# What America's Struggle with Abortion Access Means for Reproductive Healthcare in Rhode Island

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## The Texas Heartbeat Act and the Current State of US Abortion Legislation

On September 1, 2021, Texas legislators passed the Texas Heartbeat Act, also known as Senate Bill 8 or "SB8," and in doing so changed the landscape of abortion care overnight. Whereas other "heartbeat bills" have failed to be enacted due to the historic Roe v. Wade ruling, SB8 has thus far evaded repeal by way of deeming "aiding and abetting" abortion after 6 weeks as a civil infraction to be enforced by private citizens rather than by government agencies. This law has resulted in a near total halt to abortion provision in Texas due to fears of overwhelming litigation for anyone involved in assisting in an abortion in any way, from providers and clinic staff to Uber drivers and family members. In a region like Texas' Rio Grande Valley, there is only one abortion clinic to meet the needs of millions of people, and the most severe effects have disproportionately landed on those with already limited resources and barriers to accessing healthcare.[1] Texans seeking abortion after 6 weeks of pregnancy have had to find care in neighboring states, across international borders, self-manage their abortions, or – if no care is able to be arranged – default into carrying undesired pregnancies. The SB8 legislation has coincided with a groundswell of other anti-abortion bills throughout the country. In 2021, states enacted 106 abortion restrictions, the most ever in a single year since the passage of Roe v. Wade.[2] According to the Guttmacher Institute, 58% of people who identify as women aged 13–44 currently live in a state considered "hostile" towards abortion access.[3] The Coastal US is not necessarily insulated from such hostility. In fact, despite the landmark 2019 passage of the Rhode Island Reproductive Privacy Act, which codified the right to abortion into our state legislature, restrictions still exist. In addition to a requirement for parental consent for persons under 18, Rhode Island state policy excludes insurance coverage for abortion for state employees and Medicaid patients, representing one in three Rhode Islanders. These laws disproportionately restrict abortion access for young, low-income persons and people of color who are overrepresented in the Medicaid program, restricting private medical decisions about their bodies and reproductive futures, and further entrenching minorities into disadvantaged positions.

## A Persistent Connection Between Discrimination and Restricting Abortions

In the pre-Civil War era, abortion before "quickening" was a common practice. At the time, most reproductive care, including birthing and abortion, was provided by midwives – many of whom were women of color, immigrants, and slaves.[4] Following the Civil War, the American birth rate was falling as women sought more freedom over their roles in society; this decline was especially striking among middle and upper class white families.[5] Subsequently, anti-abortion propoganda and moral panic regarding the decline of the white birth rate was on the rise. The medical community became highly involved in these cultural and political discussions. Horatio Storer, known as the father of American gynecology, lobbied the AMA shortly after its formation in 1857 to start a committee on "criminal abortion.[5] Their concerted efforts resulted in the AMA successfully delegitimizing midwifery while simultaneously lobbying state legislatures to outlaw abortion.[6] As this was at a time when women and people of color were excluded from the "legitimate" practice of medicine, essentially all reproductive care was relegated to white male physicians.

Even though all states had abortion bans on their books by 1910, affluent mostly white women who could afford to travel and pay private physician fees continued to access abortions.[7] Those who could not make these accommodations suffered the consequences. One study done in New York City in the 1960s showed that one in four childbirth-related deaths among white women was due to abortion, compared to one in two childbirth-related deaths among nonwhite women.[7] When Roe v. Wade was ultimately decided in 1973, the mortality rate from abortions sharply declined to the point that death from abortion is now exceedingly rare.[7] The increased access to abortion that followed Roe's passage lead to fewer delays in care; simultaneously, the proportion of abortions performed in the earlier stages of pregnancy, when complications are rare, rose.[7] This retrospective highlights the outsized effect that abortion laws have on autonomy, safety, and the long-standing, disproportionate, and potentially deadly burden these laws place on communities of color and socioeconomically disadvantaged communities.

## Where do we go from here?

Since Roe's passage, there have been continuous attempts to challenge and reverse it. Though many of these efforts have been unsuccessful, the recent Supreme Court hearings of United States v. Texas (regarding SB8) and Dobbs v. Jackson Women's Health represent the most serious legal threats to the constitutional right to abortion. Combined with the lack of state-level protections to abortion in a majority of states (only 15 have codified this right in their legislatures; 12 have "trigger laws" which would automatically ban all abortions if Roe was reversed)[8], we face the possibility of returning to a scarcity of accessible abortions as seen in the pre-Roe era and the subsequent harms associated with this lack of access. As physicians, we often see these harms strictly through the lens of physical health; but it is worth noting also the social harms inflicted on patients. Well over half of all persons seeking abortion are poor or low- income, and well over half are either already parents allocating their limited resources to their current children or otherwise cite that they do not have the resources to carry and subsequently care for a child.[9] The UCSF Turnaway Study found that 72% of people who sought an abortion but ultimately did not receive one ended up living in poverty, compared to 55% of those who were able to obtain an abortion, providing further evidence that restricting access to needed healthcare services like abortion perpetuates cycles of poverty.[10]

As we await Supreme Court decisions and look ahead to a new legislative session in Rhode Island, we as a healthcare community must prioritize reproductive autonomy, equity, and access for our patients and fellow Rhode Islanders. The pace of anti-abortion efforts is unlikely to let up; if unchallenged, these efforts will likely be successful in severely limiting abortion access for all, with the most significant burden falling on already historically and systematically disadvantaged communities. The medical community played an important role hundreds of years ago in suppressing reproductive choice with deleterious consequences, but we now have the opportunity to call for reproductive justice. In fact, the Rhode Island legislature is considering the Equality in Abortion Coverage Act this session, which would remove the discriminatory legislation prohibiting Medicaid and government insurance from covering abortion services. We should continue to support abortion clinicians in the state and the organizations that employ them. We need to advocate within our professional organizations for improved training for residents in abortion care, bolster this education in the primary care specialties, and support primary care offices seeking to provide abortions. Ultimately, without strong and clear effort to protect abortion access, we may quickly run out of time to stand up for reproductive justice.

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## Disclosures

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