, since it averts the need for in-person visits or extensive travel under an abuser's surveillance.

For people in abusive relationships, barriers to abortion can be life threatening.[4] Unintended pregnancies are more common in abusive relationships than in healthy relationships,[4] and homicide is a leading cause of death among pregnant people in the United States. States with laws that permit greater access to contraception, abortion, and family-planning services tend to have lower pregnancy-associated homicide rates, including among younger Black and Hispanic women, than other states, whereas states that impose higher barriers to finalizing a divorce during pregnancy than at other times have significantly higher rates of pregnancy-associated intimate partner homicide.[4]

As policymakers and courts grapple with the safety of telehealth access to medication abortion in cases of possible reproductive coercion or IPV, they should consider the existing evidence reflecting which actions are most likely to promote safety and autonomous decision making. Any perpetrator of reproductive coercion should be held accountable, whether the coercion involves forcing a person to stay pregnant, forcing a person to have an abortion, or other intimidating or manipulative behavior. Although reproductive coercion can occur in the context of telehealth-based medication dispensing, there is no evidence that permitting telehealth access to mifepristone has resulted in increased rates of reproductive coercion at the population level.

In our view, the argument that telehealth access to mifepristone

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can abet reproductive coercion targets the wrong culprit: the REMS for mifepristone, instead of the abuser. Any medication may be wrongfully diverted, and there are already laws addressing fraudulent acquisition of medication, medication diversion, or forcing people to take medication against their will. Someone who forces medication on another person may be charged with assault and battery, for example. Reproductive coercion and IPV deserve to be taken seriously. Many existing laws intended to protect people experiencing IPV are poorly enforced, however.

Louisiana, the state challenging mifepristone access, had the highest rate of perinatal homicide by firearm in the United States in 2018–2021[5]; the majority of these homicides are perpetrated by intimate partners. Policymakers should focus their efforts on applying and enhancing existing domestic-violence laws and safety measures. Further undermining autonomous decision making and limiting reproductive health care options reinforces perpetrators' control and jeopardizes people's ability to escape abuse.

An audio interview with Elizabeth Tobin-Tyler is available at NEJM.org

Clinicians are often in a position to identify approaches for enhancing autonomy, to recognize warning signs of reproductive coercion, and to responsibly conduct screening and make referrals. Women who experienced reproductive coercion have reported that clinicians could have helped them by sharing information about nondetectable forms of contraception, such as long-acting reversible methods, including intrauterine devices and implants.[3] Availability of discreet forms of contraception — methods that an abuser cannot easily see or remove — is critical because reproductive agency helps protect against violence. Supporting autonomy also includes facilitating access to abortion, when it's desired by the patient. Telehealth-based medication dispensing may be the safest option in the context of surveillance by an abuser and barriers to in-person access to abortion.

Physicians in specialties that involve commonly caring for women of reproductive age, including primary care, emergency medicine, and obstetrics and gynecology, should receive training during residency in routinely assessing pregnancy intentions and patient safety and in identifying signs of reproductive coercion, including contraceptive sabotage, pregnancy-related pressure, sexual coercion, and interference with health care access. In addition, clinicians should remain vigilant for subtler clinical red flags, including inconsistent contraceptive use, frequent requests for emergency contraception, and repeated visits for pregnancy testing or STI testing.[3]

Best practices for screening include ensuring privacy (conducting screening away from intimate partners); completing screening over more than one visit (including virtually), when needed; being sensitive to patients' trauma; and making patients aware of available resources. Clinic staff should be knowledgeable about community resources, including rape crisis centers and domestic-violence advocacy organizations. Given the prevalence of IPV-related perinatal homicide, practitioners should use lethality assessment tools to measure risk and engage patients in safety-planning strategies.

The opposite of reproductive coercion is reproductive autonomy. Control of reproductive decision making and limitation of reproductive health care options, either by an abusive partner or by the government, undermines bodily autonomy and safety. We believe policies should target perpetrators of reproductive coercion rather than restrict access to evidence-based reproductive health care. Ending telehealth access to mifepristone would remove an important reproductive health care option for the people who may need it most.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on August 29, 2026, at NEJM.org.

1. Diep K, Castillo Sanchez B, Ranji U, Salganicoff A. Abortion trends before and after Dobbs. KFF. July 22, 2026 (https://www.kff.org/womens-health-policy/abortion-trends-before-and-after-dobbs/).
2. Gemzell-Danielsson K, Lindh I, Brynhildsen J, et al. Home use of mifepristone for medical abortion: a systematic review. BMJ Sex Reprod Health 2025;51:221-31.
3. Grace KT, Anderson JC. Reproductive coercion: a systematic review. Trauma Violence Abuse 2018;19:371-90.
4. Boyle KM, Regoeczi W, Meyer CB. State divorce laws, reproductive care policies, and pregnancy-associated homicide rates, 2018-2021. JAMA Netw Open 2024;7(11):e2444199.
5. Dholakia A, Monuteaux MC, D'Ambrosi G, McLone SG, Fleegler E, Lee LK. Firearm homicide in pregnant women and state-level firearm ownership. JAMA Netw Open 2025;8(11):e2542447.

DOI: 10.1056/NEJMp2608826
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