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How the Texas Heartbeat Bill Will Affect Low-Income Women of Color Across the US: A Commentary

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Abstract

Governor Greg Abbott of Texas signed a law in May 2021 that will prohibit healthcare providers from performing abortion services after the detection of a fetal heartbeat. With this, Texas has joined several other states, mostly concentrated in the South and Midwest, that ban abortions after approximately six weeks. The subtleties of the Texas law are slightly different from the other states, but the detrimental repercussions will be the same: penalizing providers for attempting to benefit the health and wellbeing of their patients, resulting in less access to safe and legal abortion care. In this commentary, we discuss how the loss of access to abortion in the heavily populated, diverse state of Texas will overwhelmingly affect low-income individuals and women of color. We also seek to explain how this law is part of a larger agenda that will have a greater impact on all fifty states, especially if the precedent set by *Roe v. Wade* is overturned by a new Mississippi case recently taken up by the Supreme Court of the United States to be heard later this year. Ultimately, we aim to

demonstrate how laws aimed at restricting access to abortion will disproportionately affect Black, Hispanic, and low-income women, exacerbating racial health disparities already faced by marginalized groups. We conclude with steps physicians, medical students, and legislators can take to ensure safe and equitable access to abortion care, ensuring one's bodily autonomy.

Note from the Editor: This piece was written before the US Supreme Court officially reversed 1973 Roe v. Wade ruling in June 2022.

BACKGROUND: THE TEXAS HEARTBEAT BILL

On May 19, 2021, Texas Governor Greg Abbott signed a law that would ban abortions after six weeks of pregnancy.¹ The bill went into effect on September 1, 2021, when Texas joined over a dozen states that ban abortion after the presence of a fetal heartbeat.² Texas has put its own twist on the law by calling on its citizens to act as whistleblowers and prosecutors. Citizens may sue individuals, healthcare professionals, or anyone helping an individual obtain abortion care after six weeks.¹ Citizens are offered a bounty for reporting and prosecuting anyone who aids in accessing or provides an abortion after six weeks. Rather than large organizations, smaller groups and individual providers, who cannot financially sustain being involved in lawsuits, will be targeted.

This attempt to ban abortion is not scientifically founded. The basis of this law purports that if a fetal heartbeat is detected, it is too late for an abortion. However, the “heartbeat” that they are referring to at six weeks is just the electrical activity of cardiac myocytes — not a fully developed heart.^{3,4} The “heartbeat” that is detected is secondary to myocytes firing energy as they learn how to work. This does not equate to a pumping, functional heart. At six weeks, the heart is in a primitive state, the brain has not fully developed, the lungs are not mature, and the embryo is not able to feel pain because the neural network is not complete.⁵ Viability is a medical, not legal term, and it is not the role of the government to enforce religious definitions of viability onto medical practice.

One study found that women became aware of their pregnancies on average at 5.5 weeks of gestation; however, there is a sizable number of women who do not realize that they are pregnant until two menstrual cycles (i.e. approximately eight

weeks) have passed.⁶ This is because many women deal with irregular menstrual cycles, such that their periods will occasionally not happen within four weeks.⁷ For the 3-10% of American women with Polycystic Ovary Syndrome, going multiple months without a period is normal.⁸

Laws like this are particularly frustrating, because they are written and approved by people without medical expertise and who look nothing like the population most affected. The bill was endorsed by 19 Texan state senators, including all 18 of the white Republican senators (12 men, 6 women) and a Hispanic male Democratic senator.⁹ This law was not made with women, especially women of color, in mind. In 2020, 37% of women who sought a termination of pregnancy in Texas identified as Hispanic, 29% Black, and 84% unmarried.¹⁰ Women who are non-white or non-adherent to the traditional nuclear family structure are largely targeted by this ban, which covertly discriminates against these demographics.

WHO WILL BE MOST AFFECTED

The repercussions of this law will impact far beyond Texas. A recent Mississippi law aiming to entirely ban abortions after 15 weeks has been approved to be heard by the Supreme Court on December 1, 2021 [11]. Despite being struck down by lower courts for being unconstitutional — as it contradicts the precedent set by *Roe v. Wade* and *Planned Parenthood v. Casey*—the majority conservative Supreme Court has decided to take it on. The threat that this case brings to women's reproductive health is exactly what healthcare professionals feared when Justice Amy Coney Barrett was rushed to appointment. If the precedent of *Roe v. Wade* is overturned in this case, abortion would likely become illegal in 22 states, mostly clustered in the South and the Midwest, and 41% of women of

childbearing age across the country would have to travel on average 279 miles to reach their closest abortion provider.¹²

Obtaining an abortion will become impossible for people who cannot financially afford the cost of travel and the procedure. In other words, *this will make receiving a safe and legal abortion unattainable specifically for low-income women, immigrants, and women of color.* Meanwhile, wealthy women will likely still be able to attain safe and legal abortions.

Abortion care is increasingly concentrated amongst women below the poverty level.¹³ While the abortion rate amongst white women in the United States is 10/1000, it is 27.1/1000 amongst Black women and 18.1/1000 amongst Hispanic women.¹³ This demonstrates that socioeconomic status, access to healthcare, racism and discrimination play a role in *requiring* an abortion. Furthermore, Black women are over three times more likely than white women to experience a pregnancy-related death or severely morbid event during their pregnancy and postpartum period.^{14,15} Forcing pregnancy and birth onto women will not only increase these disparities but also prevent them from receiving quality care from trained clinicians due to legal limitations placed on training to perform abortions. By financially draining and legally penalizing abortion providers and non-profit organizations such as Planned Parenthood, the number of unsafe abortions and maternal mortality rates will increase. We have seen this happen globally and will likely see it happen domestically through bills such as these.¹⁶

WHAT LEGISLATION CAN DO

There are many ways legislators could decrease the incidence of abortion, instead of spending their resources fighting to restrict *access* to abortions. One of these measures includes funding initiatives aimed at destigmatizing birth control in low-income communities. Black and low-income women have been historically abused by the medical system, including through forced long-term birth control and sterilizations.¹⁷ There is reasonable medical mistrust in these communities,¹⁸ hence there is a need to assuage perceptions surrounding birth

control in minority communities through public service announcements, culturally sensitive health education grassroots work, and anti-racism and implicit bias training for physicians.

Countries with the most restrictive abortion laws also have the highest rates of abortion.¹⁹ Therefore legislators who want to reduce the number of abortions in their communities should endorse other measures, including 1) investing funding into comprehensive, medically accurate sexual education in public schools across the country, particularly in communities of color; 2) investing in social support, such as public education, healthcare, subsidized childcare on a national scale; 3) raising the federal minimum wage; 4) investing more resources into the foster care system; and 5) increasing access to high-quality prenatal care aimed at reducing racial disparities in maternal health outcomes. Essentially, legislative efforts aimed at reducing unwanted pregnancies, coupled with measures increasing support for people who choose to have children, reduce the incidence of abortion more than legislative efforts to restrict abortion access.²⁰

DISCUSSION

As one can see, “pro-life” legislators are not fighting for quality of life. They are simply *pro-birth*. Often, these legislators push for women to give birth to a child, and then absolve themselves of any responsibility to assist the parents or child afterward. Abortion is not a first-line method for family planning, and many people who need abortion services only get there after multiple systemic failures. Legislators who truly wanted to reduce the number of abortions would be working upstream, funding equitable access to healthcare and health education to prevent unplanned pregnancy. Instead, the political debate around abortion access is centered around controlling and colonizing bodies.

Reproductive justice is defined as the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.¹⁷ The impact of current proposed legislative interference like the Texas Heartbeat Bill will be far reaching. In 2011, nearly half of the 6.1 million pregnancies in the

United States were unintended.²¹ Over 60% of unintended pregnancies from 2015-2019 ended in abortion.¹⁹ This is a decision made by millions yearly. Restricting and limiting abortion access would violate the principles of reproductive justice and of bodily autonomy.

While it may take time to effect large-scale change in the U.S. legislature, the medical community possesses the capability to defend the rights of patients every day until then. The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”²² To promote, support, and create the opportunity for people to optimize all facets of their health, physicians must be more than just physicians: they must be physician-advocates for the health and safety of their patients, their communities, and beyond.

It is the right of the birthing person, not the government, to make choices about when, how, and if they want to carry a pregnancy. It is a medical decision to be discussed between patient and physician, not legislated by predominantly white men, who will never have to make such decisions. Destroying the legal precedent that protects this right will have devastating consequences on the health and safety of entire communities, not only birthing people. Criminalizing abortion only succeeds in making abortions more dangerous. We have seen this fail time and time again to lower rates of abortion all over the world, while disproportionately endangering marginalized groups, particularly women of color.¹⁹

CONCLUSION

As future clinicians, we need to be advocates for the health and wellbeing of diverse patient populations. Medical students and physicians must advocate to their legislators for the passage of policies to ensure complete access to abortion care. It is vital to encourage state and federal legislators to pass legislation that will protect women's reproductive rights unwaveringly. Currently, the legislature to support at a federal level includes the Women's Health Protection Act, a congressional act that seeks to create legal protection for abortion

providers and their patients and to protect against medically unnecessary restrictions on abortion, which impact accessing health care.²³

With the ultimate goal of protecting the right to safe, legal, and accessible abortions on the federal level, states can take action now by passing internal legislation to protect these rights, should the precedent set by *Roe v. Wade* be overturned by the Supreme Court. Massachusetts passed the ROE Act in December 2020 and New York passed the Reproductive Health Act in 2019 to codify provisions from *Roe v. Wade* into state law and remove unnecessary barriers.^{24,25} Several other states are also passing similar laws, but many more need to follow in their footsteps. Healthcare practitioners, as constituents, need to step up to demand these provisions be set in place for the safety of ourselves and our patients.

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