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Texas Senate Bill 8 and Abortion Experiences in Patients With Fetal Diagnoses

A Qualitative Analysis

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OBJECTIVE: To describe experiences with abortion counseling and access in patients with lethal or life-limiting fetal diagnoses in Texas after enactment of Senate Bill 8 (SB8).

METHODS: In this qualitative study, we interviewed patients who obtained abortions after enactment of SB8, using semi-structured interviews to explore how restrictions affected abortion care. Two researchers coded all transcripts using an inductive technique and analyzed themes in an iterative approach.

RESULTS: We interviewed 16 participants who reported gestational durations from 13 to 29 weeks at the time of abortion. Participants described loss of the therapeutic patient–physician relationship and feelings of isolation while pursuing abortion due to the limitations imposed by SB8. For example, participants felt there was a physician "gag rule" regarding abortion ("the unspoken word of termination"), resulting in the need to find information about pregnancy options outside of the medical community and further highlighting the privilege of financial resources necessary to obtain an abortion on their own. Participants also expressed fears regarding confidentiality with their support systems and clinicians ("I would joke around and say, well don't sue me, but halfway mean it") and personal safety when self-referring for abortion ("…am I making the right choice on where I need to go? Is it safe?").

CONCLUSION: Abortion restrictions and bans such as SB8 erode the patient–physician relationship, evoking fear and safety concerns during a vulnerable time for those undergoing abortion for lethal or life-limiting fetal diagnoses. They force patients to shoulder the significant burden of understanding pregnancy options and navigating the process of abortion alone, which is likely to have greater effects on those with fewer resources.

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Patients diagnosed with fetal conditions in pregnancy choose abortion at varied rates (47–95%) depending on the population studied, accessibility of abortion, and fetal diagnosis.[1–3] Most lethal or life-limiting fetal diagnoses are detected in the second trimester; options for abortion at this time include labor induction and dilation and evacuation.

Before September 2021, abortion was legal in Texas through 20 weeks of gestation (22 weeks since last menstrual period), with significant restrictions. Although exceptions to the gestational duration limit previously included "severe fetal abnormalities" per the Texas Health and Safety Code,[4] state law prohibited private insurance coverage of abortion for this indication.[5] Additionally, patients were mandated to receive state-directed materials and to have an ultrasound image of the pregnancy displayed and described before a 24-hour waiting period before an

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abortion could be performed.[6] Similar restrictions on abortion care have been shown to negatively affect patient experience through unmet expectations and preferences.[7]

On September 1, 2021, Texas Senate Bill 8 (SB8) became effective, prohibiting abortion in the presence of gestational cardiac activity, with no exception for fetal diagnoses.[8] Senate Bill 8 and subsequent comparable laws differ from other abortion restrictions in their method of enforcement. This style of ban offers a monetary award to uninjured private citizens who file civil lawsuits against those who provide aid to, or perform, an abortion in violation of the law; thus, they are sometimes referred to as "bounty hunter" abortion restrictions. With Texas' neighboring states progressively more hostile to abortion care after the overturning of *Roe v Wade* by the U.S. Supreme Court, there are increasingly fewer locations that provide abortion at increasing gestational durations.[9]

Given limited information regarding patient experiences with abortion in hostile settings, our overall aim was to describe experiences with abortion counseling and access in people with lethal or life-limiting fetal diagnoses in Texas to observe the effects of abortion restrictions. Initial recruitment for our study preceded SB8 implementation and continued after, allowing us to observe the effects in real time. For this analysis, we focused on the effects of SB8.

METHODS

We conducted a qualitative study using semi-structured interviews with patients who received or sought care in Texas for lethal or life-limiting fetal diagnoses. We received local IRB exemption given interview procedures with minimal risk to participants. Between July 2021 and June 2022, we used purposive sampling to identify potential participants. After SB8 enactment, we altered our recruitment from four Texas clinics that provide abortion care to include Texas genetic counselors and out-of-state abortion facilities in New Mexico, Oklahoma, and Colorado. Entry criteria included age 18 years or older, English- or Spanish-speaking, care in Texas for a lethal or life-limiting fetal diagnosis (based on the referring health care professional's clinical judgment), and no more than 6 months since abortion. Patients with these characteristics were given a flyer by referring health care professionals; those interested could contact the study team through secure voicemail or a study webpage. The study webpage included information about the study objectives and methods, and it identified the study team as reproductive health physicians seeking to better understand experiences with abortion in people who had care in Texas. We completed all contact by telephone. To confirm eligibility, the study team asked participants to report their age, primary language, and fetal diagnosis before choosing a time for the consent process and interview. English-language interviews were conducted by the primary investigator (C.B.), and Spanish-language interviews were conducted by a fluent co-investigator (E.S.).

Interviews included open-ended and semi-structured questions (Appendix 1, available online at http://links.lww.com/AOG/D27). To protect participant confidentiality, we collected minimal demographic data as applicable to the research question. The semi-structured interviews covered fetal diagnosis, pregnancy options counseling, abortion decision-making, and postabortion reflections. During the postabortion reflections section, participants were specifically asked, "In 2021, the Texas legislature passed a law to prevent abortion [or participant's preferred terminology] for fetal indications like yours. How did this impact you?" The interviews were audio-recorded, transcribed verbatim, and reviewed for accuracy. Interviews in Spanish were transcribed and translated into English by our institutional certified translation services. Participants received a $50 gift card.

Two investigators individually reviewed and coded all transcripts and subsequently met to discuss and resolve any discrepancies (C.B. and E.S.). Both interviewers were White female obstetrician–gynecologists who provide abortion care and have worked in the Texas medical system. Race–ethnicity and gender identity were included in an attempt to be transparent about researcher characteristics that may influence the research, per SRQR (Standards for Reporting Qualitative Research) guidelines. Given that no pre-existing framework was available on this topic, we used an inductive technique to develop and refine codes using a constant comparative approach throughout recruitment. Codebook organization was performed with NVivo 12 software. After the codebook was finalized, all codes were reviewed to identify themes, which then were discussed with the other study team members to develop overarching frameworks. Additional study team members included three obstetrics and gynecology specialists in Complex Family Planning–one White man, one Asian woman, and one Middle Eastern and North African woman; two provided abortion care in California, and one provided abortion care in Texas and Oklahoma when legally allowed. We aimed to enroll participants until thematic saturation was achieved; this point was identified by the two investigators performing coding and confirmed with the remaining study team

members when no new themes emerged in the final interviews. Guidance from qualitative research methodology suggested that we would need a minimum of 12 interviews.[10] In presentation of the data, participants are identified by gestational duration at the time of abortion and abortion location by state. Because SB8 was implemented during recruitment and findings pertinent to the effects of abortion restrictions are of timely importance, we have chosen to limit this initial analysis of our study to those who had abortions after SB8 was enacted.

RESULTS

We enrolled and interviewed 20 participants, of whom 16 underwent abortions after enactment of SB8 and were included in this analysis. Participants were aged 25–40 years; 15 interviews were conducted in English, and one was conducted in Spanish. Abortions occurred between 13 and 29 weeks of gestation at medical facilities in Colorado, New Mexico, and Washington. No participants were recruited from the Oklahoma referral site, and one participant who was referred from a Texas genetics counselor ultimately underwent an abortion in Washington. Fetal diagnoses included chromosomal conditions (eg, triploidy) and structural conditions (eg, anencephaly). Interview duration was a mean of 58±20 minutes.

When assessing the effect of SB8 on abortion care in patients with lethal or life-limiting fetal diagnoses, four key themes were identified from participants: 1) a perceived physician "gag rule" regarding abortion, 2) a need to obtain information about pregnancy options outside of the medical community and navigate the resources required to obtain an abortion on their own, 3) fears regarding confidentiality with clinicians and their support systems, and 4) a need to assess personal safety when self-referring for abortion. Overall, these themes resulted in loss of the therapeutic patient–physician relationship and feelings of isolation while pursuing abortion.

Participants expressed the feeling of a physician gag rule, or inability to speak openly about abortion, through phrases like, "the unspoken word of termination" (18 weeks, New Mexico) and "taboo to talk about" (29 weeks, Colorado). Some participants further described the feeling that clinicians wanted to discuss abortion but feared legal ramifications. For example, one person (20 weeks, New Mexico) described her interaction with her health care professionals:

> I felt like they were all deer in headlights. I felt like they were really stuck and were struggling to find the words to say. I felt like they wanted to say something, but they couldn't. And they were afraid. I felt like they had just all this information in their heads and in their hearts and wanted to give it to us but couldn't.

To avoid a direct discussion that may be perceived as unlawful, others experienced clinician communication about abortion in a roundabout way. One person recalled an encounter in which her physician indirectly indicated locations that provide abortion later in pregnancy. According to the participant, the physician stated that, "We're not allowed to discuss termination in this state. But you know, this time during the year, I frequently like to travel to New Mexico, Colorado, or New York" (18 weeks, New Mexico). Several people described other methods of indirect communication, such as displaying information about abortion on a computer screen for the participant to self-review or speaking after-hours through personal communication methods.

The lack of clear and direct communication led to confusion and distrust. One person recounted that a maternal–fetal medicine specialist had discussed the option of abortion given her fetal diagnosis. However, the following week, when the patient was seen by a different maternal–fetal medicine in the same practice, she brought up abortion and was told, "We can't advise you to do that in the state of Texas and no one in this office would have said anything like that to you" (19 weeks, New Mexico). Participants also expressed that they felt some physicians withdrew care after the decision to proceed with abortion. One person stated, "I feel like once I mentioned ending my pregnancy, that was confirmation for them that they needed to no longer follow up with anything else" (18 weeks, New Mexico).

Given the lack of support from their physicians, participants described the need to find their own information about pregnancy options and self-navigate the resources required to obtain an abortion in the setting of SB8 restrictions. As with many patients seeking abortion, participants addressed their finances as a major factor in their ability to receive an out-of-state abortion; an abortion procedure and associated travel is an upfront, unanticipated out-of-pocket cost, with many citing figures between $10,000 and $20,000. Some participants commented on relief from private abortion funds, without which they would not have been able to afford the abortion, and others specifically noted their financial resources as a privilege not shared by all. When asked what was helpful during the process, one person answered that the "crass answer is…money" (18 weeks, New Mexico).

More specific to those affected by SB8, participants also discussed heavy reliance on personal resources of knowledge. Due to limited counseling with the perceived physician gag rule, all participants reported directing their own search for information about fetal diagnosis, pregnancy options, or abortion. An example of a sentiment reiterated by many participants was, "I felt like I had to do my own research…I tried not to go full on Google…but I felt like that was all I had" (26 weeks, Colorado). The benefit of personal resources of knowledge was specifically noted by participants with relevant backgrounds (eg, medical student, nurse, funeral home director, and special education teacher). Others had a close friend or family member who acted as a resource of knowledge. For example, one person discussed her fetal diagnosis with her mother-in-law, who works with children with special needs, and it was through her mother-in-law, not her clinicians, that she realized abortion was an option (19 weeks, New Mexico). Another participant, having experienced a prior pregnancy with the same inheritable fetal condition, described her decision as easy based on prior knowledge despite a lack of significant guidance from her physicians (13 weeks, New Mexico).

Due to the bounty-hunter style of enforcing SB8 through civil suits filed by private citizens, participants discussed fears about the confidentiality of their abortions. Many noted a fear of discussing abortion plans with their doctors. One participant said, "I didn't know if I could talk to my doctor…like you have doctor-patient confidentiality…but the ban makes it feel like you're doing something wrong. And I just didn't feel safe talking to anybody about it" (19 weeks, New Mexico). Furthermore, this person questioned how to obtain medical records for a safe transition to out-of-state care while maintaining confidentiality.

Participants also reported confidentiality concerns among their support systems and discussed how this affected their ability to process the trauma of a lethal or life-limiting fetal diagnosis. Although SB8 targets those who aid in an illegal abortion and excludes the patient themselves, participants mentioned fear of being sued or putting their friends or family at risk of being sued. "It's been a miserable, miserable experience. The fact that I can't talk about it openly when I want to…I would joke around and say…don't sue me, but halfway mean it…to keep it all bottled up just makes it even harder" (27 weeks, Colorado).

Lastly, participants discussed the burden of self-referring for abortion given the lack of referral or recommendation from their clinicians. For many, safety concerns stemmed from not having a trusted reference. One participant (13 weeks, New Mexico) used the following words to describe her experience:

> They can't recommend us where to go. That was the issue. And I don't want to go and Google it and go to the random places, because I don't know what kind of people are there-…If my doctor is recommending someone, then it is good, because I trust them. But if they can't help, and tell me where to go, now what?

Other participants noted safety concerns specifically related to the inability to meet out-of-state health care professionals before the procedure, as well a lack of choice in their doctor because of limited procedure availability. The latter statement was further supported by many participants and perceived to be an effect of the influx of Texas patients into out-of-state clinics. Reflective of common sentiments about the effect of out-of-state care, one person stated, "You're pushing your patient out of state to get care with some other doctor that I don't know. And I think that was more scary than anything. Versus if I could have done it here in Texas with a provider that I feel safe with" (29 weeks, Colorado).

DISCUSSION

Due to limitations imposed by SB8, participants described loss of the patient–physician relationship and support during the process of understanding pregnancy options and pursuing abortion. Patients perceived that clinicians were silenced due to fear of state restrictions, leading to miscommunication and isolation. Although financial cost, a well-established barrier to abortion,[11] was noted by patients, knowledge obtained through one's occupation, prior experience, or a support person was also considered a critical resource given a lack of information from the medical community. The bounty-hunter style of SB8 enforcement created uncertainty about patient–physician confidentiality as well as fear of legal repercussions for oneself or one's support system. Lastly, safety concerns resulted from abortion self-referral without trusted physician guidance.

Increasing antiabortion legislation and the reversal of *Roe v Wade* have spurred interest in research on patient experiences with abortion care in hostile settings. Two recent publications provide physician perspectives on abortion in states with significant restrictions. A *New England Journal of Medicine* perspective featured findings from interviews with Texas patients and physicians regarding abortion care after passage of SB8.[12] It describes a broad "chilling effect" on health care professionals; in the perspective piece,

some physicians were legally advised against discussing abortion in any terms. Notably, this pervasive effect has been described previously in literature assessing repercussions of the "global gag rule," a U.S. government policy that blocks federal funding for international nongovernmental organizations that perform, provide referral for, or advocate for abortion.[13] In addition, a recently published qualitative study of obstetrician–gynecologists in Ohio concludes that, "…institutional interpretations of abortion regulations undermined physician expertise and professional autonomy…"[14] It is reasonable to connect these physician perspectives to our patients' perceptions; regulation-born erosion is being felt on both sides of the patient–physician relationship.

Abortion bans that silence health care professionals, such as SB8, have been shown to create confusion and fear. On a global scale, uncertainty regarding interpretation of the global gag rule and concern for lost funding led to institutional overimplementation and self-censorship outside the scope of the rule.[13] For example, the gag rule led to spurious concerns about the legality of discussing contraception and using the word "abortion" in a research context. Similarly in our study, despite all participants having received legal abortions, they self-censored information about their abortions from their physicians and support systems. Furthermore, although SB8 does not target the person obtaining the abortion themselves, participants explicitly feared being personally sued. This chilling effect disrupted continuity of care (eg, transferring medical records) and was a barrier to the therapeutic effect associated with disclosing and seeking support for a traumatic life event.

Our findings suggest that restrictions such as those in SB8 may worsen disparities between those who can and cannot access abortion. As abortion care is pushed out of state, investment of significant personal financial resources (eg, transportation, lodging, childcare, time off work) will likely increase for many, and existing abortion funds are finite. Equally concerning is the identification of personal knowledge-based resources from one's occupation or experiences as a replacement for physician counseling and recommendation. Dependence on both kinds of resources could further increase the gap in abortion access between those who obtain the knowledge and means to seek abortion and those who do not. Although no study exists on the effect of pregnancy continuation in a patient who desired abortion for a fetal diagnosis, the negative effect of continued pregnancy in those who desire or seek abortion is well-established.[15,16]

Strengths of our study include the in-depth interview format and ongoing recruitment after enactment of SB8, which allowed us the unique opportunity to capture information during this consequential change. The self-referral process created limitations; those who contacted the research team are potentially different in some ways from those who did not. Notably, approximately 30% of Texans speak Spanish, but it was the primary language of only a single study participant.[17] Participants younger than age 18 years were not included and may face additional barriers to maintaining confidentiality and accessing abortion. Furthermore, this sample represents only those who chose and underwent abortion and not patients who were counseled and chose pregnancy continuation or who chose abortion but, due to barriers, did not obtain it.

Since we performed this study, the abortion landscape in the United States has continued to evolve. After the overturning of *Roe v Wade* by the U.S. Supreme Court in June 2022, abortion access is now decided by each individual state. In Texas, House Bill 1280 has made all abortion illegal, with the exception of threat to the life of the mother, with both criminal and civil penalties for anyone who performs or attempts to perform an abortion in the state.[18] Although qualitative research helps to form a framework for the effects of such abortion restrictions, further research is needed to quantify the effects on our patients.

In summary, for those undergoing abortion for a fetal diagnosis, bounty-hunter style abortion restrictions such as SB8 erode the patient–physician relationship, evoke fear and safety concerns, and create a significant burden on patients to understand pregnancy options and navigate the process of abortion alone. These restrictions could have greater effects on those with fewer resources, especially in a rapidly changing and increasingly hostile abortion landscape nationwide.

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