Miscarriage, Stillbirth, & Reproductive Justice

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ABSTRACT. *Each year in the United States, millions of women's pregnancies end not with the birth of a living child, but in miscarriage or with the birth of a dead, stillborn child. Marginalized women face a higher risk of these undesired endings. Compared to white women, black women are twice as likely to suffer a late miscarriage and to give birth to a stillborn child. Compared to wealthier women, women of lower socioeconomic status face a heightened risk of miscarriage and are twice as likely to give birth to a stillborn child.*

Miscarriage and especially stillbirth are significant life experiences for women. Yet, they receive little attention within women's rights movements. For years, the reproductive rights movement has avoided the topics of miscarriage and stillbirth due to their supposed conflict with fetal personhood. Motivated to highlight the experiences of marginalized women, women of color introduced the more holistic reproductive justice movement. Despite its broader lens, however, reproductive justice still does not highlight women's experiences of miscarriage and stillbirth.

This Article seeks to cure these omissions and to define women's reproductive justice-based rights concerning miscarriage and stillbirth. She has a right to prenatal care aimed at preventing miscarriage and stillbirth. She has a birth justice right to give birth to her stillborn child as she desires and to be fully informed of her treatment options for miscarriage, including the costs of those options. She has a right to culturally appropriate mental and emotional health treatment after miscarriage or stillbirth. Last, she has a right to parent her stillborn child, a motherhood entitled to legal recognition in the form of tax benefits, birth certificates, tort claims, and entitlement to autopsies.

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I. INTRODUCTION

On February 22, 2019, a 24-year-old Honduran woman being held in border custody in Texas gave birth to her son.[1] She was 27 weeks pregnant, just days before her third trimester, and went into premature labor.[2] Before medical help could arrive, she gave birth to a stillborn baby boy.[3] She and her son were then transported to a hospital forty minutes away.[4]

Little else is known about this woman. Perhaps she had wanted an abortion but could not obtain one in Honduras, where abortion is illegal.[5] Or, maybe she desired her child and wanted to raise him somewhere other than Honduras, a country where two thirds of people live in poverty and increasing gang membership and activity has made it "one of the deadliest countries in the world."[6] Maybe she, like many others, came to America in hopes of a better future for her son—a parenting decision thwarted by his stillbirth.

News coverage of this child's stillbirth questioned the quality of health care pregnant detainees receive while in custody.[7] The government declined to investigate, however, explaining that "for investigative and reporting purposes, a stillbirth is not considered an in-custody death,"[8] even though a viable fetus is considered capable of "independent existence," a "second life" eligible for state protection in abortion jurisprudence.[9] We do not know about her health care before his stillbirth, and we also do not know about her health care after his stillbirth. We do not know whether she was able to hold and spend time with him, giving her a chance to say goodbye to her son.[10]

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[1] Scott Bixby, *Migrant Woman's Pregnancy Ends in Stillbirth, in ICE Detention*, Daily Beast (Feb. 25, 2019), https://www.thedailybeast.com/migrant-woman-miscarried-baby-boy-in-ice-custody; *see also* Mihir Zaveri, *Woman Delivers Stillborn Baby While in ICE Custody*, New York Times (Feb. 25, 2019), https://www.nytimes.com/2019/02/25/us/mother-birth-ice-custody.html.

[2] Bixby, *supra* note 1.

[3] *Id.*

[4] *Id.*

[5] Human Rights Watch, *Honduras: Abortion Ban's Dire Consequences* (June 6, 2019), https://www.hrw.org/news/2019/06/06/honduras-abortion-bans-dire-consequences.

[6] Nichole Sobecki, *Why People Flee Honduras*, Politico Magazine (June 7, 2019), https://www.politico.com/magazine/story/2019/06/07/honduras-why-people-flee-photos-227087; *see also* Marcia Biggs & Julia Galiano-Rios, *Why families by the thousands are fleeing Honduras for the U.S.* (Mar. 20, 2019), https://www.pbs.org/newshour/show/why-families-by-the-thousand-are-fleeing-honduras-for-the-u-s (quoting a mother explaining that she "want[s] a better life for [her] son").

[7] Zaveri, *supra* note 1.

[8] U.S. Immigration and Customs Enforcement, *Joint Statement from ICE and CBP on stillbirth in custody*, (Feb. 25, 2019) https://www.ice.gov/news/releases/joint-statement-ice-and-cbp-stillbirth-custody; *see also* Zaveri, *supra* note 1 (quoting the director of United States research for the Migration Policy Institute that "it would seem unlikely detention was the cause" of the stillbirth because she was detained only a few days).

[9] Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 870 (1992).

[10] *See infra* notes 272-275 and accompanying text (discussing researchers' almost unanimous agreement that holding the baby after stillbirth is beneficial for parents).

This woman is just one of millions of pregnant women in the United States who makes a choice to parent her child but does not physically produce a living child at the end of pregnancy. Possibly as high as one fourth of pregnancies end in miscarriage, the term for a pregnancy loss before twenty weeks of pregnancy.[11] Another one in one hundred pregnancies end in stillbirth, the death of the unborn baby while still in the womb after twenty weeks of pregnancy but before birth.[12] These rates translate to millions of women miscarrying and tens of thousands more giving birth to a dead, stillborn baby each year in the United States.[13] Many women consider their miscarriages to be significant life events.[14] And, needless to say, giving birth to a dead baby is traumatic and significant for women.[15] Miscarriage and especially stillbirth can have long-term psychological consequences for women.[16]

Notably, not all women face the same risks of miscarriage and stillbirth. A black woman's risk of miscarriage after ten weeks of pregnancy is double that of a white woman's.[17] A black woman's risk of stillbirth is also double that of a white woman's.[18] Women of lower socioeconomic status also face an increased risk of miscarriage and their risk of stillbirth is again double that of woman of lower socioeconomic status.[19] A white woman's increased education lowers her risk of stillbirth, but a black woman's increased education does not.[20]

Despite the significance of miscarriage and stillbirth in women's lives, these pregnancy-ending experiences are rarely featured in activism for women's reproductive freedoms. The reproductive rights movement focuses on a woman's right to choose abortion.[21] The movement assumes a binary—either the woman is able to obtain an abortion or will give birth to and raise a living child.[22] The opposing pro-life side has acknowledged that pregnancies end in miscarriage and stillbirth, but only to weaponize a woman's grief as evidence of fetal personhood.[23] In response, the pro-choice reproductive rights

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[11] *See infra* Part III.A.

[12] *Id.*

[13] *Id.*

[14] MMJ van den Berg, et al., *Patient-centered early pregnancy care: a systematic review of quantitative and qualities studies on the perspectives of women and their partners*, 24:1 HUMAN REPRO. UPDATE 106, 113 (2018).

[15] *See infra* notes 134-136.

[16] *See infra* notes 132-136.

[17] *See infra* Part III.A.

[18] *Id.*

[19] *Id.*

[20] *Id.*

[21] *See infra* Part II.

[22] *See infra* Part III.B.

[23] *Id.*

movement has opted to avoid the topics of stillbirth and miscarriage to the greatest extent possible.[24]

Fortunately, women of color introduced a more holistic approach to women's reproductive rights eventually named the reproductive justice movement.[25] Aiming to highlight the experiences of marginalized women, the movement rejects the individualistic notion of choice because not all women get to choose.[26] Similarly, marginalized women have also faced oppression of more than just their right to not have a child, prompting the movement to recognize the equally important rights to have a child and to parent that child.[27] Reproductive justice also recognizes these as positive rights, requiring support to help a mother parent and raise her child.[28] Legal scholars have increasingly embraced reproductive justice as the more appropriate framework for women's reproductive freedoms.[29] Despite its holism, however, the reproductive justice framework still does not emphasize women's experiences of miscarriage and stillbirth.[30] Some mentions exist, but for the most part, reproductive justice still assumes the same binary that a woman has an abortion or parents a living child.[31]

This Article attempts to cure this omission. It uses a reproductive justice analysis to define women's rights concerning miscarriage and stillbirth, an analysis that is especially necessary for marginalized women. Just as marginalized women additional difficulties in obtaining abortions and parenting their children, women of color and poor women also face a higher likelihood of miscarrying their pregnancies and giving birth to a stillborn baby.

The first right is the right to preventative prenatal care. Reproductive justice already recognizes a woman's right to health care, to which marginalized women often have less access,[32] including the right to prenatal care. But the emphasis in prenatal care must be on prevention of miscarriage and stillbirth.[33] Numerous studies in Europe suggest that differing medical care explains the socioeconomic disparity in the stillbirth risk,[34] a concern that should be even greater in the United States. Women must have access to preventative prenatal

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[24] *Id.*

[25] *See infra* Part II.

[26] *Id.*

[27] *Id.*

[28] *Id.*

[29] *See e.g.,* Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 730 (2018); Priscilla A. Ocen, *Incapacitating Motherhood*, 51 U.C. DAVIS L. REV. 2191, 2240 (2018); Erwin Chemerinsky & Michele Goodwin, *Abortion: A Woman's Private Choice*, 95 TEX. L. REV. 1189, 1235-36 (2017); Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 YALE L.J. 1394, 1425 (2009); *see also* REPRODUCTIVE RIGHTS AND JUSTICE STORIES (2019) (Melissa Murray, Katherine Shaw, & Reva B. Siegel editors).

[30] *See infra* Part III.C.

[31] *See infra* Part III.C.

[32] *See infra* Part IV.B.

[33] *Id.*

[34] *Id.*

care—prenatal care that includes education of women on the risk of stillbirth and the known, simple preventative measures.[35] Reproductive justice's intersectional lens also highlights the need for new research on the causes of miscarriage; the usual assumption about chromosomal abnormalities assumes miscarriages before twelve weeks, not explaining miscarriages after twelve weeks, the type of miscarriage of which black women face a double risk.[36]

A woman also has birth justice rights within stillbirth.[37] Reproductive justice already recognizes a woman's right to give birth as she chooses and to be free from undesired and unnecessary medical interventions commonly labeled "obstetric violence."[38] Giving birth to a stillborn child is "physiologically identical"[39] to giving birth to a living child, although more traumatic.[40] A woman has a right to give birth to her stillborn child as she desires, including a medically unnecessary cesarean delivery if she so desires.[41] A woman also has a right to be informed of all of her treatment options in case of miscarriage, including information on the costs.[42]

A woman's reproductive-justice based right to health care includes not just empowering health care for the physical consequences of miscarriage and stillbirth, but also her right to mental and emotional health care.[43] Studies show that although black women face a higher risk of miscarriage and stillbirth, they have less access to bereavement support.[44] Studies also show that parents of color are less inclined to hold the baby after stillbirth despite its beneficial psychological effects grief and that black women find support groups less helpful than white women.[45] Reproductive justice's emphasis on the experiences of marginalized women helps show that mental health support is not a one size fits all.[46]

Last, a woman has a right to parent her stillborn child.[47] Empirical studies confirm parental identification, as do longstanding state laws making parents responsible for the final disposition of their stillborn child's body.[48] Various legal measures of affirming parenthood after stillbirth—tax benefits, stillbirth birth certificates, tort claims, and insurance coverage for autopsies—

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[35] *Id.*

[36] *Id.*

[37] *See infra* Part IV.C.

[38] *Id.*

[39] Joanne Cacciatore, *The Unique Experiences of Women and Their Families After the Death of a Baby*, 49 SOC. WORK HEALTH CARE 134, 135 (2010).

[40] *See infra* Part IV.C.

[41] *Id.*

[42] *Id.*

[43] *See infra* Part IV.D.

[44] *Id.*

[45] *Id.*

[46] *Id.*

[47] *See infra* Part IV.E. I describe in this section why parenthood exists after stillbirth, but not after miscarriage.

[48] *Id.*

are controversial under the reproductive rights framework but perfectly consistent with the reproductive justice framework.[49]

The organization of the Article is as follows. Part II describes the initial reproductive rights movement and its more holistic replacement, the reproductive justice movement. Part III explains miscarriage and stillbirth, and both movements' essentially and incorrectly assume a binary—that a woman either has an abortion or her pregnancy ends in the birth of a living child. Part IV then argues that the reproductive justice framework feature women's experiences of miscarriage and stillbirth and describes women's reproductive-justice based rights concerning miscarriage and stillbirth. Part V briefly concludes.

II. FROM REPRODUCTIVE RIGHTS TO REPRODUCTIVE JUSTICE

"The mainstream reproductive rights movement has roots in a broader women's rights movement that advocated for women's equality, articulating reproductive and sexual freedom as the means to self-determination, full participation in society, and emancipation from patriarchal control."[50] A necessary freedom to achieve that self-determination, participation, and emancipation was a woman's ability to control her body—either by "controlling reproduction through the use of contraception or by deciding whether to terminate a pregnancy."[51] The reproductive justice movement thus focused on the right to not have a child.[52] Activists first tried to lobby state legislatures to expand the availability of contraception and abortion, but had little success.[53] They then turned to the courts, where they eventually had great success.[54]

That success included the Supreme Court's opinions in *Griswold v. Connecticut*[55] and then in *Roe v. Wade*.[56] First, in *Griswold*, advocates for the reproductive rights movement convinced the Supreme Court to announce a right to contraception in the form of the Court's invalidating laws that restricted the distribution of contraception.[57] Then, in *Roe*, the Court declared unconstitutional Texas's law banning abortion at any time during pregnancy, thereby recognizing a right to abortion,[58] although also recognizing the state's

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[49] *Id.*

[50] Angela Hooton, *A Broader Vision of the Reproductive Rights Movement: Fusing Mainstream and Latina Feminism*, 13 AM. U. J. GENDER SOC. POL'Y & L. 59, 61 (2005).

[51] Seema Mohapatra, *Law in the Time of Zika: Disability Rights and Reproductive Justice Collide*, 84 BROOK. L. REV. 325, 339 (2019).

[52] *Id.*

[53] Hooton, *supra* note 53, at 61.

[54] *Id.*

[55] 381 U.S. 479 (1965).

[56] 410 U.S. 113 (1973).

[57] *Griswold*, 381 U.S. at 485-86.

[58] *Roe*, 410 U.S. at 162-64.

interest in regulation of abortion.[59] The Court based both rights on a right to privacy,[60] a right defined negatively as to be "free from state interference."[61]

As the reproductive rights movement continued to grow, "[w]omen of color activists" expressed some concerns.[62] The right to abortion in *Roe* was based on privacy, but not all women had equal opportunities for privacy. These activists "began to point out in the 1970s and 1980s that only women who could afford to enter the marketplace of choices—motherhood, abortion, and adoption—had access to this zone."[63] Put another way, "[p]rivacy assumes access to resources and a level of autonomy that many people do not have. A privacy approach cannot accommodate the fact that many people rely on government support for their daily activities …."[64]

Women of color also were concerned that the emphasis on privacy and that the individualistic notion of choice "mask[ed] the different economic, political, and environmental contexts in which women live their reproductive lives."[65] A woman's "class, race, gender, sexuality, status of their health, and access to health care"[66] all affect a woman's reproductive life and preclude "choice." For instance, a woman without financial resources "could not exercise choice in the same way"[67] as a woman with such resources. The emphasis on choice also "disguises the way that laws, policies, and public officials differently" treat women based on those circumstances.[68]

Women of color also disagreed with the narrow focus of reproductive rights movement—the right to not have a child via contraception and abortion. The movement ignored the "other side of the coin: the right to reproduce and to be a mother …."[69] Again, a narrow focus on prevention

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[59] *Id.* at 162. Balancing the woman's right and the state's interests, the Court held that the state's interest in protecting the woman's health allowed restrictions on abortion only after the first trimester (12 weeks) because before then, abortion was safe. *Id.* at 163. The Corut also held that the state's interest in potential life allowed restrictions on abortion only after viability, the point at which "the fetus then presumably has the capability of meaningful life outside the mother's womb." *Id.* The Supreme Court changed all of this in *Planned Parenthood of Southeastern Pa. v. Casey*. 505 U.S. 833 (1992). In *Casey*, the Court held that the state's interest in potential life allowed it to regulate abortion throughout the woman's pregnancy and to ban abortion after viability. *Id.* at 869-70.

[60] *Id.* at 152; *Griswold*, 381 U.S. at 485-86.

[61] Hooton, *supra* note 53, at 62.

[62] LORETTA ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION 47 (2017).

[63] *Id.*

[64] Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. OF LAW & SOC. SCI. 327, 329 (2013).

[65] ROSS & SOLINGER, *supra* note 62, at 47.

[66] *Id.*

[67] *Id.*; *see also* Rebouche, *supra* note 78, at 592 (explaining that "mainstream reproductive rights organizations" in the US "overlooked or undermined the experiences of marginalized populations of women").

[68] *Id.*

[69] ROSS & SOLINGER, *supra* note 62, at 48.

reflected that white women had been behind the reproductive rights movement; the main reproductive oppression that white women had faced had affected prevention of pregnancy. But women of color and other marginalized women had also faced reproductive oppression related to having a child, examples including the separation of children from their enslaved mothers and forced sterilization.[70] Because of this history, the right to have a child was of "crucial concern"[71] and just as important "to women's dignity and safety (and the dignity and safety of her community)"[72] as is the right to not have a child.

This new movement was finally named "reproductive justice" in 1994 a group of black women who had gathered in Chicago.[73] The name reproductive justice "splices *reproductive rights* with *social justice* to achieve *reproductive justice*.[74]" As is apparent from its history, one foundation of the reproductive justice framework is critical race theory. Critical legal theorist Kimberle Williams Crenshaw introduced the concept of intersectionality in the late 1980s to "illustrate how racial and gender oppression interact in the lives of Black women."[75] Reproductive justice is similarly "based on the understanding that the impacts of race, class, gender, and sexual identity oppressions are not additive but integrative"[76] and only a holistic lens can address them. It is intersectional, focusing on "the ways in which aspects of social status and social identity (e.g., age, race/ethnicity, socioeconomic class, socioeconomic class, sexual orientation, gender identity, religion, ability)" all affect and impact women's experiences."[77]

The reproductive justice movement envisions a broader concept of reproductive freedom. The comprehensive focus includes "(1) the right to have a child; (2) the right not to have a child; and (3) the right to parent the children we have, as well as to control our birthing options, such as midwifery."[78] None of these rights is more important than the other; they are

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[70] *Id.* at 19, 94-95.
[71] *Id.* at 55.
[72] *Id.*
[73] *Id.* at 63.
[74] *Id.* at 9.
[75] *Id.* at 73.
[76] *Id.* at 74.
[77] Joan C. Chrisler, Ph.D., *Introduction: A Global Approach to Reproductive Justice-Psychosocial and Legal Aspects and Implications*, 20 WM. & MARY J. WOMEN & L. 1, 4 (2013).
[78] Loretta Ross, *What is Reproductive Justice*, REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 4, https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051; *see also* Rachel Rebouché, *Reproducing Rights: The Intersection of Reproductive Justice and Human Rights*, 7 UC IRVINE L. REV. 579, 592 (2017) (explaining the four commitments of the RJ movement as "the recognition of women's intersecting identities, the limits of 'choice' and U.S. privacy rights, the inclusion of reproductive issues outside of abortion, and community or local management of reproductive healthcare services").

equally important.[79] "At the heart of reproductive justice is this claim: all fertile person and persons who reproduce and become parents require a safe and dignified context for these most fundamental human experiences."[80] These are positive rights, requiring the state to provide assistance and social supports so that women can exercise these rights to not have a child, have one, and parent one.[81]

These goals are broad, meaning the movement advocates for a woman's right and access to many, many services. They include "specific, community-based resources including high-quality health care, housing and education, a living wage, a healthy environment, and a safety net for times when these resources fail. "[82] Women also need access to "comprehensive sex education, STI prevention and care, alternative birth options, adequate prenatal and pregnancy care, domestic violence assistance, adequate wages to support our families, safe homes, and so much more."[83] And to "protection against rape and access to affordable and effective birth control, healthcare, including but not limited to abortion services, prenatal care, support in childbirth and postpartum, support for breastfeeding mothers, early childcare for infants and toddlers, income support for parents who stay home to care for young babies, and high quality public education for school age children."[84] Without wide-ranging services and support, "[s]afe and dignified fertility management, childbirth, and parenting are impossible …."[85]

Notably, the reproductive justice movement is activism beyond just the courts. Rights exist because they are human rights, not because of a court declaration.[86] In fact, reproductive justice believes that a litigation-focused strategy is ineffective and that the needs of marginalized women have specifically fallen through the cracks because of reproductive rights's litigation strategy.[87] Similarly, a litigation-based approach, at least currently, is incapable of addressing numerous reproductive justice rights, the right to health care being an example.[88] Instead, "the reproductive justice framework calls for an

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[79] Luna & Luker, *supra* note 64, at 328 (explaining reproductive justice as "equally about the right to not have children, the right to have children, the right to parent with dignity, and the means to achieve these rights"); *see also id.* at 328 ("Reproductive justice encompassed the right to not have a child but also moved beyond that to include the right to have a child and the right to parent any children one has.").

[80] ROSS & SOLINGER, *supra* note 62, at 9.

[81] *Id.* at 168-69.

[82] *Id.*

[83] Luna & Luker, *supra* note 64, at 328.

[84] West, *supra* note 29, at 1425.

[85] ROSS & SOLINGER, *supra* note 62, at 9.

[86] *Id.*

[87] Luna & Luker, *supra* note 64, at 336; *see also id.* at 330 (330 (2013) (summarizing other critiques of litigation-based strategy, including that court cases spur countermobilization and that court wins tend to be watered-down due to legal rhetoric).

[88] ROSS & SOLINGER, *supra* note 62, at 125.

integrated approach that draws on constitutional protections and movement-based policy strategies."[89]

III. The Omission of Miscarriages and Stillbirths

Each year, millions of desired pregnancies end unhappily. As many as one fourth of all pregnancies end in miscarriage before twenty weeks of pregnancy. And at least one percent of pregnancies will end with the baby dying in the womb after twenty weeks of pregnancy, with the women then giving birth to her stillborn baby. Both can be significant life experiences for women.

Yet neither the reproductive rights nor the reproductive justice movement has featured them. The reproductive rights movement, in fact, has specifically avoided the topics of miscarriage and stillbirth, believing such avoidance is necessary to protect abortion rights. The topics of miscarriage and stillbirth fit well within the broadened focus of the reproductive justice framework—especially because marginalized women face greater risks of both miscarrying and giving birth to a stillborn baby—yet it is difficult to find mentions of the two within reproductive scholarship and activism.

A. Miscarriages and Stillbirths Defined

In the United States, a miscarriage is a pregnancy loss that occurs before twenty weeks of pregnancy and a stillbirth is a pregnancy loss that occurs after twenty weeks of pregnancy but before birth. Miscarriage is the much more common form of pregnancy loss.[90] Studies reveal that anywhere from 10-25% of all clinically recognized pregnancies will end in miscarriage. The vast majority of miscarriages, possibly as high as 80%, occur in the first twelve weeks of pregnancy.[91] The highest risk exists in the first six weeks, and the risk drops once a heartbeat is confirmed.[92] Once the pregnancy hits 13

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[89] Ocen, *supra* note 29, at 2240.

[90] The American Pregnancy Association website lists seven different types of miscarriages including 1) a threatened miscarriage, which is actually bleeding due to implantation, 2) an inevitable or incomplete miscarriage, 3) a complete miscarriage, where the fetal tissue has emptied out of the uterus, 4) a missed miscarriage where "embryonic death has occurred but there is not any expulsion of the embryo, 5) a blighted ovum, where the fertilized egg implants but never develops, 6) an ectopic pregnancy, where the fertilized egg implants in the fallopian tube, and 7) a molar pregnancy, a "genetic error during the fertilization process that leads to the growth of abnormal tissue within the uterus." *Miscarriage: Pregnancy Complications*, Am. Pregnancy Assoc., https://americanpregnancy.org/pregnancy-complications/miscarriage/ (last visited Nov. 11, 2019).

[91] Rena Goldman, *A Breakdown of Micarriage Rates by Week*, Healthline Parenthood (Oct. 13, 2018), https://www.healthline.com/health/pregnancy/miscarriage-rates-by-week#causes.

[92] *Id.*

weeks, the risk of miscarriage drops to around 5%.[93] Exact numbers are likely impossible, but it is safe to assume that millions of women in the United States suffer a miscarriage each year.

Although less common, about a 1% risk of stillbirth exists in every pregnancy,[94] totaling approximately 26,000 stillborn babies born every year in the United States.[95] The risks of stillbirth for women is greatest at "(20-23 weeks) and at the end of gestation (39-41 weeks) …."[96] Almost half of all stillbirths globally occur during childbirth.[97] One percent may seem like a small risk, but stillbirth is more common than the death of a living infant before his first birthday. A baby is actually ten times more likely to be stillborn than to die from Sudden Infant Death Syndrome.[98] Multiple studies state that "[m]ore babies die as a result of stillbirth than of all other causes of infant deaths combined."[99] Additionally, the United States's stillbirth rate remains higher "than in many other high-income countries, and rates continue to decrease in other high-income countries."[100] More specifically, in a study posted in the medical journal The Lancet, of the listed 49 high-income countries, the United State's annual percentage stillbirth rate reduction from 2000-2015 was lower than all but one other country.[101]

These are the generalized risks for all women, but in reality, not all women face the same risks of miscarriage and stillbirth. Importantly, the risks differ by race and socioeconomic class. Black women are twice as likely as white women to miscarry after ten weeks of pregnancy. Black women are also twice as likely as white women to lose their child to stillbirth after twenty weeks of pregnancy. Similarly, women of lower socioeconomic status face an increased risk of miscarriage and are twice as likely as to lose their child to stillbirth as are women of higher socioeconomic status. And from an intersectional lens, although a white woman's risk goes down as she ascends socioeconomically, a black woman's does not.

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[93] *Id.*

[94] CTR. FOR DISEASE CONTROL, *Stillbirth*, https://www.cdc.gov/ncbddd/stillbirth/facts.html

[95] MacDorman & Gregory, *supra* note __, at 1.

[96] *Id.* at 4. MacDorman

[97] World Health Organization, Maternal, Newborn, Child, and Adolescent Health: Stillbirths, https://www.who.int/maternal_child_adolescent/epidemiology/stillbirth/en/ (last accessed Jan. 10, 2019).

[98] Joanne Cacciatore, *Effects of Support Groups on Post Traumatic Stress Responses in Women Experiencing Stillbirth*, 55 OMEGA J. DEATH & DYING 71, 72 (2007).

[99] Joanne Cacciatore & Suzanne Bushfield, *Stillbirth: A Sociopolitical Issue*, 23 J. WOMEN & SOCIAL WORK 378, 380 (2008) (internal citations omitted) (hereinafter, Cacciatore, *Sociopolitical*).

[100] Jessica M. Page et al., *Potentially Preventable Stillbirth in a Diverse U.S. Cohort*, 131 OBSTETRICS & GYNECOLOGY 336, 338 (2018).

[101] Vicky Flenady, et al., *Stillbirths: Recall to Action in High-Income Countries*, 387 THE LANCET 691, 693 (2016).

More specifically, starting with race, a study published in 2012 concluded that black women in the study "were more likely than white women to experience a pregnancy loss."[102] The study found no difference in the risk of miscarriage before 10 weeks, but found that "black women have a nearly 2-fold higher risk of miscarriage compared with white women during gestations weeks 10-20."[103] The study found this result even after adjusting for age, miscarriage history, and planned versus unplanned pregnancies.[104] The study also cautioned the overall disparity in miscarriage rate may also be higher given that 1/3 of the black women who participated in the study had a college education and thus "might be expected to be at a lower risk of miscarriage than blacks in the general population."[105]

"Stillbirth statistics, published annually since 1922, have always reported stillbirth data by race (white and nonwhite until 1990) and *always* shown a large excess in stillbirths for non-white deliveries."[106] Rates have improved overall, but the racial gap still exists and has increased. For instance, more recently, "[s]ince 1990, the racial gap appears to have widened, particularly for non-Hispanic black deliveries."[107] The rate for non-Hispanic Black women is fifteen years behind the rate for white women—the 2005 11.1 rate "was roughly equivalent to the white rate in 1990."[108] The non-Hispanic Black stillbirth rate of 11.1 in 2005 was roughly equivalent to the total "white" rate in 1990." Also since 1990, "the non-Hispanic white rate has improved by 19%, while the non-Hispanic black rate has improved by only 13%.[109]

A 2015 study found a "2.2 fold increased risk of stillbirth" for non-Hispanic black women.[110] The overall increased risk is 2.2%, but the disparity more specifically differs according to the timing in pregnancy. The "black/white disparity in hazard for stillbirth is highest at 20-23 weeks with a 2.8 fold increased risk and declines with increasing gestation, reaching the lowest value at 39-40 weeks, with a 1.6 fold increased relative risk."[111] Similarly,

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[102] Sudeshna Mukherjee, *Risk of Miscarriage Among Black Women and White Women in a US Prospective Cohort Study*, 177:11 Am. J. of Epidemiology, 1271, 1273 (2013).

[103] *Id.* at 1276.

[104] *Id.*

[105] *Id.* at 1277.

[106] Carol J. Rowland Hogue & Robert M. Silver, *Racial and Ethnic Disparities in United States: Stillbirth Rates: Trends, Risk Factors, and Research Needs*, 35(4) SEM. IN PERINATOLOGY 221, 221-22 (2011) (emphasis added).

[107] *Id.*.

[108] *Id.*

[109] *Id.*

[110] Marian Willinger, et al., *Racial Disparities in Stillbirth Risk Across Gestation in the United States*, 201(5) AM. J. OBSTET. GYNECOL. 469e, 469e6 (2009).

[111] *Id.* at 469e6-7. "The hazard of stillbirth for Hispanics was similar to non-Hispanic whites throughout pregnancy." *Id.* at 469e2.

a 2009 study concluded that "[t]he elevated risk of stillbirth for non-Hispanic blacks occurred predominantly prior to 24 weeks' gestation."[112]

Turning to class, studies have also found that risk of miscarriage is also related to socioeconomic status. A 2012 study in Denmark measured socioeconomic status based on "educational level, maternal income, and labour market attachment." [113] The study concluded that "[e]ducational level and income were inversely associated with the risk of spontaneous abortion,"[114] the medical term for miscarriage, which is defined in Denmark as before twenty weeks of pregnancy.[115]

Studies also conclude that low socioeconomic status also increases the risk of stillbirth: "Socioeconomic disadvantage, as measured by low levels of mothers' or fathers' education, occupational status or income, is associated with raised risks of stillbirth even in countries with universal insurance coverage and generous welfare provisions."[116] A 2001 study in Sweden found "a more than twofold increase in risk of stillbirth for women with the lowest SES compared with the highest," and an even higher risk for "intrapartum and term antepartum stillbirths."[117] The study found this conclusion especially problematic because intrapartum and term antepartum stillbirths occur during childbirth and after 37 weeks of pregnancy, respectively, and are thus likely the most preventable type of stillbirth.[118] Thus, women with lower socioeconomic status face a higher risk of losing their child to the most preventable types of stillbirths. A 2012 study in England found that women face a "higher risk of stillbirth in deprived areas" in England, "with rates twice as high in the most deprived areas compared with the least deprived."[119] "Significant deprivation differences were seen between the most and least deprived groups in all causes except mechanical events that occurred during labour."[120] A study of all stillbirths across Europe concluded that "if all women faced the stillbirth risks of the most educated, the number of stillbirths would be 25 % lower."[121] Similarly, a study in England concluded that "[i[f the stillbirth rates seen in the

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[112] Stillbirth Collaborative Research Network Writing Group, *Association between Stillbirth and Risk Factors Known at Pregnancy Confirmation*, 306:22 JAMA __ (2011).

[113] Filippa Nyboe Norsker, et al., *Socioeconomic position and the risk of spontaneous abortion: a study within the Danish National Birth Cohort*, 2(3) BRIT. MED. J. OPEN 1, 2 (2012).

[114] *Id.*

[115] *Id.*

[116] Jennifer Zeitlin, et al., *Socioeconomic inequalities in stillbirth rates in Europe: measuring the gap using routine data from the Euro-Peristat Project*, BIOMED CENT. PREGNANCY & CHILDBIRTH, Jan. 8, 2016, at 2.

[117] Olof Stephansson, *The influence of socioeconomic status on stillbirth risk in Sweden*, 30:6 Int'l J. of Epidemiology 1296, 1300 (2001).

[118] *Id.*

[119] Sarah E. Seaton, et al., *Socioeconomic inequalities in the rate of stillbirths by cause: a population-based study*, 2(3) BRIT. MED. J. Open 1, 4 (2012).

[120] *Id.*

[121] Zeitlin, et al., *supra* note 116, at 8.

least deprived areas were seen throughout the population, there would be a third less stillbirths in England, nearly 900 fewer each year."[122]

Combining race and class, generally speaking, a higher educational level decreases the risk of stillbirth, but that's only for white women.[123] "More research is also needed to probe the cultural and social determinants of racial disparities in risk among blacks and Hispanics as higher educational status appears to widen rather reduce these disparities."[124]

Returning to the experiences of miscarriage and stillbirth more generally, the physical experiences differ due to the difference in the extent of the pregnancy. Physically, most miscarriages will involve bleeding. A very early miscarriage is called a chemical pregnancy, which may account for over half of miscarriages. This miscarriage occurs "shortly after implantation, resulting in bleeding that occurs around the time of [an] expected period." Because of the timing, a woman can easily not know she is pregnant and mistake that bleeding for a period.[125] "The earlier … the pregnancy, the more likely that [the] body will expel all the fetal tissue by itself …."[126] Later miscarriages will also involve bleeding, but more of it and possibly visible "products of conception."[127] Surgery may be necessary if the uterus does not empty itself.[128]

The physical experience of stillbirth, especially stillbirth at term, meaning after 37 weeks of pregnancy, is more similar to the birth of a live child. Because of medicalization, the woman will often learn ahead of time that her child has died while still in the womb. She will then need to give birth to him, just like she would a living child. Assuming no complications, the labor will be induced just as is commonly done with a live child. Again assuming no complications, a woman will give birth to her child, although one study concludes that women face a much higher risk of life-threatening complications during delivery of a stillborn baby than a live birth.[129] Or, if

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[122] Sarah E. Seaton, *Socioeconomic inequalities in the rate of stillbirths by cause: a population-based study*, 2(3) BRIT. MED. J. Open (2012),

[123] Willinger, *supra* note 110, at 469e7 ("In general, a higher educational level (> 12 years) was associated with a substantial reduction in stillbirth risk for white women (30%) but only a small reduction for black women.").

[124] *Id.* at 469e8.

[125] *Miscarriage: Pregnancy Complications*, Am. Pregnancy Assoc., https://americanpregnancy.org/pregnancy-complications/miscarriage/ (last visited Nov. 11, 2019).

[126] *Id.*

[127] Heather Rowe and Alexandra J. Hawkey, *Miscarriage*, *in* ROUTLEDGE INTERNATIONAL HANDBOOK OF WOMEN'S SEXUAL & REPRODUCTIVE HEALTH (Jane M. Ussher, Joan C. Chrisler, Janette Perz, eds., 2019).

[128] Medical treatment of miscarriage and stillbirth is discussed more thoroughly in *infra* Part IV.A.2.

[129] *See generally* Elizabeth Wall-Wieler, et al., *Severe Maternal Morbidity Among Stillbirth and Live Birth Deliveries in California*, 134(2) OBSTETRICS & GYNECOLOGY 310 (Aug. 2019) (explaining that the chances of life-threatening complications for the woman are five times greater in a stillbirth than a live birth).

stillbirth occurs during childbirth, the woman will learn of her child's death after he is born. Either way, current medical standard of care is to then offer that the mother can hold her baby just like she would her living baby,[130] a measure that studies almost unanimously conclude is psychologically beneficial.[131]

Even if a woman is physically okay after miscarriage or stillbirth, she can still have long-lasting mental and emotional health issues. No standard reaction to miscarriage and stillbirth exists.[132] Emotions after miscarriage include a "range of severity, from expressions of ambivalence, relative indifference, or relief at one end of the spectrum to the need for psychiatric care at the other."[133]

Research has shown that more intense reactions are common in stillbirth.[134] Women after stillbirth are at risk for "chronic depression, suicidal ideation, drug or alcohol abuse, and pervasive post traumatic stress disorder (PTSD) symptomology."[135] The risk of maternal depression is long-term, with effects not just on the mother but also on any living children. One study expressed concern that stillbirth contributes to "social differences in health" and a "transgenerational cycle of ill-health" stemming from "maternal depression."[136]

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[130] PREGNANCY LOSS AND INFANT DEATH ALLIANCE, POSITION STATEMENT: BEREAVED PARENTS' RIGHT TO SELF-DETERMINATION REGARDING THEIR BABY, August 2016, 2, http://www.plida.org/wp-content/uploads/2012/01/PLIDA_BereavedParentsRighttoSelf-Determination.pdf; *see also* Joanne Cacciatore, *The Silent Birth: A Feminist Perspective*, 54 SOCIAL WORK 91, 93 (2009) ("Improved standards of compassionate care in hospitals, supportive nurturance from family and friends, and support groups contribute to a lessening of posttraumatic stress responses and chronic, debilitating grief.") (hereinafter Cacciatore, *Feminist*); *see also* Carol Sanger, *"The Birth of Death": Stillborn Birth Certificates and the Problem for Law*, 100 CALIF. L. REV. 269, 283-85 (2012) (describing changes in hospitals allowing parents to spend time with the infant and preparing memory boxes for parents).

[131] Samantha Murphy & Joanne Cacciatore, *The Psychological, Social, and Economic Impact of Stillbirth on Families*, 22 SEMINARS IN FETAL & NEONATAL MED. 129, 130 (2017); Elizabeth Kirkley-Best & Kenneth R. Kellner, *The Forgotten Grief: A Review of the Psychology of Stillbirth*, 52 AM. J. ORTHOPSYCHIATRY 420, 426 (1982) (describing that research shows "almost unanimous agreement that seeing and holding the infant is helpful in successful grief resolution").

[132] Kirkley-Best & Kellner, *supra* note 131, at 425 (cautioning that "great individual differences and a variety of other factors [] may account for both quantity and quality of response to loss in pregnancy").

[133] Heather Rowe and Alexandra J. Hawkey, *Miscarriage*, in ROUTLEDGE INTERNATIONAL HANDBOOK OF WOMEN'S SEXUAL & REPRODUCTIVE HEALTH (Jane M. Ussher, Joan C. Chrisler, Janette Perz, eds., 2019); *see id.* (explaining that "[o]nly a minority of women experience [psychological] symptoms for more than six months").

[134] Kirkley-Best & Kellner, *supra* note 131, at 425

[135] Joanne Cacciatore, *Effects of Support Groups on Post Traumatic Stress Responses in Women Experiencing Stillbirth*, 55(1) OMEGA 71, 73 (2007).

[136] Zeitlin, et al., *supra* note 116, at 2.

One last important difference between miscarriage and stillbirth is preventability. Most miscarriages are believed to be due to fetal abnormalities, especially miscarriages before twelve weeks of pregnancy, which is the majority of miscarriages. If due to fetal abnormalities, they are unpreventable.[137]

Unlike miscarriages, however, only a very small minority of stillbirths are due to abnormality. Specifically, only around 7% of 2.6 million stillbirths that occur yearly globally (using a 28 week definition of stillbirth) are due to congenital abnormalities, and even some of those abnormalities are actually preventable if the mother takes folic acid.[138] That numerous countries have devoted resources to and successfully lowered their own stillbirth rates—by as much as 20%—demonstrates the preventability of stillbirth.[139] Moreover, a recent study specific to the United States conservatively estimated that at least one fourth of stillbirths in the United States are preventable.[140]

B. Reproductive Rights's Avoidance

As already described, the reproductive rights movement has focused mostly on the rights to contraception and to abortion, both of which enable

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[137] *See infra* Part IV.B for a deeper discussion of research priorities for miscarriage prevention.

[138] Joy E. Lawn et al., *Stillbirths: Rates, Risk Factors, and Acceleration Towards 2030*, 387 LANCET 587, 597 (2016). Despite this evidence, a pervasive myth exists that stillbirths are "mostly due to non-preventable congenital abnormalities." Likely contributing to this myth is the conflation of miscarriage and stillbirth. Joanne Cacciatore & Jill Wieber Lens, *The Ultimate in Women's Labor: Rethinking Feminism Around Pregnancy, Birthing, and Grieving a Dead Baby*, *in* ROUTLEDGE INTERNATIONAL HANDBOOK OF WOMEN'S SEXUAL & REPRODUCTIVE HEALTH (Jane M. Ussher, Joan C. Chrisler, Janette Perz, eds., 2019);

[139] An Australian governmental committee recently held a hearing regarding new initiatives to decrease Australia's stillbirth rate. Witnesses testified about the successes of other countries. One example pointed to was the Netherlands, which began a program in 2001 that led to a 55% reduction of stillbirths over the next fourteen years. Report of Australian Senate Select Committee on Stillbirth Research and Education, § 7.29, at 113 (Dec. 2018), available at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth_Research_and_Education/Stillbirth/Report (hereinafter "Australian Senate Committee Report"). Ten years later, Scotland implemented its Maternity Care Quality Improvement Collaborative and reduced that its stillbirth rate, then one of the highest in the Europe, by 22% over the next four years. *Id.* England decreased its stillbirth rate by 19% in the last decade. *Numbers of Stillbirths in the UK falls to Record Low*, Tommy's (July 2018), https://www.tommys.org/our-organisation/about-us/charity-news/number-stillbirths-uk-falls-record-low. In 2016, England also recently announced its goals to cut its stillbirth rate by 20% by 2020 and by 50% by 2025. In the same year, the National Health Service introduced the "Saving Babies Care Bundle" in certain hospitals, and the stillbirth rate in those hospitals has fallen by 20%. *Saving Babies' Lives Care Bundle*, NHS, https://www.england.nhs.uk/mat-transformation/saving-babies/ (last visited Oct. 30, 2019).

[140] Page et al., *supra* note 100, at 340. The study specifically used the words "potentially preventable" instead of preventable, and discussed that "[t]here is no generally accepted definition of what constitutes a 'preventable' cause of stillbirth." *Id.*

the choice to not have a child. The movement has also assumed that the binary choice dictates the outcomes—that if the woman doesn't have the ability to terminate her pregnancy, she will later give birth to a living baby.

This assumption is apparent in *Roe v. Wade*.[141] Justice Blackmun explained that "[t]he detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent"[142]:

> Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved.[143]

Similarly, in *Casey*, the Court noted women's need for access to abortion "[b]ecause motherhood has a dramatic impact on a woman's educational prospects, employment opportunities, and self-determination, restrictive abortion laws deprive her of basic control over her life."[144] All of these described detriments assume that if a pregnant woman can't get an abortion, she will give birth to a *living* child. This assumption, of course, is not accurate.

When confronted by the reality of miscarriage and stillbirth, the reproductive rights movements has opted to change the subject. This is because of the pro-life strategy of fetal personhood. "Since the late 1960's, pro-lifers had deployed fetological studies, slideshows, and medical articles to establish the personhood of the fetus."[145] "[I]f the courts recognized fetal personhood, unborn children could claim the same constitutional rights as anybody else."[146]

In *Roe*, the Court rejected the idea of a fetus as a person. Yet, the Court still managed to encourage arguments based on fetal personhood. In oral argument, Justice Stewart asked Roe's lawyer what would be the effect if the Court concluded that a fetus were a person under the Fourteenth Amendment and Roe's lawyer admitted "I would have a very difficult case."[147] Justice Blackmun's opinion's also stated that if a fetus were a person, "the appellant's case, of course, collapses, for the fetus' right to life would then be guaranteed specifically by the Amendment."[148]

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[141] 410 U.S. 113 (1973).

[142] *Id.* at 153.

[143] *Id.*

[144] Casey v. Planned Parenthood, 505 U.S. 833, 928 (1992).

[145] MARY ZIEGLER, AFTER ROE: THE LOST HISTORY OF THE ABORTION DEBATE 164 (2015).

[146] *Id.* at 165.

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[148] Roe v. Wade, 410 U.S. 113, 156–57 (1973).

Thus, even though the Court rejected fetal personhood, it admitted that abortion could not be constitutional if a fetus were a person, causing pro-lifers to not give up on the fetal personhood argument. To help establish it, pro-lifers looked beyond the Fourteenth Amendment. Part of "the longterm, end-game strategy of pro-life forces has included an attempt to have fetuses declared 'children' or 'persons' in as many legal contexts as possible."[149]

Women after stillbirth have similarly sought legal recognition of their stillborn children.[150] Just as pro-lifers deem a fetus as an unborn child, a person, women identify their stillborn children as people even though they died while still in the womb. Pro-lifers have looked to use parents' grief as a weapon, hoping that "[t]he emotional power of parents pleading for legal recognition of their unborn children may sway societal views and incite political action" about abortion.[151]

In response, the reproductive rights movement decided to avoid discussing miscarriage and stillbirth. "Because anti-abortion activists base their argument on the presence of fetal … and embryonic personhood," the reproductive rights movement "have studiously avoided anything that might imply or concede such a presence. The fear … is that if one were to acknowledge there was something of value lost, one would thereby automatically accede the inherent personhood of embryos/fetuses."[152] Avoidance is necessary because the topics of miscarriage and stillbirth (supposedly) so "overlap[]with issues of fetal personhood so central to abortion politics."[153] The reproductive rights movement has thus "surrendered the discourse of pregnancy loss to antichoice activists."[154]

C. Reproductive Justice's Non-Emphasis

Despite its much broader lens, it is still difficult to find mentions of miscarriage and stillbirth within reproductive justice literature. That does not mean that reproductive justice advocates have specifically excluded miscarriage and stillbirth as did advocates for reproductive rights. "There is no

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[149] Kenneth A. De Ville & Loretta M. Kopelman, *Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy*, 27 J.L. MED. & ETHICS 332, 335 (1999)

[150] Examples include wrongful death claims applied to stillbirth and birth certificates, both of which are discussed in Part IV. *infra*.

[151] Murphy S. Klasing, *The Death of an Unborn Child: Jurisprudential Inconsistencies in Wrongful Death, Criminal Homicide, and Abortion Cases*, 22 PEPP. L. REV. 933, 978–79 (1995).

[152] LINDA L. LAYNE, MOTHERHOOD LOST: A FEMINIST ACCOUNT OF PREGNANCY LOSS IN AMERICA 240 (2003).

[153] Linda Layne, *Unhappy Endings: a feminist reappraisal of the women's health movement from the vantage of pregnancy loss*, 56 SOC. SCI. & MED. 1881, 1889 (2003); *see also* LAYNE, *supra* note 152, at 294 ("Because the issues framing the meaning of miscarriage and stillbirth resonate so strongly with the abortion debate, most feminists have maintained a studied silence on the topic.").

[154] LAYNE, *supra* note 152, at 239.

agreed upon list of issues for reproductive justice activists to address,"[155] meaning no issues are specifically or strategically excluded. Still, reproductive justice advocates have certainly not emphasized miscarriage and stillbirth as evidenced by the only minimal mentions within the scholarship.

One mention was in Loretta Ross and Rickie Solinger's description of historical reproductive oppression in the United States. They discuss how slave owners had a financial interest in ensuring that enslaved women would reproduce, providing a source of hard laborers.[156] Yet slave owners worked "enslaved women vigorously hard, far into their pregnancies."[157] They describe that "[m]any women, near the end of their term and exhausted, lost their pregnancies right there in the fields," presumably meaning that women gave birth to stillborn babies right there in the fields. Ross and Solinger explain that such stillbirths were "all too common since profit-maximizing owners refused to allow enslaved midwives to attend or to call in physicians to supervise, even when such attendance was routine for their kin."[158] Ross and Solinger also discuss how pregnant women on Louisiana sugar plantations worked sixty-seventy hours a week in ninety-degree heat, causing them to "suffer[] from insufficient blood supply to their placentas" and hypertension, causing these enslaved women to experience a "high percentage of miscarriages and stillbirths."[159] And thus, Ross and Solinger described enslaved women suffering miscarriages and stillbirths as one form of the reproductive oppression that black women faced historically.

Another mention of miscarriage and stillbirth within the reproductive justice framework is more modern. It is a concern over what is being called the "criminalization" of pregnancy, meaning the criminal arrests of women in relation to their miscarriages or stillbirths.[160] This emphasis is consistent with reproductive justice as "troubling racial and class disparities exist in how states intervene in the lives of pregnant women."[161] Marginalized women are targeted. What most of this scholarship misses (and this article highlights), however, is the fact that marginalized women—black women and poor women especially—are also at an inherently higher risk for miscarriage and stillbirth in the first place.

The one specific mention that I could that focuses on stillbirth itself as a woman's reproductive experience comes from Dr. Joan Chrisler within her discussion of reproductive justice on a global perspective. Specifically, she

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[155] Chrisler, *supra* note 77, at 4.

[156] ROSS & SOLINGER, *supra* note 62, at 18

[157] *Id.* at 19.

[158] *Id.*

[159] *Id.* at 20.

[160] *See e.g.*, Chemerinsky & Goodwin, *supra* note 29, at 1235-36; Dawn Johnsen, *State Court Protection of Reproductive Rights: The Past, the Perils, and the Promise*, 29 COLUM. J. GENDER & L. 41, 72-73 (2015); Maya Manian, *Lessons from Personhood's Defeat: Abortion Restrictions and Side Effects on Women's Health*, 74 OHIO ST. L. J. 75, 94-95 (2013).

[161] Chemerinsky & Goodwin, *supra* note note 29, at 1235.

mentions that "[i]nfant mortality is an important component of reproductive justice" and that to women, who "risk their lives and health to produce children … to say that stillbirth or infant mortality is disappointing is an understatement."[162] She then explains the need for universal health care, including "prenatal and antenatal care for mother and fetus/infant … and appropriate medical intervention for high-risk pregnancies and births" all of which are "obviously crucial to healthy children."[163]

But that's pretty much it. These minimal instances are not representative of how many women choose to be pregnant but have those pregnancies end in miscarriage or stillbirth, and of the significance of these experiences for women. Nor are they representative of the historical and still current increased risks of miscarriage and stillbirth for marginalized women.

IV. REPRODUCTIVE JUSTICE-BASED RIGHTS CONCERNING MISCARRIAGE AND STILLBIRTH

An involuntary ending of pregnancy is likely the second most common reproductive experience a woman will endure, second to the birth of a living child. Yet, the reproductive rights movement ignores it and the reproductive justice movement does not emphasize it. This lack of acknowledgement of miscarriage and stillbirth "systematically minimizes and marginalizes negative reproductive outcomes."[164]

This section is normative, explaining why and how the reproductive justice should feature miscarriage and stillbirth. One reason has already been implied; if reproductive justice aims to feature the unique difficulties that marginalized women face in their reproductive lives, it must highlight the experiences of miscarriage and stillbirth. Women's experiences of miscarriage and stillbirth are also consistent with reproductive justice's rejection the reproductive right's "choice" rhetoric, recognizing that a disconnect exists between choice and outcome and also rejecting the individualism inherent in that rhetoric. Women experiencing miscarriage and stillbirth experience that same disconnect and are not at fault for it. The individualistic notion of choice masks the effects of race and socioeconomic status on miscarriage and stillbirth, just as it masks those effects on ability to abort a pregnancy or parent her child.

This section then describes the reproductive-justice based rights of women concerning miscarriage and stillbirth. The first right is to preventative prenatal care. Reproductive justice already recognizes a woman's right to health care, to which marginalized women often have less access, including prenatal care. This right, however, must emphasize the right to prenatal care to help prevent miscarriage and stillbirth. The second right is a woman's birth justice right to give birth to her stillborn child as she chooses, including a

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[162] Chrisler, *supra* note 77, at 11.
[163] *Id.* at 11–12.
[164] Layne, *supra* note 153, at 1887.

medically unnecessary cesarean delivery. Similarly, a woman should also be fully informed of her medical treatment options after miscarriage, including the potential costs. The next right is to mental and emotional health care, to which, again, marginalized women often have less access. Last, a woman has a right to parent her stillborn child, a parenthood deserving of legal recognition. Various legal measures of affirming parenthood after stillbirth—tax benefits, stillbirth birth certificates, tort claims, and insurance coverage for autopsies—are controversial under the reproductive rights framework but perfectly consistent with the reproductive justice framework.

A. The Lack of Choice within Miscarriage and Stillbirth

As reproductive justice recognizes, "choice" does not accurately describe a woman's reproductive experiences. It often does not reflect how women actually feel; "[i]n fact, reproductive decision-making is often difficult and painful, and is not always experienced as a choice."[165] It is also inaccurate because not all women get to choose. Some women, especially marginalized women, may "choose" to get an abortion, but that does not mean that they can access one. Unlike the reproductive rights framework, reproductive justice recognizes that a woman's choice does not dictate her outcome.

The same is true for miscarriages and stillbirth. Nothing about miscarriage or stillbirth feels like "choice."[166] To the contrary, the same disconnect between choice and outcome exists. These are women who have chosen either to be pregnant or to continue to be pregnant—chosen to parent the child to which (they thought) they would eventually give birth. But making this choice does not mean that these women will give birth to a living child however many months later. Instead, and contrary to their choice, women miscarry or give birth to a stillborn baby.

Reproductive justice rejects the choice rhetoric not only for its inaccuracy, but also due to the individualism inherent in choice. Choice rhetoric puts the onus on the woman. She has the right to choose; if she does not obtain an abortion, that is her fault for not exercising her choice. Professor Robin West explained how the same effect applies to the choice to parent. It has made the "decision to parent, no less than the decision not to parent, [] a chosen consumer good or lifestyle,"[167] making society's only role to ensure that the parent's decision is well-informed.[168] Parenting is expensive. But if the parent is informed and chooses still to parent, then the expense of parenting

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[165] Chrisler, *supra* note 77, at 3.

[166] Chrisler did not mention miscarriages or stillbirths in discussing how reproductive experiences often do not feel like choices. Her examples included women who suffer from infertility and unable to access reproductive technology, women whose children die in their infancy, and women "coerced or misled into sterilization." *Id.*

[167] West, *supra* note 29, at 1409.

[168] *Id.*

is "not a source of injustice or even a cause for worry"[169] and there "is no reason to publicly subsidize the choice."[170] Choice rhetoric "legitimates … the lack of public support given parents in fulfilling their caregiving obligations."[171] Reproductive justice rejects this legitimation and instead recognizes a positive right that the state needs to help a woman exercise her rights to abortion and to parent.[172]

The same individualism in choice has also had harmful effects for women who have suffered miscarriage and stillbirth. Anthropologist Linda Layne long ago explained that "choice" implies individual control.[173] She also explained that it "is embedded in a culture of meritocracy," that "if one is diligent and hard- working enough, [] problems can be avoided."[174] As Layne explained, "[a]n unintended and unexamined consequence" of these ideas of choice and its implication of control is that "women may be assumed responsible for their pregnancy losses."[175] The woman who miscarries or whose child is stillborn apparently did not work hard enough. Layne argued that choice and control "contribute[]to maternal blame and self-blame when pregnancies are not perfect."[176]

A reproductive justice analysis of miscarriage and stillbirth, however, rejects this individualism. This analysis recognizes that a woman's ability "to determine her own reproductive destiny is linked directly to the conditions in her community."[177] These same conditions in her community and legal and structural impediments affect a woman's ability to keep a pregnancy and give birth to a living child at its end. "Instead of claiming that the alleged pathologies of individuals" are to blame for miscarriages and stillbirths, the intersectional reproductive justice lens encourages us to look outward to determine if something other than the individual woman could help explain the causes of miscarriage and stillbirth; removing the focus from the individual

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[169] *Id.* at 1410.

[170] *Id.* at 1411; *see also* Ocen, *supra* note 29, at 2240 (explaining that under the reproductive rights framework, "the state is under no obligation to correct the structural inequality that limits reproductive choice for marginalized women or to provide resources necessary for the expression of reproductive autonomy").

[171] *Id.*

[172] ROSS & SOLINGER, *supra* note 62, at 168-69.

[173] Layne, *supra* note 153, at 1888.

[174] *Id.*

[175] LAYNE, *supra* note 152, at 241.

[176] Layne, *supra* note 153, at 1881; *see also* Kirkley-Best & Kellner, *supra* note 131, at 422 (explaining that women "meticulously" review "the events of [their] pregnanc[ies]" and blame themselves); Joanne Cacciatore et al., *Condemning Self, Condemning Other: Blame and Mental Health in Women Suffering Stillbirth*, 35 J. MENTAL HEALTH COUNSELING 342, 343 (2013) ("nearly all mothers of stillbirth babies report intense behaviorial *and* characterological self-blame following the baby's death").

[177] Loretta Ross, *What is Reproductive Justice*, REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 4, https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051

woman and her choices, and especially "centering the reproductive experiences of marginalized women[,] broadens the scope" and enables us to identify "institutions and actors that undermine the reproductive destinies of women" including with respect to the risks of miscarriage and stillbirth."[178] Although not connecting her argument to reproductive justice, Linda Layne argued that "[t]he liberal emphasis on individualism [] deflects attention from social causes of pregnancy loss."[179] Layne suggested that these social causes include "domestic violence, inadequate prenatal care, and exposure to environmental toxins."[180]

The various studies connecting miscarriage and stillbirth to race and low socioeconomic status similarly look to "social" non-individualized reasons to explain the racial and class disparities. A study concerning race and miscarriage suggested this explanation: "environmental or produce exposures that accrue over weeks across pregnancy …."[181] One of the European studies on stillbirth and socioeconomic class suggested that women of lower socioeconomic status face a higher risk because of "higher stress, less social support and depression, teenage motherhood, unplanned pregnancies, a higher prevalence of chronic health conditions, such as hypertension, diabetes, or obesity as well as poor access to antenatal care and receipt of suboptimal care."[182] Essentially, the consequences of poverty may explain the class disparity.

Another structural factor possibly affecting the class disparity in the stillbirth rate is access to abortion, the same lack of access that reproductive justice highlights. A study in England found more stillbirths due to congenital abnormalities in most economically deprived group, which could mean that women with higher socioeconomic status are terminating their pregnancies and women with lower socioeconomic status are not.[183] A study in Europe similarly mentioned this possibility, suggesting that poorer women didn't terminate their pregnancies due to "perhaps either because of lack of access to screening or differences in attitudes to pregnancy terminations."[184]

Ultimately, these studies stress the need for additional research to "probe the cultural and social determinants of racial disparities in" the stillbirth

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[178] Ocen, *supra* note 29, at 2240.

[179] Layne, *supra* note 152, at 244.

[180] *Id.*

[181] *Id.* Study also suggests that these later losses, especially those occurring after 16 weeks, "may share a pathophysiology similar to that of early preterm birth or stillbirth …." *Id.*

[182] Zeitlin, et al., *supra* note 116, at 2. The study also suggested that women of lower socioeconomic class are more likely to smoke. *Id.* But the 2001 Sweden study concluded smoking could account for only a "minor part of the increase in risk." Olof Stephansson, *The influence of socioeconomic status on stillbirth risk in Sweden*, 30:6 INT'L J. OF EPIDEMIOLOGY 1296, 1300 (2001). The possibility of inequity in health care is covered in the next Section.

[183] Sarah E. Seaton, Socioeconomic inequalities in the rate of stillbirths by cause: a population-based study, 2(3) BRIT. MED. J. OPEN (2012).

[184] Zeitlin, et al., *supra* note 116, at 11.

risk[185] and "the distal determinants of stillbirth risk which are accumulated over the life course and relate to parental health status, behaviours and knowledge preceding the pregnancy."[186] A reproductive justice lens that rejects individualism and individual meritocracy similarly emphasizes the need for this research. Reproductive justice has already highlighted the need for safe and healthy environments—environmentally healthy[187] and free from domestic violence[188]—as necessary for women to exercise their right to parent their children. The same is true for women wanting to "parent" and protect their unborn child so that their pregnancy ends with him being born alive.

B. The Right to Preventative Prenatal Care

The reproductive justice movement already highlights women's right to health care: "Access to healthcare—not merely as a matter of the 'right to choose' contraception or abortion, but as a matter of the general affordability, availability, and cultural appropriateness of a wide range of health services for women and families—is a priority issue for the movement."[189] The movement-defining 2005 Essay for Reproductive Justice by the Asian Communities for Reproductive Justice specifically explained the "reproductive health" framework of reproductive justice.[190] The Essay explained that "lack of access to reproductive health services for women, and health care in general, is seen as a lack of information, a lack of accurate health data, or a lack of available services."[191] The Essay also explained that the reproductive justice movement's focus with reproductive health care is often on services for and education on "reproductive tract infection (RTI) and sexually transmitted disease (STD) prevention," and also "includes comprehensive sex education, access to effective contraception, abortion services and counseling, family planning, HIV/AIDS prevention and treatment, and cancer prevention and treatment."[192] Other literature more specifically recognizes the right to prenatal care. Rickie Solinger described the women's right to "safe, respectful, and

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[185] Willinger, *supra* note 110, at 469e8.

[186] *Id.* at 2.

[187] *See* Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J. L. & PUB. POL'Y 47, 61 (2014) ("From its inception, the reproductive justice movement has been globally conscious and explicitly tied to the environmental justice movement."); Lauren Kuhlik, *Pregnancy Behind Bars: The Constitutional Argument for Reproductive Healthcare Access in Prison*, 52 HARV. C.R.-C.L. L. REV. 501, 506 (2017) ("[R]eproductive justice advocates can work with environmental justice advocates to promote healthy environments in which individuals can raise their children.").

[188] ROSS & SOLINGER, *supra* note 62, at 9-11).

[189] Wiley, *supra* note 187, at 63.

[190] *A New Vision for advancing our movement for reproductive health, reproductive rights, and reproductive justice*, Asian Communities for Reproductive Justice, at 2 (2005), https://www.oursplatform.org/wp-content/uploads/ACRJ-A-New-Vision.pdf

[191] *Id.*

[192] *Id.*

affordable medical care during and after pregnancy."[193] Other literature emphasizes the right and access to prenatal care for immigrant women in the United States.[194]

Thus, the reproductive justice movement already recognizes the right to health care, a right that includes prenatal care,[195] but does not connect the prenatal care to prevention of miscarriages and stillbirth. The reproductive justice movement has already recognized a connection between lack of access to prenatal care and infant mortality,[196] and studies demonstrate that the same connection exists to stillbirth. The movement should also increase its advocacy for proper prenatal care for all pregnancy women, with an emphasis on prenatal care as preventative of miscarriage and stillbirth. This emphasis should include integrating education for women of the known, simple measures that can help prevent stillbirth.

As mentioned above, a study of stillbirths in Sweden found "substantial unexplained social differences in stillbirth risk" based on a woman's socioeconomic status.[197] The authors of the study were especially confused and concerned about the class disparity because Sweden is "a country where the population is regarded as relatively homogeneous, and where pregnant women should have equal opportunities to receive free antenatal and obstetric care."[198] Yet, the class disparity existed and "low social class was most associated with term antepartum and intrapartum stillbirths, which may be regarded as potential preventable deaths."[199] The authors ultimately suggested that "the quality of [medical] care may differ with social class"[200] and "that women of low social class may need more attention, support and observation at antenatal and obstetric clinics during pregnancy and labour."[201] Similarly, a study on the race disparity in the stillbirth rate suggested that "pregnancy and labor-related conditions contributed more to the stillbirth risk among black women than among white women" and thus improvements in prenatal care and "early pregnancy health for black women have the potential to reduce the disparity in stillbirth risk."[202]

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[193] Rickie Solinger, *Conditions of Reproductive Justice*, in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 42, https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051.

[194] ROSS & SOLINGER, *supra* note 62, at 144-49.

[195] *Id.* at 91 (describing numerous instances of denials of health care to women, including denial of "drug treatment for pregnant women" and delaying immigrant woman's access to "Medicaid-covered prenatal and other health care").

[196] ROSS & SOLINGER, *supra* note 62, at 91.

[197] Olof Stephansson, *The influence of socioeconomic status on stillbirth risk in Sweden*, 30:6 Int'l J. of Epidemiology 1296, 1299 (2001).

[198] *Id.*

[199] *Id.*

[200] *Id.*

[201] *Id.*

[202] Willinger, *supra* note 110, at 469e7. The same study also suggested that black women's increased risk of stillbirth at term (after 37 weeks of pregnancy) may be because

Concerns connecting stillbirth to prenatal care should be even greater in the United States, unlike Sweden, women do not have equal opportunities to receive prenatal care. Here, "insurance is the gateway to health care."[203] A poor woman's likely only option for insurance is often only a government-sponsored program. Medicaid, which covers as many as half of all births in the United States each year,[204] provides insurance for prenatal care, labor and delivery, and 60 days of coverage for after birth. The Affordable Care Act expanded Medicaid and benefited pregnant women by enabling them access to Medicaid before pregnancy, meaning they could "receive regular health care before getting pregnant and therefore be able to prepare for a healthy pregnancy," and eliminating the delays of obtaining Medicaid only after becoming pregnant, which often resulted in delayed prenatal care.[205] But not all states expanded Medicaid coverage, leaving many poor women with no option for insurance until signing up for Medicaid after they get pregnant. Texas is one of those states. A recent ProPublica article explained that in Texas, about 21% of women who give birth in state don't get prenatal care until the second trimester, and another 10% don't start until the third trimester or never do so.[206]

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doctors do not induce labor in black women as often as they do white women. *Id.* The Stillbirth Collaborative Research Network Writing Group explained that that the prepregnancy risk factors for stillbirth that tend to be more frequent among black women include: maternal age under 20 years, "low maternal education, previous stillbirth, previous cesarean delivery, obesity, chronic hypertension, diabetes, systemic lupus erthematosis, and multiple gestation." Stillbirth Collaborative Research Network Writing Group, *Association between Stillbirth and Risk Factors Known at Pregnancy Confirmation*, 306:22 JAMA __ (2011). At the same time, other prepregnancy risk factors associated with stillbirth tend to not be present in black women, including smoking and first pregnancy. *Id.*

[203] Liz Kukura, *Giving Birth under the ACA: Analyzing the Use of Law as a Tool to Improve Health Outcomes*, 94 NEB. L. REV. 799, 830 (2016).

[204] Usha Ranji, et al., *Expanding Postpartum Medicaid Coverage*, Kaiser Family Foundation(May 22, 2019), https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/.

[205] Kukura, *supra* note 203, at 830.

[206] Nina Martin & Julia Belluz, *The Extraordinary Danger of Being Pregnant and Uninsured in Texas*, ProPublica (Dec. 6, 2019), https://www.propublica.org/article/the-extraordinary-danger-of-being-pregnant-and-uninsured-in-texas. The reason is because of the inability to sign up for Medicaid until pregnant, which a woman may not discover until even the sixth week of pregnancy (half way point of the first trimester). *Id.* The application is long and any glitch can delay approval. *Id.* These delays are not unavoidable as other states have better procedures to get women enrolled, but Texas's system is currently lacking. *Id.* If the delay is too long, a woman may be unable to find a doctor as some doctors will also refuse new patient beyond a certain week of pregnancy, usually 28 weeks but some as early as 20 weeks. *Id.* Plus, not all doctors are eager to treat Medicaid-insured pregnant women. The ProPublic article explained that "[p]roviders are paid only about half as much for Medicaid patients as for privately insured ones," and thus some "Texas OB-GYNs in private practice choose to avoid, capping the total of Medicaid patients they accept, limiting the number of high-risk women or opting out altogether." *Id.*

Even if a woman is insured, she may not have easy access to quality prenatal care. In 2018, the American College of Obstetricians and Gynecologists warned that "[l]ess than one half of rural women live within a 30-minute drive to the nearest hospital offering perinatal services. Within a 60-minute drive, the proportion increases to 87.6% in rural towns and 78.7% in the most isolated areas."[207] An article in an Australian publication dedicated to improving remote health recently explained that "[t]he further a woman lives away from a major city, the greater the chance she has of experiencing a stillbirth."[208] The article further discussed that a recent study by the Australian Institute of Health and Welfare had determined "women living in remote and very remote areas are 65 percent more likely to lose their babies in the perinatal period than women living in major cities and inner regional areas."[209]

Access to preventative prenatal care is the first step. The second step it to ensure that prenatal care includes education of women on the risk of stillbirth and the known, simple preventative measures.[210] As mentioned, only around 7% of 2.6 million stillbirths that occur yearly globally (using a 28 week definition of stillbirth) are due to congenital abnormalities, and even some of those abnormalities are actually preventable if the mother takes folic acid.[211] Thus, over 90% of stillbirths each year are not inevitable and instead are potentially preventable. Numerous countries have created initiatives to reduce their stillbirth rates, and those initiatives include educating women about the risk of stillbirth and advising them to take simple measures to help prevent it—not smoking, sleeping on their side later in pregnancy, and monitoring fetal movement. Programs in the Netherlands, Scotland, and England all include patient education of these measures and their connection to helping prevent stillbirth.[212] In just the past twenty years, both Norway and Scotland have

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[207] ACOG Committee Opinion, Committee on Health Care for Underserved Women, *Health Disparities for Rural Women* (2018) ("Less than one half of rural women live within a 30-minute drive to the nearest hospital offering perinatal services. Within a 60-minute drive, the proportion increases to 87.6% in rural towns and 78.7% in the most isolated areas. During 2008–2010, rural women aged 18–64 years reported the highest rates of delayed care or no medical care due to cost (18.6%) and no health insurance coverage (23.1%), both rates increased since 2002–2004."), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women.

[208] *Improving Remote Maternity Care*, 116 Crana Plus Magainze: The Voice of Remote Health, at 84, available at https://www.flipbookpdf.net/web/site/0e963f6b2556c3510c4a2646149dc5762596c569FBP18408067.pdf.html?fbclid=IwAR0nVVNhizdQuCk-Ck3bkFlABd0ZEj8GS-GIFRodlasdRgMBaGe-Cy2FUZU#page/1

[209] *Id.*

[210] I've written separately on a woman's right to her doctor's disclosure of the risk of stillbirth and its preventative measures. *See generally* Jill Wieber Lens, *Stillbirth and Blindsided Mothers*, (on file with author).

[211] Joy E. Lawn et al., *Stillbirths: Rates, Risk Factors, and Acceleration Towards 2030*, 387 LANCET 587, 597 (2016).

[212] *See supra* note 139 and accompanying text.

reduced their stillbirth rates by over 20%.[213] England reduced its rate by almost 20% in just five years.[214]

The importance of monitoring fetal movement cannot be understated. Any reduction in movement can indicate a potential problem. But only if the woman knows of the connection between fetal movement and stillbirth will she know of the importance of seeking medical attention if she notices a change. If there is a problem, the doctor can start delivery to get the still-alive baby out of the womb and prevent stillbirth. A study in Norway suggested a 30% reduction of stillbirth due to educating pregnant women on the risk of stillbirth and the importance of monitoring fetal movement.[215] Closer to home, "Count the Kicks," an initiative started by bereaved mothers in Iowa, seeks to educate women on the importance of fetal movement and created an app that pregnant women can use to monitor their baby.[216] In the first five years after the group's creation, Iowa's stillbirth rate decreased by almost 30%.[217]

Research has revealed these simple preventative measures for stillbirth, but research needs to continue for both stillbirth and miscarriage prevention. Reproductive justice's intersectional lens can play an important part in developing research focuses, perhaps focusing on the racial and class disparities in the risks.[218] For example, miscarriages are currently believed unpreventable. According to the American Pregnancy Association, "[s]ince the cause of most miscarriages is due to chromosomal abnormalities, there is not much that can be done to prevent them."[219] Assuming this is true,[220] this is

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[213] *Id.*

[214] *Id.*

[215] Julie Victoria Holm Tveit, et al., *Reduction of late stillbirth with the introduction of fetal movement information and guidelines – a clinical quality improvement*, 9:32 BIOMED CENT. PREGNANCY & CHILDBIRTH 4 (2009), https://bmcpregnancychildbirth.biomedcentral.com/track/pdf/10.1186/1471-2393-9-32.

[216] *See generally* Michael Ollove, *Pregnant women are told to count fetal kicks to help prevent stillbirth*, Wash. Post., (Oct. 15, 2018), https://www.washingtonpost.com/national/health-science/pregnant-women-are-told-to-count-fetal-kicks-to-help-prevent-stillbirths/2018/10/12/0448e8ca-b51a-11e8-a2c5-3187f427e253_story.html.

[217] Rekha Basu, *Successful plan to save infants from stillbirth still needs to reach more minority moms*, Des Moines Register (Feb. 13, 2019), https://www.desmoinesregister.com/story/opinion/columnists/rekha-basu/2019/02/13/count-kicks-iowa-pregnancy-health-success-preventing-stillbirths-still-needs-reach-more-black-moms/2793947002/

[218] Linda Layne, *A Woman's Health Model for Pregnancy Loss: A Call for a New Standard of Care*, 32:3 FEMINIST STUD. 573, 595 (2006) (explaining that research on prevention of miscarriage needs to take into account "women of all backgrounds").

[219] *Miscarriage: Pregnancy Complications*, Am. Pregnancy Assoc., https://americanpregnancy.org/pregnancy-complications/miscarriage/ (last visited Nov. 11, 2019). Scientists are also likely wary of drugs to reduce the chance of miscarriage because of DES, "a 1950s pharmacological attempt to reduce miscarriage that resulted in devastating, multigenerational iatrogenic disease." Layne, *supra* note 218, at 591.

[220] Anthropologist Linda Layne laments that "[t]here has been strikingly little effort to prevent pregnancy loss. One reason for this is that miscarriages … are regarded as evidence not of pathology, but of the body operating as it should." Layne, *supra* note 218, at 591 (2006).

miscarriages before 12 weeks, in the first trimester. Black women, however, face an increased risk of miscarriage *after* ten weeks (and after twelve weeks). Abnormalities "are less common in later losses,"[221] like the later miscarriages after ten weeks of which black women face an increased risk. Thus, the fatalism surrounding miscarriage (because of chromosomal abnormalities) likely assumes *white* women's miscarriages. Research into preventing miscarriages for black women may then have more promise.

Relatedly, studies have suggested a connection between a black woman's increased risk of miscarriage in 10-20 weeks and 2.8% higher risk of stillbirth between twenty and twenty-four weeks of pregnancy.[222] Another study suggested a connection between the increased stillbirth rate and the fact that a black woman's risk of preterm birth, meaning birth before 28 weeks of pregnancy, is more than three times greater than a white woman's.[223] The causes could easily be related.[224] But we don't know. A 2009 study emphasized the need to study racial and ethnic disparities in stillbirth, just as researchers have done within the context of infant mortality, as it could be "a critical indicator of racial disparity in health."[225] Reproductive justice's recognition that women's experiences of miscarriage and stillbirth differ based on race highlights the need for this research that can help make prenatal care more preventative.

C. Birth Justice Rights for Stillbirth and Miscarriage

Reproductive justice advocates have also identified concerns based on the medical care women receive during childbirth. "[P]regnant women are vulnerable to many birth injustices."[226] The label "obstetric violence" is increasingly being used to describe the disrespectful, abusive, or neglectful treatment women often experience during childbirth. Professor Elizabeth Kukura recently vividly described the many types of medically unnecessary and unwanted medical procedures imposed on women in childbirth, forced surgeries like episiotomies and cesarean section deliveries and unconsented medical procedures like labor induction and forceps-assisted delivery.[227] Also, many women report that they are "denied midwifery services" and that

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She points out, however, that "[t]he research on which this view is based … is decades old." *Id.*

[221] *Id.*

[222] Sudeshna Mukherjee, *Risk of Miscarriage Among Black Women and White Women in a US Prospective Cohort Study*, 177:11 Am. J. of Epidemiology, 1271, 1277 (2013).

[223] Stillbirth Collaborative Research Network Writing Group, *Association between Stillbirth and Risk Factors Known at Pregnancy Confirmation*, 306:22 JAMA __ (2011).

[224] Stillbirth Collaborative Research Network Writing Group, *Association between Stillbirth and Risk Factors Known at Pregnancy Confirmation*, 306:22 JAMA __ (2011).

[225] Willinger, *supra* note 110, at 469e1.

[226] ROSS & SOLINGER, *supra* note 62, at 188.

[227] Kukura, *supra* note 29, at 730-35.

"hospital staff members often ignore a woman's birthing plans."[228] Other scholars have also argued "that women of color experience a disproportionate amount of medical intervention in their births for non-medical reasons."[229]

"Ending coercive medicine is a reproductive justice goal."[230] Specifically aimed at that goal is the concept of "birth justice," which focuses on the woman's rights within the "actual conditions of birth."[231] It is the "right to give birth with whom, where, when, and how a person chooses"[232] "without pressure or aggressive nonemergency interventions."[233] Similarly, "[a] birthing woman must always be provided with full prior information when conditions requiring unexpected medical interventions exist" and "must not lose their right to refuse medical care."[234] Additionally, birth justice recognizes the "right to determine their own birth plans, use midwives and doulas if they so choose, and have home births or free standing birthing centers if they prefer." Again, this is a right; reproductive justice recognizes that "deciding how one gives birth is an essential part of human dignity."[235] This right enables a woman's "pursuit of birth as an empowering experience free from coercion for all people, regardless of identity or circumstances."[236]

Birth justice concepts assume the birth of a living child, but apply equally to stillbirth as "[t]he process of giving birth to a stillborn baby is physiologically identical to that of a live born baby, although … significantly more traumatic."[237] Similar concerns about unwanted medical interventions also exist with respect to treatment of miscarriage. "Many women who have suffered a loss report dissatisfaction with the care they received."[238] In one

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[228] ROSS & SOLINGER, *supra* note 62, at 188.

[229] Luna & Luker, *supra* note 64, at 340-41.

[230] ROSS & SOLINGER, *supra* note 62, at 190.

[231] Luna & Luker, *supra* note 64, at 340-41; *see also* Rickie Solinger, *Conditions of Reproductive Justice*, in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 42 https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051 (describing reproductive justice rights to include "[t]he right to decide among birthing options and access to those services").

[232] ROSS & SOLINGER, *supra* note 62, at 262.

[233] *Id.* at 190.

[234] *Id.*

[235] Kukura, *supra* note 29, at 762.

[236] *Id.*

[237] Cacciatore, *supra* note 39, at 135.

[238] Layne, *supra* note 218, at 595. Dissatisfaction and anger may be even more prevalent for marginalized women. In one of the few studies devoted to African American parents, many parents reported experiencing "negative treatment by healthcare providers that added to the trauma of losing a child." Jackelyn Y. Boyden, *Experiences of African American Parents Following Perinatal or Pediatric Death: A Literature Review*, 38 DEATH STUDIES 374, 377 (2014). Marginalized women, especially, can feel that doctors do not hear them and dismiss their concerns. African American parents with lower socioeconomic status also expressed

study, that number was 80% of those surveyed, all of whom "report[ed] feeling angry about their care."[239] In some ways, the need to empower women in these unfortunate situations may be even greater than in live childbirth as "[p]regnancy loss can quickly result in vulnerability; imposing care can worsen the psychological impact."[240]

Just as the does with the birth of her living child, a woman has a right to give birth to her stillborn child as she chooses. But the circumstances of coerced or forced treatment differ in live childbirth and stillbirth. With a living child, birth justice was motivated by a concern for forced surgeries, specifically cesarean deliveries. With stillbirth, the concern is for forced vaginal delivery—that women desire a cesarean delivery and instead are forced to give birth vaginally.

A woman first has a decision to make regarding the timing of her child's birth. As she is still adjusting to the reality that her child died in her womb, she will learn that she still needs to give birth to her child. "The most unexpected reality for parents was that when a child is stillborn, a woman still has to go through labor and delivery."[241] Delivery may be immediately necessary due to maternal conditions,[242] but absent those conditions, a woman

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suspicion that doctors did not try as hard as possible to save their children due to the parents' insurance status. *Id.* at 377.

Another factor affecting all women's satisfaction with health care during miscarriage and stillbirth is doctor's reactions. Because of the high rate of miscarriage, physicians see miscarriages very often. LAYNE, *supra* note 152, at 70. Doctors often consider miscarriages "humdrum and dull because they are rarely life-threatening, require only routine intervention, and generally cannot be reversed." *Id.* In studies of parents after stillbirth, many comment on the "emotional unavailability of medical personnel." Elizabeth Kirkley-Best & Kenneth R. Kellner, *The Forgotten Grief: A Review of the Psychology of Stillbirth*, 52 AM. J. ORTHOPSYCHIATRY 420, 426 (1982). Doctors report having difficulty transitioning "from delivery of the stillborn to counseling or support, which was not viewed as a common role for OB/GYNs." Kelley & Trinidad, *supra* note 241, at 5. Several surveyed obstetricians felt "underprepared for a shift to palliative care and counseling and tended to defer to social workers or nurses to provide needed support for patients, or to other families who have experienced stillbirth. *Id.*

[239] Layne, *supra* note 218, at 595.

[240] *Late Intrauterine Fetal Death and Stillbirth*, Royal College of Obstetricians & Gynaecologists, Green-top Guidelines No. 55 (Oct. 2010), § 4.2, at 4, https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_55.pdf. [hereinafter RCOG Guideline]; Layne, *supra* note 218, at 586 ("[T]he very act of being able to choose seems to have a positive mental health effect."). Many points regarding medical care in this Article are taken from medical guidelines developed by England's Royal College of Obstetricians and Gynaecologists. The RCOG guidelines are far more comprehensive and expansive than guidelines promulgated by American College of Obstetrics and Gynecologists. This disparity is not surprising given that England has devoted resources to studying prevention of pregnancy loss and the United States has not.

[241] Maureen C. Kelley & Susan B. Trinidad, *Silent Loss and the Clinical Encounter: Parents' and Physicians' Experiences of Stillbirth—a Qualitative Analysis*, BIOMED CENT. PREGNANCY & CHILDBIRTH, Nov. 27, 2012, at 4.

[242] RCOG Guideline, *supra* note 240, § 6.1, at 12,

could safely delay delivery for a short period if she so desires, giving her more time to process.[243]

Whether delivery is immediate or delayed, a woman also has another decision to make regarding the method of childbirth. Sometimes, after learning that her child has died in utero, a woman actually desires a (not medically necessary) cesarean delivery.[244] Sometimes, women may incorrectly think that "that a quick caesarean section followed by resuscitation might save the baby" or that the baby will still feel pain and that a cesarean would be "less traumatic for the baby."[245] Or, women may also want a cesarean delivery because they fear for their own safety or it might just "be one of the few ways that women feel they can exercise some control over their situation."[246] Additionally, women often resist a doctor's recommendation for a vaginal delivery because they "do not appreciate the [doctor's] automatic shift of priorities to the mother and her future pregnancies" within that recommendation."[247]

Whatever the reason, women actually request a cesarean delivery of their stillborn child even though it is not medically necessary. Consistent with birth justice, a doctor should not dismiss the woman's desires and instead impose a vaginal delivery. Instead, the doctor seek "to identify and understand [the] women's thoughts and wishes but without trying to shape them."[248] "Discussions should aim to support maternal/paternal choice."[249] The doctor should provide the woman accurate information on "the risks and benefits of medical procedures," including cesarean delivery.[250] The doctor should also provide the woman information to help dispel any inaccurate beliefs she has regarding the baby's survival or ability to feel pain. "[W]hen supported and given good information about potential physiological, psychological and social benefits most women see the value in a vaginal birth, and many have positive and valuable experiences, though it is manifestly important that women feel in control of the decision-making process and that the mode of delivery isn't

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[243] *Id.*

[244] *See* Vicky Flenady, et al., *Meeting the Needs of Parents After a Stillbirth or Neonatal Death*, 121 BJOG 137, 139 (2014) ("A natural parental response is sometimes to request immediate operative delivery and a recommendation to proceed with labour and delivery may be construed as insensitive.").

[245] D Siassakos, et al, *All bereaved parents are entitled to good care after stillbirth: a mixed-methods multicenter study (INSIGHT)*, 125 BRIT. J. OBSTETRICS & GYNAECOLOGY 160, 166 (2017).

[246] Paul Richard Cassidy, *Care quality following intraueterine death in Spanish hopsitals: results from an online survey*, 18:22 BIOMED CENT. PREGNANCY & CHILDBIRTH, 1, 9 (2018), https://bmcpregnancychildbirth.biomedcentral.com/track/pdf/10.1186/s12884-017-1630-z

[247] D Siassakos, et al, *supra* note 245, at 166.

[248] RCOG Guideline, *supra* note 240, § 4.2, at 4.

[249] *Id.*

[250] Farah Diaz-Tello & Lynn M. Paltrow, Nat'l Alliance Pregnant Women Working Paper: Birth Justice as Reproductive Justice 3 (2010), http://www.advocatesforpregnantwomen.org/BirthJusticeasReproRights.pdf.

imposed."[251] Ultimately though, consistent with birth justice, if the woman makes an informed decision for a cesarean delivery, the doctor should accede to her wishes.

Miscarriage does not involve childbirth, but it can still involve medical treatment. Concerns may not be as strong regarding unwanted medical procedures surrounding miscarriage, but anecdotal evidence shows that women may not be fully informed of their treatment options or the details of those options.

Numerous treatment options exist in the case of a missed miscarriage or an imminent miscarriage. A missed miscarriage occurs when the woman learns at her 12 weeks appointment that she has miscarried although she has had no symptoms. An imminent miscarriage is if the woman learns her baby's heart is still beating but it stopped developing.[252] In either case, numerous treatment options exist—the woman can wait and miscarry naturally,[253] she can take the same medication used for a medicated abortion,[254] or she can have a surgery called a dilation and curettage in which the doctor removes the fetal tissue from the woman's uterus. It does not appear common practice for a

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[251] Cassidy, *supra* note 246, at 9-10, https://bmcpregnancychildbirth.biomedcentral.com/track/pdf/10.1186/s12884-017-1630-z; *see also* Vicky Flenady, et al., *Meeting the Needs of Parents After a Stillbirth or Neonatal Death*, 121 BRIT. J. OBSTETRICS & GYNAECOLOGY 137, 139 (2014) ("[W]ith due attention to individualized advice and effective arrangements for pain relief during labour, concerns and distress about 'labouring with a dead baby' can be resolved.").

[252] Layne has explained how medicalization has also changed the experience of pregnancy loss "in numerous, unanticipated, and unexamined ways." Linda L. Layne, *Pregnancy and infant loss support: A new, feminist, American, patient movement?*, 62 SOCIAL SCI. & MED. 602, 603 (2006). For stillbirth, that includes diagnosis before birth and "labor and delivery in a hospital or surgical extraction." *Id.*

[253] Layne advocates that a woman be thoroughly educated concerning "what [the miscarriage] might look like, how one might feel, what one might want to do." *Id.* at 590; *see also* van den Berg, et al., *supra* note 14, at 113 ("Patients liked to receive information on the degree of pain and blood loss to expect while awaiting a spontaneous miscarriage ….). Similarly UK National Institute for Health and Care Excellence guidelines say to give women "oral and written information about what to expect throughout the process, advice on pain relief and where and when to get help in an emergency." NICE Guideline, *Ectopic pregnancy and miscarriage: diagnosis and initial management*, Nat'l Inst. For Health and Care Excellence, 1.5.5 (Apr. 17, 2019), https://www.nice.org.uk/guidance/ng126/resources/ectopic-pregnancy-and-miscarriage-diagnosis-and-initial-management-pdf-66141662244037.

[254] *Id.* at 587. Numerous women have complained that a pharmacist has been unwilling to fill a prescription for Misprostol because of religious beliefs, even though the woman needs the drug because of miscarriage. *See e.g.,* Elisha Fieldstadt, *Michigan pharmacist denies women miscarriage medication over religious beliefs*, NBC NEWS, (Oct. 18, 2018), https://www.nbcnews.com/news/us-news/meijer-pharmacist-denies-michigan-woman-miscarriage-medication-citing-religious-beliefs-n921711; Louis Lucero II, *Walgreens Pharmacist Denies Woman with Unviable Pregnancy the Medication Needed to End It*, N.Y. TIMES (June 25, 2018), https://www.nytimes.com/2018/06/25/us/walgreens-pharmacist-pregnancy-miscarriage.html.

doctor to advise the woman of all these options.[255] In a Slate article, the author noted that "[n]one of the women I spoke to for this piece were given the full menu of options when their miscarriages were discovered" and were instead given the doctor's apparently preferred D&C.[256]

If a woman has options on her care, she should also be advised of the costs. Waiting would cost nothing, the drug would likely cost a few hundred dollars, and a D&C would likely cost thousands of dollars.[257] Anecdotal evidence suggests that uninsured women pay between $4,000 and $9,000 for a D&C and insured women pay between $250 and $1,200 out-of-pocket.[258] Numerous women report being blindsided by a bill for a D&C; expensive bills only increase the difficulty of grieving.[259] Pricing a specific D&C may be difficult, but women should at least be informed of the potential costs in comparison to her other options.[260]

D. The Right to Mental and Emotional Health Care

Variations in reaction to miscarriage and stillbirth exist due to both the individual woman and her circumstances. A marginalized woman can easily have an emotional experience different from a white woman of higher socioeconomic status. Circumstances like "economic hardship, racism and

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[255] ACOG Practice Bulletin, *Early Pregnancy Loss*, Am. Coll. Of Obstetricians and Gynecologists, 132:5 OBSTETRICS & GYNECOLOGY e197, e199 (Nov. 2018) (explaining that if no complications exist, "[p]atients should be counseled about the risks and benefits of each option"), https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb200.pdf?dmc=1&ts=20181207T1637252429.

[256] Jessica Grose, *The Cost of a Miscarriage*, Slate (Mar. 26, 2015), https://slate.com/human-interest/2015/03/the-cost-of-a-miscarriage-we-talk-about-the-emotional-pain-but-not-the-financial-hurt.html

[257] Catherine Pearson, *After Miscarriage Come the Bills*, Huffington Post (Mar. 28, 2019), https://www.huffpost.com/entry/after-a-miscarriage-next-come-the-bills_l_5c950630e4b0a6329e15eb83

[258] Grose, *supra* note 256.

[259] *Id.*

[260] Ayana Lage, *The Hidden Financial Toll of Having a Miscarriage*, Wash. Post (Dec. 11, 2019), https://www.washingtonpost.com/lifestyle/2019/12/11/hidden-financial-toll-having-miscarriage/ (explaining the bills received after a D&C and wondering if she "would've picked a cheaper option if I'd known how much I'd owe"). ACOG's practice bulletin discusses the costs of the three treatment options, explaining that "surgical management in an operating room is more costly than expectant or medical management," although it can be less expensive if performed without general anesthesia in an office visit. ACOG Practice Bulletin, *Early Pregnancy Loss*, *supra* note 255, at e202 (explaining that if no complications exist, "[p]atients should be counseled about the risks and benefits of each option"). And an office D&C may not be possible as doctors report "safety concerns" and expense given that they would need "to invest in equipment and training." Grose, *supra* note 256. The ACOG bulletin also mentions a U.S. study that concluded "that medical management with misoprostol was the most cost-effective intervention." ACOG Practice Bulletin, *Early Pregnancy Loss*, *supra* note 255, at e202. The practice bulletin does not indicate that the doctor should discuss costs with the patient.

discrimination, lack of social and professional support, and history of illness and death in the family"[261] affect a woman's experience. A study specific to African American parents explained that "the grief experienced by bereaved African American parents may be of particular concern, given the unique aspects of their experience and culture."[262] The "realities of everyday life add[] to the burden African Americans faced after the loss of a child"[263]— including "socioeconomic stressors, the prevalence of illness and death in families, a lack of support by others, and negative encounters with healthcare and other professionals."[264]

Individual circumstances and cultural values affect grief and access to support; "[n]ot only are women of color more likely to experience loss and have limited access to bereavement support …."[265] Similarly, circumstances affect the effectiveness of different types of support.[266] These realities may help explain why "African American parents reported high levels of drug and alcohol use, eating, weight gain, and sleep disturbances 3 years after the child's death."[267]

Yet existing guidelines for emotional and mental health support after miscarriage and stillbirth are generalized. For instance, the RCOG guidelines state that "[c]ounselling should be offered to all women and their partners," "parents should be advised about support groups,"[268] and that "[b]ereavement officers should be appointed to coordinate services."[269] The RCOG guidelines also recommend that hospitals offer women and parents leaflets with information on "named carers," "local contact points," autopsies, "expectations for physical recovery," "lactation suppression" … "details of national and local parent support groups" … [and] "plan for follow-up."[270] The ACOG guidelines are less comprehensive. They explain that a referral "to a bereavement counselor, religious leader, peer support group, or mental

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[261] Boyden, *supra* note 238, at 378.

[262] *Id.* at 375.

[263] *Id.* at 376.

[264] *Id.*; *see also id.* at 378 ("Racism, discrimination, economic disadvantage, and health disparities greatly influence bereavement (Rosenblatt & Wallace, 2005) and may create a high vulnerability to further disruption, loss, and trauma for many African Americans.").

[265] Layne, *supra* note 218, at 594.

[266] Paulina Van, *Coping With Grief After Involuntary Pregnancy Loss: Perspectives of African American Women*, 32:1 J. OF OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 28, 28 (2003) (explaining that "spiritual beliefs and practices, cultural values, [and] attitudes toward seeking health services" affect the effectiveness of support).

[267] Boyden, *supra* note 238, at 378.

[268] RCOG Guideline, *supra* note 240, § 8.2, at 18.

[269] *Id.* § 8.2, at 19.

[270] *Id.* § 11.3, at 25-26.

health professional may be advisable for management of grief and depression."[271]

Notably, the RCOG guidelines do note that "carers should be aware of and responsive to possible variations in individual and cultural approaches to death."[272] This is consistent with the reproductive justice framework, to recognize that marginalized women do experience miscarriage and stillbirth differently due to their circumstances. The ACOG guidelines, in the United States, however, lack any such recognition of a marginalized woman's possibly different experience.

Research has already shown two examples of how culture can affect the effectiveness of support mechanisms after a parent's experience of stillbirth. The first is the recommendation that parents hold their stillborn baby, a measure that researchers almost unanimously agree that holding the baby after stillbirth is beneficial for parents.[273] "[T]he modern standard of care is to offer grieving parents repeated and extended opportunities to have close contact with their baby."[274] In studies, almost no parent expresses regret over holding the baby, but almost all express regret over not holding the baby.[275] Holding the baby gives the mother an opportunity to parent her child; it gives her "an opportunity to nurture her baby, a chance for her to care for the baby, which can be as a natural biological reaction after giving birth."[276] In one survey, nearly all the mothers who held their baby reported feeling "tenderness, warmth and grief … while some also felt pride."[277] Holding the baby is such an important part of grief resolution that guidelines advise medical

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[271] Clinical Management Guidelines for Obstetrician-Gynecologists, *Management of Stillbirth*, ACOG Practice Bulletin No. 102 (2009), https://starlegacyfoundation.org/wp-content/uploads/acog-management-of-stillbirth1.pdf.

[272] RCOG Guideline, *supra* note 240, § 8.2, at 18-19.

[273] Kirkley-Best & Kellner, *supra* note 131, at 426 (describing that research shows "almost unanimous agreement that seeing and holding the infant is helpful in successful grief resolution").

[274] PREGNANCY LOSS AND INFANT DEATH ALLIANCE, POSITION STATEMENT: BEREAVED PARENTS' RIGHT TO SELF-DETERMINATION REGARDING THEIR BABY, August 2016, 2, http://www.plida.org/wp-content/uploads/2012/01/PLIDA_BereavedParentsRighttoSelf-Determination.pdf; *see also* Joanne Cacciatore, *The Silent Birth: A Feminist Perspective*, 54 SOCIAL WORK 91, 93 (2009) ("Improved standards of compassionate care in hospitals, supportive nurturance from family and friends, and support groups contribute to a lessening of posttraumatic stress responses and chronic, debilitating grief.") (hereinafter Cacciatore, *Feminist*); *see also* Sanger, *supra* note 130, at 283–85 (describing changes in hospitals allowing parents to spend time with the infant and preparing memory boxes for parents).

[275] Murphy & Cacciatore, *supra* note 131, at 130; Kirkley-Best & Kellner, *supra* note 131, at 426 (describing that research shows "almost unanimous agreement that seeing and holding the infant is helpful in successful grief resolution").

[276] Ingela Radestad, et al., *Holding a stillborn baby: mothers' feelings of tenderness and grief*, 17(3) BRIT. J. OF MIDWIFERY 178 (2009).

[277] *Id.*

professionals to continue to ask parents in the hours after birth as "[t]he opportunity for contact is fleeting and final."[278]

But some parents may be especially hesitant to hold their stillborn baby, especially African American fathers.[279] Parents may need appropriate encouragement from health professionals whose words and conducts will affect a parent's decision.[280] "[P]arents particularly value professional guidance about exactly *how* to see and hold," including for "how long," "how best to see and photograph," "what to expect if they want to bath, dress or sleep next to their baby, and how the passing of time will alter the baby's temperature, appearance, and touch."[281] In one study, most African American "fathers were very reluctant to hold their infants but did with encouragement from nurses or family members."[282]

Another common measure to address grief after stillbirth mentioned in both the RCOG and ACOG guidelines is referral to a support group. A 2007 study by Dr. Joanne Cacciatore concluded that "[w]omen who participated in support groups after the death of their child to stillbirth experienced significantly fewer traumatic stress symptoms than women in [the] study who did not attend support groups."[283]

In one of the few studies concerning the experiences of African American women, however, one third reported attending a support group, but "indicated that groups they attended had few or no other African American women, which made their sharing somewhat constrained."[284] A typical comment from these women was: "Support groups and counselors are thought to be only for White women with money. Cultural differences make our grieving that much harder. We are not expected to go to counseling and [are] brought up to make it on our own, to try to be strong, but can't. [We're taught that] the only thing you need to do is get on your knees [to pray] and you'll be okay."[285] Similarly, in a 2005 study of low-income African American parents after perinatal death, *no* participant attended support group. "This finding suggests that traditional mechanisms for providing follow-up care for

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[278] Carol Kingdon, et al, *The Role of Healthcare Professionals in Encouraging Parents to See and Hold their Stillborn Baby: a Meta-Synthesis of Qualitative Studies*, PUBLIC LIB. OF SCIENCE One https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4495992/pdf/pone.0130059.pdf

[279] Karen Kavanaugh & Patricia Hershberger, *Perinatal Loss in Low-income African American Parents: The Lived Experience*, 34:5 J. OBSTET. GYNECOL NEONATAL NURS. 595, 603 (2005).

[280] Carol Kingdon, et al, *supra* note 278, at 15 ("The behavior and opinions expressed by healthcare professionals were found to be especially pertinent in the decision making processes of parents.").

[281] *Id.*

[282] Kavanaugh & Hershberger, *supra* note 279, at 603.

[283] Joanne Cacciatore, *Effects of Support Groups on Post Traumatic Stress Responses in Women Experiencing Stillbirth*, 55(1) OMEGA 71, 83-84 (2007).

[284] Van, *supra* note 266, at 32.

[285] *Id.*

parents after a perinatal loss, such as making a referral to a hospital-based parent support group, may not be appropriate for these parents."[286]

Other support mechanisms may be more appropriate for marginalized women. For instance, "African American parents may be more likely to rely on religion to cope with the loss of their child."[287] Parents with a lower socioeconomic status are likely to experience "greater despair and higher levels of depression" due to funeral and burial expenses.[288] Medical professionals should thus "direct[] parents to financial assistance for burial services."[289] Ideally, mental health professionals and counselors would also be available to parents of lower socioeconomic means at limited or no cost.

More research is needed. Although "African American women experience fetal death at rates at least twice those of any other racial or ethnic group in the United States," "there is scant literature on the perspectives and experiences of African American women after these losses."[290] As research continues, though, the reproductive justice movement should advocate for "broader awareness among healthcare providers, hospital administrators, and policymakers of the complex needs of parents, and the necessity of culturally sensitive healthcare and bereavement supports following the death of a child."[291]

E. The Right to Parent Your Stillborn Child

Reproductive justice recognizes the equally important right to parent. The right to parent is a positive right that the state must is obligated to provide "social supports" to help women raise their children in "safe and healthy environments."[292] These necessary social supports include affordable housing and quality public education among many others.[293] Reproductive justice thus recognizes the connection between the state and parenting.[294]

Reproductive justice's right to parent, however, seems to assume a living child. Obviously, there's no need for affordable housing and quality public education for your child unless he is living. That said, reproductive justice does recognize the needs of women who lack children by highlighting infertility,[295] a special concern for reproductive justice given the disparity in

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[286] Kavanaugh & Hershberger, *supra* note 279, at 603.

[287] Boyden, *supra* note 238, at 378.

[288] *Id.* at 376.

[289] *Id.* at 378.

[290] Van, *supra* note 266, at 28; *see also id.* at 30 (explaining that whether "effective and ineffective [coping] strategies differ from one racial/ethnic group to another is not address in IPL [involuntary pregnancy loss] literature").

[291] Boyden, *supra* note 238, at 378.

[292] ROSS & SOLINGER, *supra* note 62, at 168-69.

[293] *Id.*

[294] *Id.*

[295] Chrisler, *supra* note 77, at 13.

access. "Pursuing fertility treatments is a class privilege," and usually one pursued by only wealthier, white women.[296] Notably, some studies have found a connection between the use of ART and stillbirth.[297] Regardless, infertility is within reproductive justice's framework. Additionally, reproductive justice has identified that "poverty creates poor conditions for mothering because it … increases rates of infant and child mortality and lower birth weights."[298] And thus some recognition of mothers without living children exists.

But more than infertility and infant and child mortality can interfere with a mother's right to parent. Stillbirth does too. In stillbirth, a woman gives birth to a child that she planned to raise; that woman is the mother of that child. She both identifies herself as a mother to that child and the state, albeit to a limited extent, identifies her as a parent.

Empirical studies after stillbirth overwhelmingly refer to parents.[299] And the conclusions of those studies affirm this parenthood. A 2012 study explained that parents "identified strongly as parents, and said they will always be parents of their stillborn child."[300] A 2018 study found similarly. It explained that parents identify their stillborn baby as a person, as their child; "[p]arents spoke about the uniqueness of their baby and how each baby had an enduring importance as a human being that mattered."[301] Similarly, parents emphasized

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[296] Rickie Solinger, *The Incompatibility of Neo-Liberal "Choice" and Reproductive Justice,* in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 39 ("Pursuing fertility treatments is a class privilege."), https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051; Seema Mohapatra, *Fertility Preservation for Medical Reasons and Reproductive Justice*, 30 HARV. J. RACIAL & ETHNIC JUST. 193, 211 (2014); Madeline Curtis, *Inconceivable: How Barriers to Infertility Treatment for Low-Income Women Amount to Reproductive Oppression*, 25 GEO. J. ON POVERTY L. & POL'Y 323, 340 (2018).

[297] Notably, some studies have found a connection between the use of ART and stillbirth. *See generally*, AA Henningsen, et al., *Trends in perinatal health after assisted reproduction: a Nordic study from the CoNARTaS group.* 30 HUM REPROD. 710 (2015); JL Marino, et al., *Perinatal outcomes by mode of assisted conception and sub-fertility in an Australian data linkage cohort,* 9(1) PUB. LIBRARY OF SCIENCE ONE (2014); K Wisborg, et al., *IVF and stillbirth: a prospective follow-up study*, 25 HUM REPROD. 1312 (2010).

[298] ROSS & SOLINGER, *supra* note 62, at 172.

[299] *See e.g.,* Joanne Cacciatore & Suzanne Bushfield, *Stillbirth: the mother's experience and implications for improving care*, 3(3) J. SOC. WORK. END LIFE PALLIATIVE CARE (2007); Kelley & Trinidad, *supra* note 241; Kirkley-Best & Kellner, *supra* note 131; Joanna Cacciatore et al., *When a Baby Dies: Ambiguity and Stillbirth*, 44 MARRIAGE & FAM. REV., 439, 443 (2008); Vicky Flenady, et al., *Support for parents after stillbirth*, 197(5) MED. J. OF AUSTRALIA (2012); Karen Kavanaugh, *Support parents after stillbirth or newborn death*, 106(9) AM. J. OF NURSING (2006); Alexander Heazell, et al., *A difficult conversation? The views and experiences of parents and professionals on the consent process for perinatal postmortem after stillbirth*, 119(8) BRIT. J. OBSTETRICS & GYNAECOLOGY (2012); Suzanne Pullen, et al., *I'll never forget those cold words as long as I live": parent perceptions of death notification for stillbirth*, 8(4) J. SOC. WORK. END LIFE PALLIATIVE CARE (2012).

[300] Kelley & Trinidad, *supra* note 241, at 11.

[301] Daniel Nuzum, et al., *The impact of stillbirth on bereaved parents: A qualitative study*, 13(1) PUBLIC LIB. OF SCIENCE ONE, at 5 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5783401/pdf/pone.0191635.pdf.

the importance of recognizing their "stillborn baby as a real baby, the baby's unique identify."[302] Parents explained that their baby's identity existed both before his birth and after; "all parents gave a name to their baby."[303] And parents described that they "actively parented their baby as they would a live baby" and that they valued the time they got to parent the baby, although that time was impossibly short.[304] Mothers explained that they had a "strong ongoing relationship with their baby" before death.[305]

As a group, women are more likely to still identify as mothers after stillbirth than they are after miscarriage. Studies have also shown that levels of prenatal bonding increase as the pregnancy progresses.[306] As many have pointed out, it's true that technology has enabled bonding earlier than in the past, but the first transabdominal ultrasound (when actually see a baby with baby parts) still doesn't occur until around 20 weeks. This is not to say that some women miscarry don't also see themselves as mothers; some do.[307] But on the whole, women are more likely to identify themselves as mothers of their unborn children than are women who miscarry.[308]

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[302] *Id.* at 5.

[303] *Id.* at 6; *see also* Kelley & Trinidad, *supra* note 241, at 10 (explaining that all parents surveyed had named their (stillborn) child).

[304] Nuzum, *supra* note 301, at 6.

[305] *Id.* at 8.

[306] Anna Maria Della Vedova et al., *Assessing Prenatal Attachment in a Sample of Italian Women*, 26 J. REPROD. & INFANT PSYCHOL. 86, 89, 95 (2008) (concluding that "prenatal attachment scores increase with the weeks of gestation").

[307] Heather Rowe and Alexandra J. Hawkey, *Miscarriage*, *in* ROUTLEDGE INTERNATIONAL HANDBOOK OF WOMEN'S SEXUAL & REPRODUCTIVE HEALTH (Jane M. Ussher, Joan C. Chrisler, Janette Perz, eds., 2019); *see id.* (explaining that some "women attribute personhood to their foetus and are emotionally invested in their pregnancy from the earliest weeks").

[308] The difference in possible parenthood is especially stark at the extremes—a woman is highly unlikely to consider herself a parent if she miscarries days after finding out she is pregnant. But she is highly likely to consider herself a parent when she gives birth to a six pound stillborn baby and holds him after his birth. That said, there is likely little difference in the woman who miscarries at 19 weeks versus the woman who gives birth to her stillborn child at 21 weeks. A woman draws the line for herself, but the law cannot rely on each woman's subjective line.

Notably, other institutions draw a later line dividing miscarriage and stillbirth. England's dividing line between miscarriage and stillbirth is at 24 weeks. National Health Services: Overview Stillbirth, https://www.nhs.uk/conditions/stillbirth/ (last accessed Jan. 27, 2019). The World Health Organization's line is at 28 weeks. World Health Organization, Maternal, Newborn, Child, and Adolescent Health: Stillbirths, https://www.who.int/maternal_child_adolescent/epidemiology/stillbirth/en/ (last accessed Jan. 10, 2019). In the United States, abortion jurisprudence draws a line at viability, which is generally thought of as at 24 weeks of pregnancy. Roe v. Wade, 410 U.S. 113, 163 (1973) (explaining that that at viability, "the fetus then presumably has the capability for meaningful life outside the mother's womb" and that state regulation of abortion after viability has "both logical and biological justifications). Some states also use this viability line for wrongful death

Additionally, the state has historically recognized a parenthood after stillbirth and has not done the same after miscarriage. For at least a century, states have required the issuance of a death certificate when an unborn baby dies in utero after twenty weeks of pregnancy,[309] now often called a fetal death certificate. The child's name is listed on the certificate if the parents so desire.[310] Some evidence exists also that states historically also issued a birth certificate for stillbirth—the same birth certificate it issued for stillbirth, with a box to check for whether the child was born alive or stillborn. For example, Tennessee's 1913 Vital Statistics Law mandated "[t]hat stillborn children or those dead at birth, shall be registered as births and also as deaths, and a certificate of both birth and death shall be filed with the local registrar in the usual form and manner."[311] Returning to modern day, another state recognition of parenthood after stillbirth is parents' legal responsibility for the final disposition of their stillborn child's body.[312] Missouri's statutory mandate specifically defines "either or both the biological mother or father of a stillborn

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claims after stillbirth. *See* Lens, *supra* note __ at 369. If anything, these examples support a line later than 20 weeks.

Besides a dividing line for parenthood, other practical reasons exist why these measures cannot be applied to miscarriage. Those reasons are detailed in the footnotes of each legal measure.

[309] National Research Council, Vital Statistics: Summary of a Workshop 90 (Nat'l Academics Press, 2009) ("Fetal deaths of 20 weeks of gestation and greater have been a reportable component of U.S. vital statistics since the 1920s."), available at https://www.ncbi.nlm.nih.gov/books/NBK219877/pdf/Bookshelf_NBK219877.pdf. States are free to define however, and different definitions although the large majority of states use a definition that will be around 20 weeks. *State Definitions and Reporting Requirements for Live Births, Fetal Deaths, and Inducted Terminations of Pregnancy,* Centers for Disease Control and Prevention/Nat'l Ctr. For Health Statistics, at 3 (1992), https://www.cdc.gov/nchs/data/misc/itop97.pdf. Fetal death certificates are required for various reasons. They can "provide[] valuable health and research data" that can be used to study the causes of stillbirth, a recognition of the potential preventability. *Funeral Directors' Handbook on Death Registration and Fetal Death Reporting*, Department of Health and Human Serv., Centers for Disease Control and Prevention 32 (2003), https://www.cdc.gov/nchs/data/misc/hb_fun.pdf (last accessed Dec. 9, 2019) That data could also indicate causes like "environmental and occupational exposures of parents on the fetus." *Id.* at 2. The data is also essential "essential in planning and evaluating prenatal care services and obstetrical programs." *Id.*

[310] *Funeral Directors' Handbook on Death Registration and Fetal Death Reporting*, Department of Health and Human Serv., Centers for Disease Control and Prevention 32 (2003), https://www.cdc.gov/nchs/data/misc/hb_fun.pdf (last accessed Dec. 9, 2019).

[311] State v. Norvell, 191 S.W. 536, 537 (Tenn. 1917). The statute also required that "burial or removal permits in the usual form shall be required" and clarified "that a certificate of birth and death shall not be required for a child that has not advanced to the fifth month of uterogestation." *Id.*

[312] *See e.g.*, CAL. HEALTH & SAFETY CODE § 7100(a)(4) (2007); ARIZ. REV. STAT. § 36-831 (1978); MO. REV. STAT. § 194.200; WIS. STAT. ANN. § 69.18 (West).

child" as the "parents" of the "stillborn child."[313] Wisconsin's statute also uses the language "parent of the stillbirth."[314]

Ultimately, the parental existence of a mother after stillbirth differs little from a mother whose infant dies minutes or days after birth. Both women have physiologically identically childbirth experiences. Both women hold their infants after birth. Days after birth, both women's bodies start to produce milk to nourish their babies, yet they lack babies to breastfeed. Both women will be issued a death certificate with their child's name on it and then be responsible for their child's final disposition. One difference does exist between their experiences though obviously—that first breath that the baby takes outside of the womb. "The metaphor of taking that first breath in the world carries strong moral significance for many people even though, at the end of gestation development, such a cutoff makes little sense medically and is essentially arbitrary."[315]

Numerous legal measures exist that affirm the parenthood of a mother whose baby dies shortly after birth. They include state issuance of a birth certificate, a death certificate, a tax benefit, and the availability of a wrongful death claim if the baby's death was due to tortious conduct. These same measures, or something similar, should also exist to affirm the parenthood of a mother whose baby dies shortly before birth. As mentioned, states already require issuance of a death certificate. Additionally, most states also already allow issuance of a stillbirth birth certificate and apply wrongful death tort law to stillbirth. Only a few states, however, recognize tax benefits for parents after stillbirth; the vast majority of the states and the federal government do not. This Article argues for even broader adoption of these already-existing measures and also introduces a new measure to affirm and aid parents after stillbirth—insurance coverage of autopsies.

States' previous adoptions of some of these measures have generated controversy and opposition, mostly from pro-choice groups. Specifically, reproductive rights activists have opposed these measures for fear that they would infringe on the right to abortion, a perhaps not irrational thought given that one long-term strategy of the pro-life movement was legal treatments of an unborn fetus the same as a living child.

The controversy disappears, however, when the measures are viewed through the reproductive justice lens. Through that lens, we see that each of these measures confirms a woman's motherhood of her stillborn child. The reproductive justice lens also reveals the necessity of these measures especially for marginalized women, specifically those of lower economic status.

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[313] MO. REV. STAT. § 194.200.
[314] WIS. STAT. ANN. § 69.18 (West).
[315] Kelley & Trinidad, *supra* note 241, at 13.

1. Tax Recognition after Stillbirth[316]

Federal tax law has long allowed a type of tax benefit for parents to claim. Until 2018, parents were able to claim children as dependents and allowed a personal exemption or deduction for each child. These exemptions recognized that children are expensive. Assuming a similar gross income between two families, "each member will not be as well off if the family has six people compared to a family that has three people." [317] And thus the dependent exemption "treat[ed] the larger family more generously on ability-to-pay grounds and imposes a lower tax liability."[318] The tax law changed in 2019, eliminating personal exemptions but also increasing the amount of the now refundable child tax credit.[319] The federal tax laws still provide parents a tax benefit because of the costs of raising children, but now does so through a credit.

Notably, parents can also claim the exemption/credit on their federal taxes if they have a living child who dies; that exemption/credit is can still be claimed in the year that their child dies. For instance, if a baby is born and survives three minutes, parents can still claim the exemption/credit in the year that the child was alive and died. Apparently, even though the child survived only minutes, children are still expensive and the parents get a tax benefit in that year.

But if the child dies three minutes *before* birth, and is stillborn, federal law does not allow the parents any sort of tax benefit. Certainly, parents after stillbirth, especially stillbirth at term, incur the same costs as the parents whose child died three minutes after birth—costs preparing for the child for supplies, clothes, the nursery, medical costs because of the stillbirth, and funeral and burial costs. Yet, only the parents whose child died after birth is allowed a federal tax benefit.

Recognizing the lack of logic in the federal system, some states do provide a tax benefit for parents after stillbirth. Arizona, Michigan, Missouri, and North Dakota recognize a dependent exemption for the year in which the child is stillborn,[320] the same type of exemption that parents are able to claim

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[316] I propose a tax benefit after stillbirth, but not miscarriage. This is because parents are much more likely to have incurred expenses preparing for the child and for his burial in the case of stillbirth than in the case of miscarriage.

[317] JOEL SLEMROD & JON BAKIJA, TAXING OURSELVES: A CITIZEN'S GUIDE TO THE DEBATE OVER TAXES (4th ed. 2008).

[318] *Id.*

[319] Matthew Frankel, *2019 Tax Changes: Everything You Need to Know*, The Motley Fool (Aug. 7, 2019), https://www.fool.com/taxes/2019-tax-changes-everything-you-need-to-know.aspx (explaining how the personal exemption was likely more beneficial for parents with many children than the expanded child tax credit).

[320] ARIZ. REV. STAT. ANN. § 43-1023 (allowing an exemption for $2300 for "each birth for which a certificate of birth resulting in stillbirth … if the child otherwise would have been a member of the taxpayer's household … in the taxable year in which the stillbirth occurred"); MICH. COMP. LAWS ANN. § 206.30 (West) (allowing a taxpayer to "claim an

for the years in which their living children live with them. Minnesota recognizes a tax credit for $2,000 "for each birth for which a certificate of birth resulting in stillbirth has been issued … in the taxable year in which the stillbirth occurred and if the child would have been a dependent of the taxpayer" under federal tax regulations.[321] Notably, this is a refundable tax credit, meaning that if the $2,000 exceeds what the taxpayer owes in taxes, the taxpayer will still receive the difference.[322]

Under a reproductive rights framework, tax benefits for stillbirth appear threatening because they treat an unborn child like a living child. After a bill to create a stillbirth tax credit failed to advance out of committee in California in 2018, the Catholic Legislative Network's press release described the bill as a "pro-life legislative proposal" "that acknowledges that life begins in the womb."[323] On the other side, one abortion scholar described the idea of tax benefits after stillbirth as demonstrating how "prenatal life can take on a life of its own."[324]

But from a reproductive justice perspective, a tax benefit is not controversial. A tax benefit is consistent with reproductive justice for two reasons. First, it affirms the mother's parenthood. In one study, a mother explained how the current lack of tax recognition denies her motherhood: "I cannot claim my daughter even once as I am told she was never born alive therefore she does not qualify as a child. This implies that I am not a mother."[325] Similarly, a bereaved mother expressing gratitude for state tax benefits explained that, to her, a tax benefit "has a much deeper meaning than money" by providing "acknowledgment" and raising "awareness."[326]

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additional exemption … in the tax year for which the taxpayer has a certificate of stillbirth"); MO. REV. STAT. § 143.161 (West) (allowing a taxpayer to deduct $120,000 for a dependent "in the taxable year in which the stillbirth occurred, if the child otherwise would have been a member of the taxpayer's household"); N.D. CENT. CODE ANN. § 57-38-30.3 (West) (allowing a taxpayer to reduce her taxable income "for each birth resulting in stillbirth … for which a fetal death certificate has been filed" "in the taxable year in which the stillbirth occurred").

[321] MINN. STAT. ANN. § 290.0685 (West).

[322] *Id.*

[323] California Catholic Conference, *Despite Bipartisan Support, Still Birth Tax Credit Bill Fails to Advance*, Catholic Legislative Network (May 31, 2018), https://www.cacatholic.org/despite-bipartisan-support-still-birth-tax-credit-bill-fails-advance.

[324] *See* Carol Sanger, *The Lopsided Harms of Reproductive Negligence*, 118 COLUM. L. REV. ONLINE 29, 46 (2017) (explaining that "abortion politics have an uncanny habit of shimmying into law in unexpected places" and that the "recognition of prenatal life can take on a life of its own" demonstrated by the "three states [that] went further and granted tax exemptions to the stillborn's parents in the year of the birth").

[325] Danielle Pollock, et al., *Voices of the Unheard: A qualitative survey exploring bereaved parents experiences of stillbirth stigma*, WOMEN BIRTH 7 (2019).

[326] Gina Harris, *Tax Exemption for Stillbirths Has a Much Deeper Meaning than Money*, Now I Lay Me Down to Sleep, https://www.nowilaymedowntosleep.org/2019/04/01/tax-exemption-for-stillbirths-has-a-much-deeper-meaning-than-money/ (last accessed Nov. 19, 2019).

Second, a tax benefit provides practical assistance and support to parents for the surprising costs of stillbirth,[327] assistance especially helpful for mothers with lower socioeconomic status. Those surprising costs include medical costs. One study estimates that a stillbirth costs about $750 more than a live birth.[328] This includes costs for the birth, the hospital stay, and tests. The medical costs may also be higher due to maternal health complications. Parents can also incur additional medical costs if they seek mental health treatment. Parents also then face additional costs related to the child's burial and funeral. Life insurance proceeds are often used to help pay for funerals, but life insurance is not available for an unborn child who is not yet alive (outside of the womb). Some parents in the United States turn to gofundme to try to raise money to cover their funeral costs.[329]

These costs add up quickly, especially for women of lower socioeconomic status. When the North Dakota legislature unanimously passed its bill created this tax deduction, the proponents explained that this will help ease the financial burden of both childbirth and funeral costs.[330] Bereaved parents testifying before a Minnesota legislative committee explained the difficulty of "coping with the loss of their full-term baby" while learning of all the costs of stillbirth.[331] They were insured, but still had to "co-pays, deductibles and other expenses" and their claim for life insurance benefits for their son were denied.[332] The best way to ensure women of lower socioeconomic status can benefit is to create a tax credit, more specifically a refundable one. If the $2,000 tax credit is refundable and the taxpayer owes only $1,000 in taxes, the taxpayer will still receive a $1,000 refund.

And again, logically, parents whose child dies shortly after birth are entitled to a federal tax benefit. The tax law affirms their parenthood and recognizes that raising their child is expensive even though he lived only

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[327] One mother explained the costs she faced after her child's stillbirth in Joni Hess, *From diagnostics to autopsy to burial, stillbirths are alarmingly expensive in America*, VOX (Jul. 30, 2019), https://www.vox.com/the-highlight/2019/7/23/20698480/stillborn-stillbirth-baby-costs-expensive.

[328] *See generally* Katherine J. Gold, et al., *Hospital Costs Associated with Stillbirth Delivery*, 17:10 MATERN. CHILD HEALTH J. 1835 (2013).

[329] *See e.g., Baby Kayden's Funeral*, GoFundMe, https://www.gofundme.com/f/baby-kaydens-funeral (last visited Nov. 7, 2019); *Baby JoJo's Funeral, Medical Cost*, GoFundMe, https://www.gofundme.com/f/babies-funeral-and-medical-cost039s (last visited Nov. 7, 2019). The UK government has a "Children's Funeral Fund for England," providing funds to help "pay for some of the costs of a funeral for a child under 19 or a baby stillborn after the 24th week of pregnancy." *Support for child funeral costs (Child's Funeral Fund for England)*, Gov UK, https://www.gov.uk/child-funeral-costs (last visited Nov. 7, 2019).

[330] https://bismarcktribune.com/news/local/govt-and-politics/stillborn-tax-exemption-bill-sees-no-opposition/article_3f98c934-b708-5505-9f7e-340481e4655a.html

[331] Lee Ann Schutz, *Tax credit proposed to help parents who have stillborn child but still face costs*, Minnesota House of Representatives (Apr. 12, 2016), https://www.house.leg.state.mn.us/sessiondaily/SDView.aspx?StoryID=10119.

[332] *Id.*

minutes. No logical reason exists to treat parents whose child dies shortly before birth differently tax-wise than parents whose child dies shortly after birth.

2. Stillbirth Birth Certificates[333]

Another legal recognition of the woman's parenthood after stillbirth is issuance of a birth certificate. As mentioned, evidence exists of a historical practice of a state issuing a birth certificate for stillbirth just as it did for a live birth,[334] which makes sense the "physiologically identical" [335] experiences of childbirth. At some point, however, this practice stopped. And states started requiring issuance of only death certificates—"fetal death certificates"—after stillbirth.

The experience of receiving a death certificate but no birth certificate after giving birth to your stillborn child is especially jarring for mothers. This state action adds to a mother's trauma—being told that your child died without similar legal acknowledgement that your child also was born, a seeming prerequisite to death. In 1994, Dr. Joanne Cacciatore gave birth to her eight-pound stillborn daughter, Cheyenne. She called to request Cheyenne's birth certificate and was told that she gave birth to a "fetus" and not her eight pound daughter. That phone call started a movement. Cacciatore started the Mothers in Sympathy and Support (MISS) Foundation and began lobbying state legislatures to create something akin to a birth certificate for stillbirth. Around 34 states currently have some version of a Certificate of Birth Resulting in Stillbirth or a Certificate of Stillbirth available to bereaved parents.[336]

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[333] A birth certificate would not be appropriate for miscarriage as, generally speaking, miscarriage does not involve childbirth; miscarriage is physiologically distinct. Additionally, some women miscarry without realizing it, precluding practical issuance of any sort of certificate.

[334] *See* State v. Norvell, 191 S.W. 536, 537 (Tenn. 1917) (discussing Tennessee's 1915 Vital Statistics Law).

[335] Joanne Cacciatore, *The Unique Experiences of Women and Their Families After the Death of a Baby*, 49 SOC. WORK HEALTH CARE 134, 135 (2010).

[336] This is according to the MISS Foundation's website. http://www.missingangelsbill.org/index.php?option=com_content&view=article&id=76&Itemid%20=61%20[https://perma.cc/BZ2Q-QU3C]. At least two states also issue voluntary certificates after miscarriage. Specifically, Florida will issue a "Certificate of Nonviable Birth" for a miscarriage between ten and twenty weeks of pregnancy. FLA. STAT. ANN. § 382.0086 (West). For stillbirth, after twenty weeks of pregnancy, Floridians can request a "Certificate of Birth Resulting in Stillbirth." *Id.* § 382.0085. A stillbirth, but not a miscarriage, requires the issuance of a "fetal death certificate." *Id.* § 382.008. Notably, it appears that a "Certificate of Nonviable Birth" is allowed only if a "health care practitioners … attends or diagnoses [the] nonviable birth" or if it occurs at a "health care facility." Additionally, the "Certificate of Nonviable Birth" lacks the same details as a fetal death certificate, details like the cause of death. Nebraska also will issue a commemorative "Certificate of Nonviable Birth" for a miscarriage that a doctor witnesses or diagnoses, and a "Certificate of Birth Resulting in Stillbirth" for a stillbirth. NEB. REV. STAT. ANN. § 71-607 (West); *id.* 71-606. Nebraska law

The fiercest opposition to birth certificates came from the reproductive rights movement. "Supporters of legal abortion have long been concerned that issuing certificates to children who have never lived may serve, as yet another legal marker equating fetal life with that of born persons and that this will, sooner or later, play its part in the recriminalization of abortion."[337] That birth certificates would "deepen[] cultural familiarity with the idea of prenatal death as the loss of a *child*," which fits too well in the pro-life political strategy of getting fetuses defined as infants and children.[338] Similarly, pro-choice groups more generally feared that birth certificates "could aid anti-choice groups as they attempt to chip away at or eliminate abortion rights,"[339] were a step toward acknowledging fetal personhood,[340] would "legitimize" the life of an unborn baby,[341] and would "push anti-choice groups one step further in their quest to make abortion tantamount to murder."[342] The slippery slope was raised: "Might, for example, states start issuing or even requiring birth certificates for aborted fetuses?"[343] Former Governor of New

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requires a fetal death certificate only for a stillbirth. NEB. REV. STAT. ANN. § 71-607 (West). Arkansas originally required a fetal death certificate and allows issuance of a "Certificate of Birth Resulting in Stillbirth" for stillbirths, but then redefined "stillbirth" to include all pregnancy losses after 12 weeks. ARK. CODE ANN. § 20-18-410 (West). Arkansas's conflation of miscarriage and stillbirth is especially dangerous because it strengthens the (inaccurate) fatalism surrounding stillbirth. *See* Joanne Cacciatore & Jill Wieber Lens, *The Ultimate in Women's Labor: Rethinking Feminism Around Pregnancy, Birthing, and Grieving a Dead Baby*, *in* ROUTLEDGE INTERNATIONAL HANDBOOK OF WOMEN'S SEXUAL & REPRODUCTIVE HEALTH (Jane M. Ussher, Joan C. Chrisler, Janette Perz, eds., 2019). Notably, the MISS Foundation opposes the issuance of any certificates for miscarriage.

[337] Sanger, *supra* note 130, at 305. Legal scholars have paid only limited attention to stillbirth birth certificates with the exception of reproductive rights scholar Carol Sanger. *See id.* Sanger presented had five reasons they should not be issued – 1) birth certificates serve important informational purposes, not expressive ones; 2) questioning whether law should be involved in attempting to alleviate grief; 3) questioning whether the law would effectively create a required mourning after stillbirth; 4) an administrative concern given that stillbirths are already recorded as and issued certificates for fetal deaths; and 5) the possible consequences that issuing certificates would have on the legality of abortion. *See generally id.*

[338] *Id.* at 305.

[339] Allison Stevens, *The Politics of Stillbirth*, Jul. 13, 2007, AMERICAN PROSPECT, http://prospect.org/article/politics-stillbirth

[340] Ilene Lelchuk, *Wrenching politics surround stillborns / Bereft moms want birth papers, but abortion complicates issue,* SFGATE, (Apr. 10, 2007), https://www.sfgate.com/news/article/Wrenching-politics-surround-stillborns-Bereft-2565630.php ("Pro-choice advocates have opposed the laws on the grounds that they could fuel the anti-abortion cause by acknowledging that an unborn fetus is a person.").

[341] Jacqueline Feldman, *Mothers of Stillborns to get Birth, not Death, Certificates*, Pittsburgh Post Gazette (Jul. 25, 2011), https://www.post-gazette.com/news/state/2011/07/25/Mothers-of-stillborns-to-get-birth-not-death-certificate/stories/201107250179 ("It has been controversial here and elsewhere because it raised sensitive issues in the debate on abortion, with some abortion rights activists concerned it might legitimize the life of an unborn baby ….").

[342] Stevens, *supra* note 339.

[343] *Id.*

Mexico Bill Richardson even vetoed a popular stillbirth birth certificate bill.[344] He claimed it was because of administrative concerns, but many suspected he did not want to lose pro-choice voters as he was also running for President at the time.[345]

But when viewed through the lens of reproductive justice instead of reproductive rights, these measures are not controversial.[346] The stillbirth birth certificate acknowledges the mother's motherhood—that she has a child who was both born and died. It provides mothers some acknowledgement of their child's birth and existence beyond his death.

3. Tort Claims[347]

Another legal recognition of parents after stillbirth is the availability of a wrongful death claim if the baby's stillbirth was due to tortious conduct, the same claim available to parents if their living child's dead is due to tortious conduct. Like stillbirth birth certificates, a majority of states recognize this type of wrongful death claim.[348] Also like stillbirth birth certificates, the biggest opposition to applying wrongful death law to stillbirth was from the reproductive rights movement—that the application would be another "legal marker equating fetal life with that of born persons,"[349] strengthening the pro-life fetal personhood argument.[350]

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[344] *Id.*

[345] *Id.*; *see also* Carol Sanger, *Legislating with Affect: Emotion and Legislative Law Making*, in PASSIONS AND EMOTIONS 61 (James Fleming, ed. 2013) (noting that Richardson's popularity declined after the veto and may have had something to do with "acting against the declared emotional desires of a well-organized and deeply sympathetic interest group").

[346] The MISS Foundation did what it could do to distance itself from abortion debate. Stevens, *supra* note 339. In other states, compromises were reached over the abortion aspect, mainly clarifications that the certificates would not apply to abortions and requiring parents to request the certificate. *See* Sanger, *supra* note 130, at 307-08 (discussing the compromises reached in state legislatures that passed stillbirth birth certificates); Stevens, *supra* note 339.

[347] I have previously explained why tort wrongful death claims should be available for stillbirth, but not for miscarriage. See Jill Wieber Lens, *Tort Law's Devaluation of Stillbirth*, 19 NEV. L. J. 955, 1005 (2019). Recourse may exist for a tortiously caused miscarriage, although causation may be difficult to prove. Miscarriage was, in fact, a common harm claimed in early negligent infliction of emotional distress claims. *Id.* at 971-72. Numerous restrictive rules limited recovery in such claims, however, make it difficult for women to recover under these claims. *Id.* at 973-74.

[348] *Id.* at 969.

[349] Kenneth A. De Ville & Loretta M. Kopelman, *Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy*, 27 J.L. MED. & ETHICS 332, 335 (1999)

[350] I've previously argued the consistency between applying of wrongful death claims to stillbirth and the reproductive rights movement. Lens, *supra* note 347, at 1010-11. The vast majority of legal scholarship on the issue concludes that an inconsistency exists. *See e.g.,* Joyce E. McConnell, *Relational and Liberal Feminism: The "Ethic of Care," Fetal Personhood and Autonomy*, 99 W. VA. L. REV. 291 (1996); Megan Fitzpatrick, *Fetal Personhood After the Unborn Victims of Violence Act*, 58 RUTGERS L. REV. 553 (2006); Erica Richards, *Loss of Potential Parenthood As A Statutory Solution to the Conflict Between Wrongful Death Remedies and Roe v. Wade*, 63 WASH. & LEE

But from a reproductive justice framework, a wrongful death claim after stillbirth is again not controversial. The claim "is in perfect alignment with reproductive justice principles, since one of its basic tenets champions the rights of people to give birth to and raise healthy babies if they so choose."[351] The mother is parent to her child, a child she chose to parent and a tortious actor deprived her of that choice. Denial of a wrongful death claim is denial of the woman's parenthood, a parenthood that reproductive justice should expressly affirm.

4. Mandatory Insurance Coverage for Autopsies[352]

No other test is as effective as an autopsy in determining the cause of stillbirth.[353] Medical guidelines recommend autopsies following stillbirth, Yet current estimates are that autopsies occur in only 30-40 percent of stillbirths in the United States.[354] The main reason for this is the cost— at least $1000, $1500, or more.[355] Insurance may or may not cover the cost of an autopsy

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L. REV. 809, 810 (2006); Amy Lotierzo, *The Unborn Child, A Forgotten Interest: Reexamining Roe in Light of Increased Recognition of Fetal Rights*, 79 TEMP. L. REV. 279, 289 (2006); Rita M. Dunaway, *The Personhood Strategy: A State's Prerogative to Take Back Abortion Law*, 47 WILLAMETTE L. REV. 327 (2011); Hutton Brown, et al., *Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth*, 39 VAND. L. REV. 597 (1986).

[351] Imani Grandi, *Alabama's Wrongful Death Suit for Nonviable Fetus Raises Thorny Reproductive Rights Questions*, REWIRE NEWS (Jan. 11, 2017), https://rewire.news/article/2017/01/11/alabama-wrongful-death-fetus-reproductive-rights/

[352] Because of the number of miscarriages and the presumed costs of testing, mandatory insurance coverage of testing of miscarriage is simply not politically feasible. Plus, it is not medically recommended—currently, testing after miscarriage is recommended only after three miscarriages, also known as recurrent miscarriage. At least some private insurance companies already cover the costs of some testing after recurrent miscarriage. *See e.g.*, *Recurrent Pregnancy Loss*, aetna Medical Clinic Policy Bullet #0348, http://www.aetna.com/cpb/medical/data/300_399/0348.html (last visited Dec. 6, 2019); *Recurrent Pregnancy Loss: Diagnosis and Treatment*, Cigna Medical Coverage Policy, https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0284_coveragepositioncriteria_recurrent_pregnancy_loss.pdf (last visited Dec. 6, 2019). I was unable to find any information regarding whether Medicaid covers the costs of testing after recurrent miscarriage. Presumably, the answer is no given that Medicaid coverage is triggered by pregnancy, and a miscarriage ends that pregnancy.

[353] RCOG Guideline, *supra* note 240, § 5.7, at 10-11.

[354] Sarah Muthler, *Stillbirth is more common than you think—and we're doing little about it*, WASH. POST. (May 16, 2016).

[355] When autopsies are free, as they are at "hospitals where the Stillbirth Collaborative Research Network has provided free testing and counseling, more than 85 percent of parents have chosen to have an autopsy of their baby"—suggesting cost is the reason most parents do not have an autopsy. *Id.* M. Human, et al., *Bereaved mothers' attitudes regarding autopsy of their stillborn baby*, 233 S. AFR. J. OBSTET. GYNAECOL. 93, 95 (1999) (explaining that "a large majority of those [parents] would are asked to provide consent" to an autopsy after stillbirth "would provide it"); *see also* REPORT OF COMMITTEE ON MATERNAL AND PERINATAL HEALTH, *Need for Perinatal Autopsies Following Stillbirth*, Texas Medical Association, (2006)

following stillbirth. The chances of coverage are greater with private insurance. But up to half of pregnancies in the United States each year are covered not by private insurance, but by Medicaid, which covers pregnant women with incomes below 133 percent of the federal poverty level,[356] the same women who face a higher risk of stillbirth due to their socioeconomic status.[357] No state Medicaid plan covers the cost of an autopsy after a child's stillbirth.[358]

If the cost of an autopsy following stillbirth is not covered by insurance, parents have to pay for it out of pocket. As already discussed, the financial costs of stillbirth add up quickly, including medical bills and funeral costs.[359] Parents after stillbirth, especially those women who were insured via Medicaid, will have to make choices about what costs are necessary and which aren't. An autopsy that may not reveal the cause of death quickly falls into the unnecessary column.

A federal law mandating insurance coverage for autopsies after stillbirth may, theoretically, be controversial under the reproductive rights movement because it could legitimize the unborn child in the same way as a tax benefit or a birth certificate. But mandatory insurance coverage of autopsies after stillbirth is consistent with a reproductive justice framework. First, it enables parents to parent their stillborn child by determining how he died. After stillbirth, parents "search[] for meaning and aim[] to uncover the reason why" their child died.[360] Even knowing that the autopsy may not discover a cause, parents are "resolute that all avenues of investigation be

("Many families cannot pay for the procedure, which typically costs about $1,000 to $1,500 in routine cases."), https://www.texmed.org/Template.aspx?id=4883. Another possible reason for the lack of autopsies is that it may be difficult for doctors to discuss the prospect of an autopsy with bereaved parents, which meant the conversation sometimes never occurs. Melissa Davey, *Australia failing to adequately investigate stillbirths, researcher finds*, THE GUARDIAN (Jan. 18, 2016), https://www.theguardian.com/australia-news/2016/jan/19/australia-failing-to-adequately-investigate-stillbirths-researcher-finds

[356] 42 U.S.C.A. § 1396d (West 2019).

[357] Data on stillbirths for women insured by Medicaid specifically is unknown, but we do know that "women with Medicaid coverage are more likely to have preterm births and low-birthweight infants, both key indicators of birth outcomes, compared to privately insured women." IssueBrief, *Access in Brief: Pregnant Women and Medicaid*, Medicaid and CHIP Payment and Access Comm'n, at 1 (Nov. 2018), https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf

[358] *See generally*, Kathy Gifford, et al., *Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey*, Kaiser Family Foundation, at 15 (Apr. 2017) (summarizing results of survey concerning state Medicaid pregnancy benefits), http://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-and-Perinatal-Benefits; *see also* REPORT OF COMMITTEE ON MATERNAL AND PERINATAL HEALTH, *supra* note 355.

[359] Joni Hess, *From diagnostics to autopsy to burial, stillbirths are alarmingly expensive in America*, VOX (Jul. 30, 2019), https://www.vox.com/the-highlight/2019/7/23/20698480/stillborn-stillbirth-baby-costs-expensive. In Part _, I suggest a tax credit or deduction to help parents. (Likely credit to help poor people).

[360] Sarah Meaney, et al., *Parental Decision making around perinatal autopsy: a qualitative investigation*, 18 HEALTH EXPECTATIONS 3160, 3164 (2014).

undertaken."[361] In a study of parents after stillbirth in Ireland, one parent explained that they chose an autopsy "[f]or Baby's sake to be honest and foremost and to make sure that we know how he died."[362] The parents wanted to "know that [they] tried to find out and that [they] did everything that [they] could to find out."[363] "Even when no definite cause of death is found, emphasis on the baby's normality seems to alleviate a great deal of parental concern."[364]

An autopsy helps the parent parent their stillborn child and also any future children as the autopsy could reveal whether something similar could affect future children. In 2006, in advocating for more autopsies following stillbirth, the Texas Medical Association described that "a perinatal autopsy leads to improved patient care through … (2) proper counseling for future pregnancies, (3) improved management approach for future pregnancies, and (4) detection of chronic disease states of the mother (e.g., thrombophilias) and prevention of maternal morbidity/mortality.[365] Specific to future pregnancies, "[d]octors can at least rule out certain conditions in the mother for her next pregnancy so that they don't spend money treating a problem that isn't there."[366]

Second, mandatory insurance coverage of autopsies after stillbirth is also consistent with reproductive justice because it helps marginalized women. Wealthier women are already able to obtain autopsies and the benefits that flow from autopsies. Pregnant women insured through Medicaid, however, need insurance coverage to be able to afford autopsies, especially given all of the other costs surrounding stillbirth.[367]

Last, mandatory insurance coverage of autopsies after stillbirth is consistent with reproductive justice because it provides population-level information that can help researchers discover the causes of stillbirth. Research is almost impossible without autopsies. "If we don't know more about why they happen, we won't be able to prevent them."[368] It's not surprising that

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[361] *Id.*

[362] *Id.*

[363] *Id.*

[364] Muthler, *supra* note 354.

[365] REPORT OF COMMITTEE ON MATERNAL AND PERINATAL HEALTH, *supra* note 355.

[366] *Id.*

[367] Notably, a very recent study of autopsies in the UK, which are free to parents, found that "mothers from the most deprived areas were less likely to consent" to an autopsy after stillbirth or neonatal death" than mothers "from the least deprived areas." Margaret J. Evans, et al., *Impact of sociodemographic and clinical factors on offer and parental consent to postmortem following stillbirth or neonatal death: a UK population-based cohort study*, ARCHIVES OF DISEASE IN CHILDHOOD – FETAL AND NEONATAL EDITION (Jan. 2020), https://fn.bmj.com/content/early/2020/01/22/archdischild-2019-318226. Medical professionals thus may need to better explain the benefits of an autopsy to parents of lower socioeconomic class as they may be less inclined to consent to one even if free.

[368] Muthler, *supra* note 354.

countries with some of the lowest stillbirth rates, countries like the Netherlands, offer free autopsies for stillbirths.[369] As part of its recent efforts to decrease its stillbirth rate, Australia is specifically investigating ways to provide free autopsies.[370]

Autopsies after stillbirth should also be available to parents in the United States without cost. This can be done through a federal law mandating private insurance coverage and coverage through Medicaid. An autopsy can be financially impossible for a grieving family, but should not be too burdensome for insurance companies as the annual 26,000 stillbirths would be spread out among insurance companies. The results of autopsies should also help to reduce medical costs in future pregnancies, which benefits both women and insurance companies.

V. CONCLUSION

After I gave birth to my son Caleb, stillborn three weeks before his due date, I attended a support group. I distinctly remember one woman's story.[371] Twice, this woman had lost her baby right around twenty weeks of pregnancy. When she had gotten pregnant a third time, she considered an abortion because she was afraid that she would lose the baby. But she ultimately chose to keep the baby. And, unfortunately, history repeated itself. No one else had a story like this woman's. She was also the only black woman in the room.

Reproductive justice's rejection of the individualistic notion of choice and its holistic lens provides an opportunity to finally highlight women's experiences of miscarriage and stillbirth and her related rights. Those rights include a woman's right to prenatal care that will help prevent the undesired end to her pregnancy. She has birth justice rights to give birth to her stillborn child as she desires and to be fully informed of her treatment options in case of miscarriage. She also has a right to culturally appropriate mental and emotional health treatment after miscarriage or stillbirth. Last, she has a right to parent her child, a positive right requiring legal recognition, no different than how various laws affirm motherhood despite an infant's death shortly after birth.

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[369] *Id.*; *see also* Davey, *supra* note 355.

[370] Stephanie Dalzell, *Government seeks advice on covering cost of stillbirth autopsies in bid to prevent further deaths*, ABC NEWS (July 4, 2019), https://www.abc.net.au/news/2019-07-04/stillbirth-autopsies-government-advice-research/11276286.

[371] Shared with permission.