

# MISCARRIAGE, STILLBIRTH, & REPRODUCTIVE JUSTICE

JILL WIEBER LENS\*

## 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.*

---

\* Professor of Law, University of Arkansas School of Law, Fayetteville. Many thanks to the organizers and participants at the 2020 Feminist Legal Theory Summer Series and the 2020 SEALS Reproductive Justice Roundtable for the opportunities to present this work-in-progress. I am also grateful for the helpful feedback provided by Meghan Boone, Greer Donley, Dr. Joanne Cacciatore, Jordan Woods, Laurent Sacharoff, Sara Gosman, Beth Zilberman, Khaled Beydoun, Brian Gallini, Carl Circo, Steve Clowney, Will Foster, and Alan Trammell. I also thank Paul Cassidy, Suzanne Pullen, and Deanna Mallareddy for helping inspire this research. I dedicate this Article to my sweet boy in heaven, Caleb Marcus Lens.

## TABLE OF CONTENTS

INTRODUCTION.....	1060
I. FROM REPRODUCTIVE RIGHTS TO REPRODUCTIVE JUSTICE .....	1065
II. THE OMISSION OF MISCARRIAGES AND STILLBIRTHS.....	1069
A. <i>Miscarriages and Stillbirths Defined</i> .....	1069
B. <i>Reproductive Rights's Avoidance</i> .....	1076
C. <i>Reproductive Justice's Non-Emphasis</i> .....	1078
III. REPRODUCTIVE JUSTICE-BASED RIGHTS CONCERNING MISCARRIAGE AND STILLBIRTH.....	1080
A. <i>The Lack of Choice Within Miscarriage and Stillbirth</i> .....	1081
B. <i>The Right to Preventative Prenatal Care</i> .....	1084
C. <i>Birth Justice Rights for Stillbirth and Miscarriage</i> .....	1090
D. <i>The Right to Mental and Emotional Health Care</i> .....	1095
E. <i>The Right to Parent Your Stillborn Child</i> .....	1099
1. <i>Tax Recognition After Stillbirth</i> .....	1104
2. <i>Stillbirth Birth Certificates</i> .....	1108
3. <i>Tort Claims</i> .....	1110
4. <i>Mandatory Insurance Coverage for Autopsies</i> .....	1111
CONCLUSION... ..	1114

## INTRODUCTION

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

Little else is known about this woman. Perhaps she had wanted an abortion but could not obtain one in Honduras, where abortion is illegal.<sup>5</sup> Or, maybe she desired her child and wanted to raise him somewhere other

1. Scott Bixby, *Migrant Woman's Pregnancy Ends in Stillbirth, in ICE Detention*, DAILY BEAST (Feb. 25, 2019, 6:45 PM), <https://www.thedailybeast.com/migrant-woman-miscarried-baby-boy-in-ice-custody> [https://perma.cc/PBP4-SSY8]; see also Mihir Zaveri, *Woman Delivers Stillborn Baby While in ICE Custody*, N.Y. TIMES (Feb. 25, 2019), <https://www.nytimes.com/2019/02/25/us/mother-birth-ice-custody.html> [https://perma.cc/SV8X-C5EW].

2. Bixby, *supra* note 1.

3. *Id.*

4. *Id.*

5. *Honduras: Abortion Ban's Dire Consequences*, HUM. RTS. WATCH (June 6, 2019, 6:00 AM), <https://www.hrw.org/news/2019/06/06/honduras-abortion-bans-dire-consequences> [https://perma.cc/ALN9-FBKG].

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.”<sup>6</sup> 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.<sup>7</sup> The government declined to investigate, however, explaining that “for investigative and reporting purposes, a stillbirth is not considered an in-custody death,”<sup>8</sup> even though a viable fetus is considered capable of “independent existence,” a “second life” eligible for state protection in abortion jurisprudence.<sup>9</sup> 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.<sup>10</sup>

This woman is just one of millions of pregnant women in the United States who make a choice to parent their child but do 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.<sup>11</sup> Another one in one hundred sixty pregnancies end in stillbirth, the death of the unborn baby while still in the womb after twenty weeks of pregnancy but before birth.<sup>12</sup> 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.<sup>13</sup> Many women consider their miscarriages to be significant life events.<sup>14</sup> And, needless to say, giving

---

6. *Why People Flee Honduras*, POLITICO MAG. (June 7, 2019), <https://www.politico.com/magazine/story/2019/06/07/honduras-why-people-flee-photos-227087> [<https://perma.cc/PP78-2NDZ>]; see also Marcia Biggs & Julia Galiano-Rios, *Why Families by the Thousands are Fleeing Honduras for the U.S.*, PBS: NEWS HOUR (Mar. 29, 2019, 6:40 PM), <https://www.pbs.org/newshour/show/why-families-by-the-thousand-are-fleeing-honduras-for-the-u-s> [<https://perma.cc/8VX7-XJJJ>] (quoting a mother explaining that she “want[s] a better life for [her] son”).

7. Zaveri, *supra* note 1.

8. *Joint Statement from ICE and CBP on Stillbirth in Custody*, U.S. IMMIGR. & CUSTOMS ENF’T (Feb. 25, 2019), <https://www.ice.gov/news/releases/joint-statement-ice-and-cbp-stillbirth-custody> [<https://perma.cc/P7T5-HA34>]; 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 Se. Pa. v. Casey*, 505 U.S. 833, 870 (1992) (plurality).

10. See *infra* notes 311–315 and accompanying text (discussing researchers’ almost unanimous agreement that holding the baby after stillbirth is beneficial for parents).

11. See *infra* notes 97–103 and accompanying text.

12. See *infra* notes 104–112.

13. See *infra* notes 104–112.

14. See M.M.J. van den Berg, E.A.F. Dancet, T. Erlikh, F. van der Veen, M. Goddijn & P.J. Hajenius, *Patient-Centered Early Pregnancy Care: A Systematic Review of Quantitative and Qualitative Studies on the Perspectives of Women and Their Partners*, 24 HUM. REPROD. UPDATE 106, 113 (2018).

birth to a dead baby is traumatic and significant for women.<sup>15</sup> Miscarriage and especially stillbirth can have long-term psychological consequences for women.<sup>16</sup>

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.<sup>17</sup> A black woman's risk of stillbirth is also double that of a white woman's.<sup>18</sup> Women of lower socioeconomic status also face an increased risk of miscarriage and their risk of stillbirth is again double that of women of higher socioeconomic status.<sup>19</sup> A white woman's increased education lowers her risk of stillbirth substantially, but a black woman's increased education lowers her risk only minimally.<sup>20</sup>

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.<sup>21</sup> The movement assumes a binary—either the woman is able to obtain an abortion or will give birth to and raise a living child.<sup>22</sup> The opposing antiabortion side has acknowledged that pregnancies end in miscarriage and stillbirth, but only to weaponize a woman's grief as evidence of fetal personhood.<sup>23</sup> In response, the pro-choice reproductive rights movement has opted to avoid the topics of stillbirth and miscarriage to the greatest extent possible.<sup>24</sup>

Fortunately, women of color introduced a more holistic approach to women's reproductive rights eventually named the reproductive justice movement.<sup>25</sup> Aiming to highlight the experiences of marginalized women, the movement rejects the individualistic notion of choice because not all women get to choose.<sup>26</sup> 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.<sup>27</sup> Reproductive justice also recognizes these as positive rights, requiring support to help a mother parent and raise her child.<sup>28</sup> Legal scholars have increasingly embraced reproductive justice as the more

---

15. See *infra* notes 147–149.

16. See *infra* notes 145–149 and accompanying text.

17. See *infra* notes 113–115 and accompanying text.

18. See *infra* notes 116–123 and accompanying text.

19. See *infra* notes 126–132 and accompanying text.

20. See *infra* note 133 and accompanying text.

21. See *infra* Part I.

22. See *infra* Section II.B.

23. See *infra* Section II.B.

24. See *infra* Section II.B.

25. See *infra* Part I.

26. See *infra* notes 66–70 and accompanying text.

27. See *infra* notes 71–75 and accompanying text.

28. See *infra* notes 81–88 and accompanying text.

appropriate framework for women's reproductive freedoms.<sup>29</sup> Despite its holism, however, the reproductive justice framework still does not emphasize women's experiences of miscarriage and stillbirth.<sup>30</sup> 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.<sup>31</sup>

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 face 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.<sup>32</sup>

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, including the right to prenatal care.<sup>33</sup> But the emphasis in prenatal care must be on prevention of miscarriage and stillbirth.<sup>34</sup> Numerous studies in Europe suggest that differing medical care explains the socioeconomic disparity in the stillbirth risk,<sup>35</sup> a concern that should be even greater in the United States, a country without universal health care. Women must have access to preventative prenatal care—prenatal care that includes education of women on the risk of stillbirth and the known, simple preventative measures.<sup>36</sup> 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.<sup>37</sup>

A woman also has birth justice rights within stillbirth.<sup>38</sup> 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

---

29. See, e.g., Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 762 (2018); Priscilla A. Ocen, *Incapacitating Motherhood*, 51 U.C. DAVIS L. REV. 2191, 2238–41 (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 (Melissa Murray, Katherine Shaw & Reva B. Siegel eds., 2019).

30. See *infra* Section II.C.

31. See *infra* Section II.C.

32. See *infra* Section II.A.

33. See *infra* Section III.B.

34. See *infra* Section III.B.

35. See *infra* Section III.B.

36. See *infra* Section III.B.

37. See *infra* Section III.B.

38. See *infra* Section III.C.

labeled “obstetric violence.”<sup>39</sup> Giving birth to a stillborn child is “physiologically identical”<sup>40</sup> to giving birth to a living child, although more traumatic.<sup>41</sup> 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.<sup>42</sup> Miscarriage will likely not involve childbirth, making birth justice inapplicable. Still, analogously, a woman should have a right to be informed of all of her treatment options in case of miscarriage, including information on the costs.<sup>43</sup>

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.<sup>44</sup> Studies show that although Black women face a higher risk of miscarriage and stillbirth, they have less access to bereavement support.<sup>45</sup> Studies also show that parents of color are less inclined to hold the baby after stillbirth, unknowingly depriving themselves of the psychological benefit of holding the baby.<sup>46</sup> Last, studies show that Black women find support groups less helpful than white women.<sup>47</sup> Reproductive justice’s emphasis on the experiences of marginalized women helps show that mental health support is not one-size-fits-all.<sup>48</sup>

Last, a woman has a right to parent her stillborn child if she desires so.<sup>49</sup> Empirical studies of parents after stillbirth confirm parental identification, as do longstanding state laws making parents responsible for the final disposition of their stillborn child’s body.<sup>50</sup> 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.<sup>51</sup>

The organization of the Article is as follows. Part I describes the initial reproductive rights movement and its more holistic replacement, the reproductive justice movement. Part II explains that both movements

---

39. See *infra* Section III.C.

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

41. See *infra* Section III.C.

42. See *infra* Section III.C.

43. See *infra* Section III.C.

44. See *infra* notes 81–88 and accompanying text.

45. See *infra* Section III.D.

46. See *infra* Section III.D.

47. See *infra* Section III.D.

48. See *infra* Section III.D.

49. See *infra* Section III.E. I describe in this section why parenthood exists after stillbirth, but not after miscarriage.

50. See *infra* Section III.E.

51. See *infra* Section III.E.

essentially and incorrectly assume a binary—that a woman either has an abortion or her pregnancy ends in the birth of a living child, erasing the realities of miscarriage and stillbirth. Part III then argues that the reproductive justice framework should feature women’s experiences of miscarriage and stillbirth and describes women’s reproductive-justice-based rights concerning miscarriage and stillbirth. The Conclusion briefly concludes.

### I. FROM REPRODUCTIVE RIGHTS TO REPRODUCTIVE JUSTICE

The reproductive rights movement is just one part of “a broader women’s rights movement that advocated for women’s equality” focused on “reproductive and sexual freedom as the means to self-determination, full participation in society, and emancipation from patriarchal control.”<sup>52</sup> None of that self-determination, participation, and emancipation is possible unless a woman is able to control her body—either by “controlling reproduction through the use of contraception or by deciding whether to terminate a pregnancy.”<sup>53</sup> Although initially broader, the reproductive rights movement has increasingly focused on this right to not have a child.<sup>54</sup> Activists first tried to lobby state legislatures to expand the availability of contraception and abortion, but had little success.<sup>55</sup> They then turned to the courts, where they eventually had great success.<sup>56</sup>

That success included the Supreme Court’s opinions in *Griswold v. Connecticut*<sup>57</sup> and then in *Roe v. Wade*.<sup>58</sup> First, in *Griswold*, advocates for the reproductive rights movement convinced the Supreme Court to announce a right to contraception by invalidating laws that restricted the distribution of contraception.<sup>59</sup> Then, in *Roe*, the Court declared unconstitutional Texas’s law banning abortion at any time during pregnancy, thereby recognizing a right to abortion<sup>60</sup> while also recognizing the state’s interest in regulation of abortion.<sup>61</sup> The Court based both rights

52. 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).

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

54. *See id.*

55. Hooton, *supra* note 52, at 61.

56. *Id.*

57. *Griswold v. Connecticut*, 381 U.S. 479 (1965).

58. *Roe v. Wade*, 410 U.S. 113 (1973), *abrogated by* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 883 (1992).

59. *Griswold*, 381 U.S. at 485–86.

60. *Roe*, 410 U.S. at 162–64.

61. *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

on a right to privacy,<sup>62</sup> a right defined negatively as to be “free from state interference.”<sup>63</sup>

As the reproductive rights movement continued to grow, “[w]omen of color activists” expressed some concerns.<sup>64</sup> The right to abortion in *Roe* was based on privacy, but not all women had equal opportunities for privacy. “Privacy 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 . . . .”<sup>65</sup> Due to *Roe*’s reliance on privacy, “only women who could afford to enter the marketplaces of choices—motherhood, abortion, and adoption, for example—had access to this zone.”<sup>66</sup>

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.”<sup>67</sup> A woman’s “class, race, gender, sexuality, . . . health [status], and access to health care”<sup>68</sup> all affect her reproductive life and preclude “choice.” For instance, a woman without financial resources “could not exercise choice in the same way”<sup>69</sup> as a woman with such resources. The emphasis on choice also “disguises the ways that laws, policies, and public officials differently” treat women based on those circumstances.<sup>70</sup>

Women of color also disagreed with the narrow focus of the 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.”<sup>71</sup> Again, a narrow focus on prevention

---

(twelve weeks) because before then, abortion was safe. *Id.* at 163. The Court 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 Pennsylvania 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 (plurality opinion).

62. *Roe*, 410 U.S. at 152; *Griswold*, 381 U.S. at 485–86.

63. Hooton, *supra* note 52, at 62–63.

64. LORETTA J. ROSS & RICKIE SOLINGER, *REPRODUCTIVE JUSTICE: AN INTRODUCTION* 47 (2017).

65. Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. L. & SOC. SCI. 327, 329 (2013).

66. ROSS & SOLINGER, *supra* note 64, at 47.

67. *Id.*

68. *Id.* at 65–66.

69. *Id.* at 47; see also Rachel Rebouché, *Reproducing Rights: The Intersection of Reproductive Justice and Human Rights*, 7 U.C. IRVINE L. REV. 579, 592 (2017) (explaining that “mainstream reproductive rights organizations” in the United States “overlooked or undermined the experiences of marginalized populations of women”).

70. ROSS & SOLINGER, *supra* note 64, at 47.

71. *Id.* 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.<sup>72</sup> 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.<sup>73</sup> Because of this history, the right to have a child was of “crucial concern”<sup>74</sup> and just as important “to women’s dignity and safety (and the dignity and safety of her community)”<sup>75</sup> as was the right to not have a child.

This new movement was finally named “reproductive justice” in 1994 by a group of Black women who had gathered in Chicago.<sup>76</sup> The name reproductive justice “splices *reproductive rights* with *social justice* to achieve *reproductive justice*.”<sup>77</sup> As is apparent from its history, one foundation of the reproductive justice framework is critical race theory. Critical legal theorist Kimberlé 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.”<sup>78</sup> Reproductive justice is similarly “based on the understanding that the impacts of race, class, gender, and sexual identity oppressions are not additive but integrative”<sup>79</sup> 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, sexual orientation, gender identity, religion, ability)” all affect and “impact women’s experiences.”<sup>80</sup>

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

---

72. See *id.* at 47–48.

73. *Id.* at 19, 94–95. Some marginalized women (allegedly) still face these exact forms of reproductive oppression—immigrant women possibly coming to the United States for a better future for their children and future children. See Camila Domonoske & Richard Gonzales, *What We Know: Family Separation and ‘Zero Tolerance’ at the Border*, NPR (June 19, 2018, 2:17 PM), <https://www.npr.org/2018/06/19/621065383/what-we-know-family-separation-and-zero-tolerance-at-the-border> [https://perma.cc/2U9R-KNGM]; Rachel Treisman, *Whistleblower Alleges ‘Medical Neglect,’ Questionable Hysterectomies of ICE Detainees*, NPR (Sept. 16, 2020, 4:43 AM), <https://www.npr.org/2020/09/16/913398383/whistleblower-alleges-medical-neglect-questionable-hysterectomies-of-ice-detainees> [https://perma.cc/4K24-EG3H].

74. ROSS & SOLINGER, *supra* note 64, at 48, 55.

75. *Id.* at 55.

76. *Id.* at 63.

77. *Id.* at 9.

78. *Id.* at 73.

79. *Id.* at 74.

80. Joan C. Chrisler, *Introduction: A Global Approach to Reproductive Justice—Psychosocial and Legal Aspects and Implications*, 20 WM. & MARY J. WOMEN & L. 1, 4 (2013).

midwifery.”<sup>81</sup> None of these rights is more important than the other; they are equally important.<sup>82</sup> “At the heart of reproductive justice is this claim: all fertile persons and persons who reproduce and become parents require a safe and dignified context for these most fundamental human experiences.”<sup>83</sup> 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.<sup>84</sup>

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.”<sup>85</sup> 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.”<sup>86</sup> And they need

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.<sup>87</sup>

Without wide-ranging services and support, “[s]afe and dignified fertility management, childbirth, and parenting are impossible.”<sup>88</sup>

Notably, the reproductive justice movement is activism beyond just the courts. Rights exist because they are human rights, not because of a court

---

81. Loretta Ross, *What is Reproductive Justice?*, in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 4, 4, <https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051> [<https://perma.cc/2R3T-GF3M>]; see also Rebouché, *supra* note 69, at 592 (explaining the four commitments of the reproductive justice 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”).

82. See Luna & Luker, *supra* note 65, at 343 (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.* (“R[eproductive 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.” (citation omitted)).

83. ROSS & SOLINGER, *supra* note 64, at 9.

84. *Id.* at 168–69.

85. *Id.* at 9.

86. *Reproductive Justice*, SISTERSONG, <https://www.sistersong.net/reproductive-justice/> [<https://perma.cc/8HQP-LXFQ>].

87. West, *supra* note 29, at 1425.

88. ROSS & SOLINGER, *supra* note 64, at 9.

declaration.<sup>89</sup> 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.<sup>90</sup> Similarly, a litigation-based approach, at least currently, is incapable of addressing numerous reproductive justice rights, the right to health care being an example.<sup>91</sup> Instead, "the reproductive justice framework calls for an integrated approach that draws on constitutional protections and movement-based policy strategies."<sup>92</sup>

## II. 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.<sup>93</sup> And at least one in 160 pregnancies will end with the baby dying in the womb after twenty weeks of pregnancy, with a woman then giving birth to her stillborn baby.<sup>94</sup> 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.<sup>95</sup> 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.<sup>96</sup>

### 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.<sup>97</sup> Miscarriage is the much

---

89. *See id.*

90. Luna & Luker, *supra* note 65, at 335; *see also id.* at 336 (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).

91. ROSS & SOLINGER, *supra* note 64, at 125.

92. Ocen, *supra* note 29, at 2240.

93. *See infra* Section II.A.

94. *See infra* Section II.A.

95. *See infra* Section II.B.

96. *See infra* Section II.C.

97. *What Is Stillbirth?*, CTR. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ncbddd/stillbirth/facts.html> [<https://perma.cc/F6DV-7GQN>].

more common form of pregnancy loss.<sup>98</sup> Studies reveal that anywhere from 10–25% of all clinically recognized pregnancies will end in miscarriage.<sup>99</sup> The vast majority of miscarriages, possibly as high as 80%, occur in the first twelve weeks of pregnancy.<sup>100</sup> The highest risk exists in the first six weeks, and the risk drops once a heartbeat is confirmed.<sup>101</sup> Once the pregnancy hits thirteen weeks, the risk of miscarriage drops to around 5%.<sup>102</sup> Nearly one million women in the United States suffer a known miscarriage each year.<sup>103</sup>

Although less common, one in 160 pregnancies end in stillbirth every year in the United States,<sup>104</sup> totaling approximately 24,000 stillborn babies born every year.<sup>105</sup> The risks of stillbirth for women is greatest at “(20–23 weeks) and at the end (39–41 weeks) of gestation.”<sup>106</sup> Almost half of all stillbirths globally occur during childbirth.<sup>107</sup> One in 160 may seem like a small risk, but stillbirth is more common than the death of a living infant before his first birthday.<sup>108</sup> A baby is actually ten times more likely to be stillborn than to die from Sudden Infant Death Syndrome.<sup>109</sup> Multiple studies state that “[m]ore babies die as a result of stillbirth than of all other causes of infant deaths combined.”<sup>110</sup> Additionally, the United States’ stillbirth rate remains higher “than in many other high-income countries,

---

98. 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.” *Signs of Miscarriage*, AM. PREGNANCY ASS’N, <https://americanpregnancy.org/healthy-pregnancy/pregnancy-complications/signs-of-miscarriage-916> [<https://perma.cc/9ZXB-A5K2>].

99. *Id.*

100. Rena Goldman, *A Breakdown of Miscarriage Rates by Week*, HEALTHLINE PARENTHOOD (Oct. 3, 2018), <https://www.healthline.com/health/pregnancy/miscarriage-rates-by-week#causes> [<https://perma.cc/3LJW-NQBF>].

101. *Id.*

102. *Id.*

103. Tanya Lewis, *Misconceptions About Miscarriages Are Common, Survey Finds*, LIVE SCI. (Oct. 17, 2013), <https://www.livescience.com/40495-misconceptions-miscarriages-common.html> [<https://perma.cc/U8UR-EJED>].

104. See *What is Stillbirth?*, *supra* note 97.

105. Marian F. MacDorman & Elizabeth C.W. Gregory, *Fetal and Perinatal Mortality: United States, 2013*, NAT’L VITAL STAT. REPS., July 23, 2015, at 1, 5.

106. Marian Willinger, Chia-Wen Ko & Uma M. Reddy, *Racial Disparities in Stillbirth Risk Across Gestation in the United States*, 201 AM. J. OBSTETRICS & GYNECOLOGY 469.e1, 469.e6 (2009).

107. *Maternal, Newborn, Child and Adolescent Health: Stillbirths*, WORLD HEALTH ORG., [https://www.who.int/maternal\\_child\\_adolescent/epidemiology/stillbirth/en/](https://www.who.int/maternal_child_adolescent/epidemiology/stillbirth/en/) [<https://perma.cc/V7ZH-ZMKK>].

108. Joanne Cacciatore & Suzanne Bushfield, *Stillbirth: A Sociopolitical Issue*, 23 J. WOMEN & SOC. WORK 378, 380 (2008) (“More babies die as a result of stillbirth than of all other causes of infant deaths combined . . .”).

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

110. See Cacciatore & Bushfield, *supra* note 108, at 380.

and rates continue to decrease in other high-income countries.”<sup>111</sup> More specifically, in a study posted in the medical journal *The Lancet*, of the listed forty-nine high-income countries, the United States’ annual percentage stillbirth rate reduction from 2000–2015 was lower than all but one other country.<sup>112</sup>

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. Starting with race, Black women are twice as likely as white women to miscarry after ten weeks of pregnancy.<sup>113</sup> A study published in 2012 concluded this after adjusting for age, miscarriage history, and planned versus unplanned pregnancies.<sup>114</sup> The study also cautioned the overall disparity in miscarriage rate may also be higher given that one third of the Black women who participated in the study had a college education and thus “might be expected to be at lower risk of miscarriage than blacks in the general population.”<sup>115</sup>

Black women are also twice as likely as white women to lose their child to stillbirth after twenty weeks of pregnancy.<sup>116</sup> “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.”<sup>117</sup> 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.”<sup>118</sup> 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 total ‘white’ rate in 1990.”<sup>119</sup> Also since 1990, “the non-Hispanic white rate has improved by 19%, while the non-Hispanic black rate has improved by only 13%.”<sup>120</sup>

---

111. Jessica M. Page et al., *Potentially Preventable Stillbirth in a Diverse U.S. Cohort*, 131 *OBSTETRICS & GYNECOLOGY* 336, 337 (2018).

112. Vicki Flenady et al., *Stillbirths: Recall to Action in High-Income Countries*, 387 *LANCET* 691, 693 (2016).

113. Sudeshna Mukherjee, Digna R. Velez Edwards, Donna D. Baird, David A. Savitz & Katherine E. Hartmann, *Risk of Miscarriage Among Black women and White Women in a US Prospective Cohort Study*, 177 *AM. J. EPIDEMIOLOGY* 1271, 1276 (2013) (“[B]lack women have a nearly 2-fold higher risk of miscarriage compared with white women during gestational weeks 10-20 . . .”).

114. *Id.*

115. *Id.* at 1277.

116. See Willinger et al., *supra* note 106, at 469.e6.

117. Carol J. Rowland Hogue & Robert M. Silver, *Racial and Ethnic Disparities in United States: Stillbirth Rates: Trends, Risk Factors, and Research Needs*, 35 *SEMINARS PERINATOLOGY* 221, 221–22 (2011) (emphasis added).

118. *Id.* at 222.

119. *Id.*

120. *Id.*

A study published in 2009 found an overall “2.2-fold increased risk of stillbirth” for non-Hispanic Black women,<sup>121</sup> 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].”<sup>122</sup> Similarly, a study published in 2011 study concluded that “[t]he elevated risk of stillbirth for non-Hispanic blacks occurred predominantly prior to 24 weeks’ gestation.”<sup>123</sup>

Turning to class, women of lower socioeconomic status face an increased risk of miscarriage. A 2012 study in Denmark concluded that “[e]ducational level and income were inversely associated with the risk of spontaneous abortion,”<sup>124</sup> the medical term for miscarriage, which is defined in Denmark as before twenty-two weeks of pregnancy.<sup>125</sup>

Other studies also conclude that women of low socioeconomic status similarly face a doubled 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.”<sup>126</sup> A 2001 study in Sweden found “a more than twofold increase in risk of stillbirth for women with the lowest [socioeconomic status] compared with the highest,” and an even higher risk for “intrapartum and term antepartum stillbirths.”<sup>127</sup> The study found this conclusion especially problematic because intrapartum and term antepartum stillbirths occur during childbirth and after thirty-seven weeks of pregnancy, respectively, and are thus likely the most preventable type of stillbirth.<sup>128</sup> 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

---

121. Willinger et al., *supra* note 106, at 469.e6.

122. *Id.* at 469.e6–7. “The hazard of stillbirth for Hispanics was similar to non-Hispanic whites throughout pregnancy.” *Id.* at 469.e2.

123. The Stillbirth Collaborative Rsch. Network Writing Grp., *Association Between Stillbirth and Risk Factors Known at Pregnancy Confirmation*, 306 J. AM. MED. ASS’N 2469, 2475 (2011).

124. Filippa Nyboe Norsker et al., *Socioeconomic Position and the Risk of Spontaneous Abortion: A Study Within the Danish National Birth Cohort*, BMJ OPEN, June 25, 2012, at 1, 4.

125. *Id.* at 1.

126. Jennifer Zeitlin et al., *Socioeconomic Inequalities in Stillbirth Rates in Europe: Measuring the Gap Using Routine Data from the Euro-Peristat Project*, BMC PREGNANCY & CHILDBIRTH, Jan. 19, 2016, at 1, 2.

127. Olof Stephansson, Paul W. Dickman, Anna L.V. Johansson & Sven Cnattingius, *The Influence of Socioeconomic Status on Stillbirth Risk in Sweden*, 30 INT’L J. EPIDEMIOLOGY 1296, 1299 (2001).

128. *Id.* at 1300.

deprived.”<sup>129</sup> “Significant deprivation differences were seen between the most and least deprived groups in all causes except mechanical events that occurred during labour.”<sup>130</sup> 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.”<sup>131</sup> Similarly, a study in England concluded that “[i]f the stillbirth rates seen in the least deprived areas were seen throughout the population, there would be a third less stillbirths in England, nearly 900 fewer each year.”<sup>132</sup>

Generally speaking, a higher educational level decreases the risk of stillbirth. But the extent of the decrease differs depending on race. One study found that >12 years of education decreased a white woman’s risk of stillbirth substantially, by 30%, but caused only a “small reduction for Black women.”<sup>133</sup> The same study called for more research “to probe the cultural and social determinants of racial disparities in risk among blacks and Hispanics, as higher educational status appears to widen rather than reduce these disparities.”<sup>134</sup>

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.”<sup>135</sup> Because of the timing, a woman can easily not know she is pregnant and mistake that bleeding for a period.<sup>136</sup> “The earlier . . . the pregnancy, the more likely that [the] body will expel all the fetal tissue by itself . . . .”<sup>137</sup> Later miscarriages will also involve bleeding, but more of it, and possibly visible “products of conception.”<sup>138</sup> Surgery may be necessary if the uterus does not empty itself.<sup>139</sup>

The physical experience of stillbirth, especially stillbirth at term, meaning after thirty-seven weeks of pregnancy, is more similar to the birth of a live child. Because of medicalization, the woman will often learn ahead

---

129. Sarah E. Seaton et al., *Socioeconomic Inequalities in the Rate of Stillbirths by Cause: A Population-Based Study*, *BMJ OPEN*, June 25, 2012, at 1, 2, 4.

130. *Id.* at 1.

131. Zeitlin et al., *supra* note 126, at 8.

132. Seaton et al., *supra* note 129, at 4.

133. Willinger et al., *supra* note 106, at 469.e7.

134. *Id.* at 469.e8.

135. *Signs of Miscarriage*, *supra* note 98.

136. *Id.*

137. *Id.*

138. *Id.*

139. Medical treatment of miscarriage and stillbirth is discussed more thoroughly in *infra* Section III.C.

of time that her child has died while still in the womb.<sup>140</sup> 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.<sup>141</sup> According to at least one study, however, a woman faces a much higher risk of life-threatening complications during delivery of a stillborn baby than a live birth.<sup>142</sup> Hopefully though, she will give birth to her child without complications. Or, if 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,<sup>143</sup> a measure that studies almost unanimously conclude is psychologically beneficial.<sup>144</sup>

Even if a woman is physically healthy after miscarriage or stillbirth, she can still have long-lasting mental and emotional health issues. No standard reaction to miscarriage and stillbirth exists.<sup>145</sup> 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.”<sup>146</sup>

Research has shown that more intense reactions are common in stillbirth.<sup>147</sup> Women after stillbirth are at risk for “chronic depression,

---

140. See Linda L. Layne, *Pregnancy and Infant Loss Support: A New, Feminist, American, Patient Movement?*, 62 SOC. SCI. & MED. 602, 603 (2006).

141. Annelee Boyle et al., *Route of Delivery in Women with Stillbirth: Results from the Stillbirth Collaborative Research Network*, 129 OBSTETRICS & GYNECOLOGY 693, 694 (2017) (“[W]ith the widespread availability of oxytocin and prostaglandins, induction of labor soon after a diagnosis of fetal death is now common.”).

142. See Elizabeth Wall-Wieler et al., *Severe Maternal Morbidity Among Stillbirth and Live Birth Deliveries in California*, 134 OBSTETRICS & GYNECOLOGY 310, 312 (2019) (explaining that the chances of life-threatening complications for the woman are four times greater in a stillbirth than a live birth).

143. PREGNANCY LOSS & INFANT DEATH ALL., POSITION STATEMENT: BEREAVED PARENTS’ RIGHT TO SELF-DETERMINATION REGARDING THEIR BABY 2 (2016) (on file with the Washington University Law Review); see also Joanne Cacciatore, *The Silent Birth: A Feminist Perspective*, 54 SOC. 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.” (citation omitted)); 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).

144. Samantha Murphy & Joanne Cacciatore, *The Psychological, Social, and Economic Impact of Stillbirth on Families*, 22 SEMINARS 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”).

145. Kirkley-Best & Kellner, *supra* note 144, 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”).

146. Heather Rowe & Alexandra J. Hawkey, *Miscarriage*, in ROUTLEDGE INTERNATIONAL HANDBOOK OF WOMEN’S SEXUAL AND 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”).

147. Kirkley-Best & Kellner, *supra* note 144, at 425.



suicidal ideation, drug or alcohol abuse, and pervasive post traumatic stress disorder (PTSD) symptomology.”<sup>148</sup> 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.”<sup>149</sup>

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.<sup>150</sup> If due to fetal abnormalities, they are unpreventable.<sup>151</sup>

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 twenty-two-week definition of stillbirth) are due to congenital abnormalities, and even some of those abnormalities are actually preventable if the mother takes folic acid.<sup>152</sup> That numerous countries have devoted resources to and successfully lowered their own stillbirth rates—by as much as 20%—demonstrates the preventability of stillbirth.<sup>153</sup> Moreover, a recent study specific to the United

---

148. Cacciatore, *supra* note 109, at 73.

149. Zeitlin et al., *supra* note 126, at 2.

150. *Signs of Miscarriage*, *supra* note 98.

151. See *infra* Section III.B for a deeper discussion of research priorities for miscarriage prevention.

152. 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.” *Id.* Likely contributing to this myth is the conflation of miscarriage and stillbirth. Joanne Cacciatore & Jill Wieber Lens, *The Ultimate in Women’s Labor: Stillbirth and Grieving*, in ROUTLEDGE INTERNATIONAL HANDBOOK OF WOMEN’S SEXUAL & REPRODUCTIVE HEALTH, *supra* note 146, at 310.

153. 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. SENATE SELECT COMM. ON STILLBIRTH RSCH. & EDUC., REPORT 113 (2018) (Austl.) [hereinafter AUSTRALIAN SENATE COMMITTEE REPORT]. Ten years later, Scotland implemented its Maternity Care Quality Improvement Collaborative and reduced 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. *Number of Stillbirths in the UK Falls to Record Low*, TOMMY’S (July 19, 2018), <https://www.tommys.org/our-organisation/about-us/charity-news/number-stillbirths-uk-falls-rec-ord-low> [<https://perma.cc/UKK7-B8U8>]. In 2014, England also announced its goals to cut its stillbirth rate by 20% by 2020 and by 50% by 2025. *Saving Babies’ Lives Care Bundle*, NHS, <https://www.england.nhs.uk/mat-transformation/saving-babies/> [<https://perma.cc/AJ2H-RURA>] [hereinafter *Saving Babies’ Lives*]. In the same year, the National Health Service introduced the “Saving Babies’ Lives Care Bundle” in certain hospitals, and the stillbirth rate in those hospitals has fallen by 20%. *Id.*; AUSTRALIAN SENATE COMMITTEE REPORT, *supra*, at 85.

States conservatively estimated that at least one-fourth of stillbirths in the United States are preventable.<sup>154</sup>

### *B. Reproductive Rights's Avoidance*

As already described, the reproductive rights movement has focused mostly on the rights to contraception and abortion, both of which enable the choice to not have a child.<sup>155</sup> 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*.<sup>156</sup> Justice Blackmun explained that “[t]he detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent”:<sup>157</sup>

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.<sup>158</sup>

Similarly, in *Casey*, Justice Blackmun 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.”<sup>159</sup> 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 movement has opted to change the subject. This is because of the antiabortion strategy of fetal personhood. “Since the late 1960s, pro-lifers had deployed fetological studies, slideshows, and medical articles to establish the personhood of the fetus.”<sup>160</sup> “[I]f the courts

---

154. Page et al., *supra* note 111, 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.* at 337.

155. *See supra* notes 54–63 and accompanying text.

156. *Roe v. Wade*, 410 U.S. 113 (1973).

157. *Id.* at 153.

158. *Id.*

159. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 928 (1992) (Blackmun, J., concurring in part, concurring in the judgment in part, and dissenting in part).

160. MARY ZIEGLER, *AFTER ROE: THE LOST HISTORY OF THE ABORTION DEBATE* 164 (2015).

recognized fetal personhood, unborn children could claim the same constitutional rights as anyone else.”<sup>161</sup>

In *Roe*, the Court rejected the idea of a fetus as a person.<sup>162</sup> 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.”<sup>163</sup> Justice Blackmun’s opinion 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.”<sup>164</sup>

Thus, even though the Court rejected fetal personhood, it admitted that abortion could not be constitutional if a fetus were a person, which caused the antiabortion movement to not give up on the fetal personhood argument. To help establish it, antiabortion activists looked beyond the Fourteenth Amendment. Part of “the long-term, 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.”<sup>165</sup>

Women after stillbirth have similarly sought legal recognition of their stillborn children.<sup>166</sup> Just as antiabortion advocates 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.<sup>167</sup> Antiabortion advocates 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.<sup>168</sup>

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 “ha[s] studiously avoided anything that might imply or concede such a presence. The fear . . . is that if one were to acknowledge that there was something of value lost, . . . one would thereby

161. *Id.* at 165.

162. *Roe*, 410 U.S. at 158.

163. Oral Reargument at 24:13, *Roe*, 410 U.S. 113 (No. 70-18), <https://www.oyez.org/cases/1971/70-18>.

164. *Roe*, 410 U.S. at 156–57.

165. 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).

166. Examples include wrongful death claims applied to stillbirth and birth certificates, both of which are discussed *infra* Part III.

167. JOHN DEFRAIN, LEONA MARTENS, JAN STORK & WARREN STORK, STILLBORN: THE INVISIBLE DEATH 61 (1986) (“The overwhelming majority of parents (nearly 90 percent) considered the baby a part of the family and named the baby.”); Cacciatore & Lens, *supra* note 152, at 312–316 (describing stillbirth as the death of a child).

168. 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).

automatically accede the inherent personhood of embryos and fetuses.”<sup>169</sup> Avoidance is necessary because the topics of miscarriage and stillbirth (supposedly) “overlap[] with issues of fetal personhood so central to abortion politics.”<sup>170</sup> The reproductive rights movement has thus “surrendered the discourse of pregnancy loss to antichoice activists.”<sup>171</sup>

### 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 agreed upon list of issues for reproductive justice activists to address,”<sup>172</sup> meaning no issues are specifically or strategically excluded. Still, reproductive justice advocates have certainly not emphasized miscarriage or 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.<sup>173</sup> Yet slave owners worked enslaved women “viciously hard, far into their pregnancies.”<sup>174</sup> They describe that “[m]any women, near the end of their term and exhausted, lost their pregnancies right in the fields,”<sup>175</sup> 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 own kin.”<sup>176</sup> Ross and Solinger also discuss how pregnant women on Louisiana sugar plantations worked sixty to seventy hours a week in ninety-degree heat, causing them to “suffer[] from insufficient blood supply to their placentas” and hypertension, which led enslaved women to experience a “high

---

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

170. Linda L. 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 Linda L. Layne, *Breaking the Silence: An Agenda for a Feminist Discourse of Pregnancy Loss*, 23 *FEMINIST STUD.* 289, 294 (1997) (“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.”).

171. LAYNE, *supra* note 169, at 239.

172. Chrisler, *supra* note 80, at 4.

173. ROSS & SOLINGER, *supra* note 64, at 18.

174. *Id.* at 19.

175. *Id.*

176. *Id.*

percentage of miscarriages and stillbirths.”<sup>177</sup> And thus, Ross and Solinger described enslaved women suffering miscarriages and stillbirths as one form of the reproductive oppression that Black women have faced.

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.<sup>178</sup> This emphasis is consistent with reproductive justice, as “troubling racial and class disparities exist in how states intervene in the lives of pregnant women.”<sup>179</sup> Marginalized women are targeted.<sup>180</sup> 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 find that focuses on stillbirth itself as a woman’s reproductive experience comes from Dr. Joan Chrisler within her discussion of reproductive justice in a global perspective.<sup>181</sup> Specifically, she 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.”<sup>182</sup> She then explains the need for universal health care, including “[p]renatal 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.”<sup>183</sup>

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.

---

177. *Id.* at 20.

178. *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).

179. Chemerinsky & Goodwin, *supra* note 29, at 1235.

180. *See id.*

181. *See* Chrisler, *supra* note 80.

182. *Id.* at 11–12.

183. *Id.* at 12.

### III. REPRODUCTIVE JUSTICE-BASED RIGHTS CONCERNING MISCARRIAGE AND STILLBIRTH

Millions of women each year experience an involuntary ending of their pregnancy. Yet, the reproductive rights movement ignores miscarriages and stillbirths and the reproductive justice movement does not emphasize them. This lack of acknowledgement of miscarriage and stillbirth “systematically minimizes and marginalizes negative reproductive outcomes.”<sup>184</sup>

This section is normative, explaining why and how the reproductive justice movement 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 of “choice” rhetoric, rejecting the individualism inherent in that rhetoric and recognizing that a disconnect exists between choice and outcome. 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, including prenatal care, to which marginalized women often have less access. This right, however, must emphasize that prenatal care is necessary 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 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 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.

---

184. Layne, *supra* note 170, at 1887.

*A. The Lack of Choice Within Miscarriage and Stillbirth*

As reproductive justice recognizes, “choice” does not accurately describe a woman’s reproductive experiences. It is inaccurate for numerous reasons. First, 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.”<sup>185</sup> Second, it is 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.<sup>186</sup> Unlike the reproductive rights framework, reproductive justice deemphasizes “choice” because it recognizes that choice does not dictate outcome.

The same is true for miscarriages and stillbirth. Nothing about miscarriage or stillbirth feels like “choice.”<sup>187</sup> 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 to alive. 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, “choice” implies that is her fault for not being able to obtain an abortion. 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,”<sup>188</sup> making society’s only role to ensure that the parent’s decision is well-informed.<sup>189</sup> Parenting is expensive. But if the parent is informed and chooses still to parent, then the expense of parenting is “not a source of injustice or even a cause for worry”<sup>190</sup> and there “is no reason to publicly

---

185. Chrisler, *supra* note 80, at 3.

186. West, *supra* note 29, at 1402–03 (describing how the constitutional right to choose abortion has failed to also guarantee access enabling that choice).

187. 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 are unable to access reproductive technology, women whose children die in their infancy, and women “coerced or misled into sterilization.” Chrisler, *supra* note 80, at 3.

188. West, *supra* note 29, at 1409.

189. *Id.* at 1409–10.

190. *Id.* at 1410.

subsidize the choice.”<sup>191</sup> Choice rhetoric “legitimizes . . . the lack of public support given parents in fulfilling their caregiving obligations.”<sup>192</sup> 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.<sup>193</sup>

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.<sup>194</sup> 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.”<sup>195</sup> 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 to be responsible for their pregnancy losses.”<sup>196</sup> 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.”<sup>197</sup>

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.”<sup>198</sup> 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 at community and legal and structural causes. Removing the focus from the individual woman and her choices, and especially “centering the reproductive experiences of marginalized women,” enables us to identify “institutions and actors that undermine the reproductive destinies of women” including with respect to the risks of miscarriage and

---

191. *Id.* at 1411 (emphasis omitted); *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”).

192. West, *supra* note 29, at 1411.

193. ROSS & SOLINGER, *supra* note 64, at 168–69.

194. Layne, *supra* note 170, at 1888.

195. *Id.*

196. *Id.* at 1889.

197. *Id.* at 1881; *see also* Kirkley-Best & Kellner, *supra* note 144, at 422 (explaining that women “meticulously” review “the events of [their] pregnanc[ies]” and blame themselves); Joanne Cacciatore, J. Frederik Frøen & Michael Killian, *Condemning Self, Condemning Other: Blame and Mental Health in Women Suffering Stillbirth*, 35 J. MENTAL HEALTH COUNSELING 342, 343 (2013) (“[N]early all mothers of stillborn babies report intense behavioral and characterological self-blame following the baby’s death . . .”).

198. Ross, *supra* note 81 at 4.



stillbirth.<sup>199</sup> Although not connecting her argument to reproductive justice, Linda Layne similarly argued that “[t]his liberal emphasis on individualism . . . deflects attention from social causes of pregnancy loss.”<sup>200</sup> Layne suggested that these social causes include “domestic violence, inadequate prenatal care, and exposure to environmental toxins.”<sup>201</sup>

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 differences in “environmental or product exposures that accrue over weeks across pregnancy” could explain the racial disparity.<sup>202</sup> 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.”<sup>203</sup> 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 groups, which could mean that women with higher socioeconomic status are terminating their pregnancies and women with lower socioeconomic status are not.<sup>204</sup> A study in Europe similarly mentioned this possibility, suggesting that poorer women did not terminate their pregnancies perhaps “either because of lack of access to screening or differences in attitudes to pregnancy terminations.”<sup>205</sup>

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

---

199. Ocen, *supra* note 29, at 2240.

200. LAYNE, *supra* note 169, at 244.

201. *Id.*

202. Sudeshna Mukherjee, Digna R. Velez Edwards, Donna D. Baird, David A. Savitz & Katherine E. Hartmann, *Risk of Miscarriage Among Black women and White Women in a US Prospective Cohort Study*, 177 AM. J. EPIDEMIOLOGY 1271, 1277 (2013). The 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.*

203. Zeitlin et al., *supra* note 126, at 2. The study also suggested that women of lower socioeconomic class are more likely to smoke. *Id.* at 11. But the 2001 Sweden study concluded smoking could account for only a “minor part of the increase in risk.” Stephansson et al., *supra* note 127, at 1300. The possibility of inequity in health care is covered in the next Section.

204. Seaton et al., *supra* note 129, at 5.

205. Zeitlin et al., *supra* note 126, at 11.

risk<sup>206</sup> 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.”<sup>207</sup> 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—free from exposure to harmful chemicals<sup>208</sup> and free from domestic violence<sup>209</sup>—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.”<sup>210</sup> An important 2005 paper entitled *A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights, and Reproductive Justice* by the Asian Communities for Reproductive Justice specifically explained the “reproductive health” framework of reproductive justice.<sup>211</sup> 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.”<sup>212</sup> 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

---

206. Willinger et al., *supra* note 106, at 469.e8.

207. Zeitlin et al., *supra* note 126, at 2.

208. 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, Note, *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.”).

209. ROSS & SOLINGER, *supra* note 64, at 9–11.

210. Wiley, *supra* note 208, at 63.

211. ASIAN CMTYS. FOR REPROD. JUST., A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS, AND REPRODUCTIVE JUSTICE 2 (2005), <https://www.oursplatform.org/wp-content/uploads/ACRJ-A-New-Vision.pdf> [<https://perma.cc/YQ9Q-4NZV>].

212. *Id.*

cancer prevention and treatment.”<sup>213</sup> Other literature more specifically recognizes the right to prenatal care. Rickie Solinger described women’s right to “safe, respectful, and affordable medical care during and after pregnancy.”<sup>214</sup> Other literature emphasizes the right and access to prenatal care for immigrant women in the United States.<sup>215</sup>

The reproductive justice movement’s right to health prenatal care<sup>216</sup> does not, however, connect prenatal care to prevention of miscarriages and stillbirth. It has connected prenatal care to infant mortality,<sup>217</sup> but not miscarriages and stillbirth. Medical studies, however, have suggested a connection between insufficient prenatal care and 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.<sup>218</sup> 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.”<sup>219</sup> 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.”<sup>220</sup> The authors ultimately suggested that “the quality of [medical] care may differ with social class”<sup>221</sup> and “that women of low social class may need more attention, support and observation at antenatal and obstetric clinics during pregnancy and labour.”<sup>222</sup> 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.”<sup>223</sup>

---

213. *Id.*

214. Rickie Solinger, *Conditions of Reproductive Justice*, in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE, *supra* note 81, at 42.

215. ROSS & SOLINGER, *supra* note 64, at 144–49.

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

217. *See id.*

218. Stephansson et al., *supra* note 127, at 1300.

219. *Id.*

220. *Id.*

221. *Id.*

222. *Id.*

223. Willinger et al., *supra* note 106, at 469.e7. The same study also suggested that Black women’s increased risk of stillbirth at term (after thirty-seven weeks of pregnancy) may be because 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 twenty years,

Concerns connecting stillbirth to prenatal care should be even greater in the United States where, unlike in Sweden, women do not have equal opportunities to receive prenatal care. Here, “insurance is a gateway to health care.”<sup>224</sup> A poor woman’s only option for insurance is often a government-sponsored program. Medicaid, which covers as many as half of all births in the United States each year,<sup>225</sup> provides insurance for prenatal care, labor and delivery, and sixty days of coverage for after birth.<sup>226</sup> Prior to passage of the Affordable Care Act, poor women could only access Medicaid after becoming pregnant, which often resulted in delayed prenatal care.<sup>227</sup> The Act enables poor women 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.”<sup>228</sup> 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.<sup>229</sup> Texas is one of those states. A recent *ProPublica* article explained that in Texas, about 21% of all 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.<sup>230</sup>

---

“low maternal education, previous stillbirth, previous cesarean delivery, obesity, chronic hypertension, diabetes, systemic lupus erythematosus, and multiple gestation.” The Stillbirth Collaborative Research Network Writing Group, *supra* note 123, at 2474 (footnotes omitted). At the same time, other pre-pregnancy risk factors associated with stillbirth tend to not be present in Black women, including smoking and first pregnancy. *Id.* at 2473.

224. Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care*, 94 NEB. L. REV. 799, 816 (2016).

225. Usha Ranji, Ivette Gomez & Alina Salganicoff, *Expanding Postpartum Medicaid Coverage*, KAISER FAM. FOUND. (May 22, 2019), <https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicare-coverage/> [<https://perma.cc/YVG7-L24J>].

226. *Id.*

227. Kukura, *supra* note 224, at 825.

228. *Id.*

229. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Nov. 2, 2020), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicare-expansion-decisions-interactive-map/> [<https://perma.cc/5FSE-BRHD>] (explaining that as of August 2020, 39 states had adopted the Medicaid expansion).

230. Nina Martin, ProPublica & Julia Belluz, *The Extraordinary Danger of Being Pregnant and Uninsured in Texas*, PROPUBLICA (Dec. 6, 2019, 5:00 AM), <https://www.propublica.org/article/the-extraordinary-danger-of-being-pregnant-and-uninsured-in-texas> [<https://perma.cc/HFH7-BBVA>]. 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 twenty-eight weeks but some as early as twenty weeks. *Id.* Plus, not all doctors are eager to treat Medicaid-insured pregnant women. The *ProPublica* article explained that “providers 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 thirty-minute drive to the nearest hospital offering perinatal services. Within a sixty-minute drive, the proportion increases to 87.6% in rural towns and 78.7% in the most isolated areas.”<sup>231</sup> 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.”<sup>232</sup> 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.”<sup>233</sup>

Emphasizing access to preventative prenatal care, however, is just the first step. The second step is to ensure that prenatal care includes education of women on the risk of stillbirth and the known, simple preventative measures.<sup>234</sup> As mentioned, only around 7% of 2.6 million stillbirths that occur yearly globally (using a twenty-eight week definition of stillbirth) are due to congenital abnormalities, and even some of those abnormalities are actually preventable if the mother takes folic acid.<sup>235</sup> 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.<sup>236</sup> In just the past twenty years, both Norway and Scotland have

---

231. COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, THE AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION NO. 586: HEALTH DISPARITIES IN RURAL WOMEN 2 (2014), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/02/health-disparities-in-rural-women.pdf> [<https://perma.cc/HTZ6-JBP3>] (“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.” (citations omitted)).

232. *Improving Remote Maternity Care*, CRANAPLUS MAG., Summer/Wet Season 2019, at 84.

233. *Id.*

234. I have written separately on a woman’s right to her doctor’s disclosure of the risk of stillbirth and its preventative measures. See Jill Wieber Lens, *Medical Paternalism, Stillbirth, & Blindsided Mothers*, 106 IOWA L. REV. (forthcoming 2020).

235. Lawn et al., *supra* note 152, at 597.

236. See *supra* note 153 and accompanying text.

reduced their stillbirth rates by over 20%.<sup>237</sup> England reduced its rate by almost 20% in just five years.<sup>238</sup>

The importance of monitoring fetal movement cannot be understated. Any reduction in movement can indicate a potential problem.<sup>239</sup> 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. 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.<sup>240</sup> 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 babies.<sup>241</sup> In the first five years after the group’s creation, Iowa’s stillbirth rate decreased by almost 30%.<sup>242</sup>

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 priorities, perhaps focusing on the racial and class disparities in the risks.<sup>243</sup> For example, miscarriages are currently believed to be 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.”<sup>244</sup> Some

---

237. See *supra* note 153 and accompanying text.

238. See *supra* note 153 and accompanying text.

239. See, e.g., Alexander E. P. Heazell et al., *Stillbirth Is Associated with Perceived Alterations in Fetal Activity—Findings from an International Case Control Study*, *BMC PREGNANCY & CHILDBIRTH*, Nov. 13, 2017, at 1; Alexander E. P. Heazell et al., *Alterations in Maternally Perceived Fetal Movement and Their Association with Late Stillbirth: Findings from the Midland and North of England Stillbirth Case-Control Study*, *BMJ OPEN*, July 6, 2018, at 1, 7; Julie Victoria Holm Tveit et al., *Reduction of Late Stillbirth with the Introduction of Fetal Movement Information and Guidelines—A Clinical Quality Improvement*, *BMC PREGNANCY & CHILDBIRTH*, July 23, 2009, at 1.

240. See Tveit et al., *supra* note 239, at 4.

241. See Michael Ollove, *Pregnant Women Are Told to Count Fetal Kicks to Help Prevent Stillbirths*, *WASH. POST.* (Oct. 15, 2018, 7:00 AM), [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](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) [<https://perma.cc/6M3Z-BTR7>].

242. Rekha Basu, *Successful Plan to Save Infants from Stillbirth Still Needs to Reach More Minority Moms*, *DES MOINES REG.* (FEB. 15, 2019, 11:28 AM), <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/> [<https://perma.cc/97DZ-L33E>].

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

244. *Signs of Miscarriage*, *supra* note 98. 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 243, at 591.

question whether this is even true.<sup>245</sup> Regardless, abnormalities can only explain miscarriages before twelve weeks, in the first trimester.<sup>246</sup> Abnormalities “are less common in later losses,”<sup>247</sup> like the later miscarriages after ten weeks (and after twelve 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 ten to twenty weeks and 2.8% higher risk of stillbirth between twenty and twenty-four weeks of pregnancy.<sup>248</sup> 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 twenty-eight weeks of pregnancy, is more than three times greater than a white woman’s.<sup>249</sup> The causes could easily be related.<sup>250</sup> But we do not 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.”<sup>251</sup> 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.

Another necessary step for preventative prenatal care is legal protections enabling women to obey their doctors’ orders—to take additional precautions to help try to prevent stillbirth and miscarriage. For instance, a doctor may advise a pregnant woman with a history of miscarriages to not lift anything over a certain weight.<sup>252</sup> Marginalized women earning low wages are the women most likely to need accommodations and also the most likely to be denied them.<sup>253</sup> Federal law prohibits discrimination on the basis

---

245. 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 243, at 591. She points out, however, that “[t]he research on which this view is based . . . is decades old.” *Id.*

246. Mukherjee et al., *supra* note 202, at 1277.

247. *Id.*

248. *Id.* at 1273.

249. The Stillbirth Collaborative Rsch. Network Writing Grp., *supra* note 123, at 2471.

250. *Id.*

251. Willinger et al., *supra* note 106, at 469.e1.

252. These were the facts in *Young v. United Parcel Service, Inc.*, a case in which a woman sued her employer for failing to accommodate her pregnancy-related lifting restriction. *Young v. United Parcel Serv., Inc.*, 575 U.S. 206 (2015).

253. Brief of Law Professors & Women’s & Civil Rights Organizations as Amici Curiae in Support of Petitioner at 37, *Young*, 575 U.S. 206 (No. 12-1226) (explaining that “[w]omen in low-wage jobs remain highly vulnerable to the harms of non-accommodation” because they “work in physically demanding jobs or highly regimented workplaces” and “are less likely to be granted even minor and costless accommodations and thus more likely to be forced out because of these conflicts”).

of pregnancy, but not all denials of accommodations are discriminatory.<sup>254</sup> Some states have more protective laws, requiring an accommodation as long as it does not pose an undue burden on the employer.<sup>255</sup> But a woman's rights should not depend on the state in which she lives. All women should have a reproductive-justice-based right to medically necessary accommodations to help prevent miscarriage and stillbirth.

### *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.”<sup>256</sup> The label “obstetric violence” is increasingly being used to describe the disrespectful, abusive, or neglectful treatment women often experience during childbirth.<sup>257</sup> Professor Elizabeth Kukura recently vividly described the many types of medically unnecessary and unwanted medical procedures imposed on women in childbirth, including forced surgeries like episiotomies and cesarean section deliveries and unconsented medical procedures like labor induction and forceps-assisted delivery.<sup>258</sup> Also, many women report that they are “denied midwifery services” and that “hospital staff members often ignore a woman’s birthing plans.”<sup>259</sup> Other scholars have also argued “that women of color experience a disproportionate amount of medical intervention in their births for non-medical reasons.”<sup>260</sup>

“Ending coercive medicine is a reproductive justice goal.”<sup>261</sup> Specifically aimed at that goal is the concept of “birth justice,” which

---

254. See *Young*, 575 U.S. at 210 (explaining that an employer may have “legitimate, nondiscriminatory” reasons for denying a pregnant employee’s requested accommodation).

255. See, e.g., CAL. GOV’T CODE § 12945(a)(3)(A) (West 2020) (prohibiting an employer from “refus[ing] to provide reasonable accommodation for an employee for a condition related to pregnancy . . . if the employee so requests, with the advice of the employee’s health care provider”); 775 ILL. COMP. STAT. 5/2-102(J)(1) (2020) (defining a civil rights violation to include an employer’s failure to “make reasonable accommodations . . . related to pregnancy or childbirth, unless the employer can demonstrate that the accommodation would impose an undue hardship on the ordinary operation of the business of the employer”); MINN. STAT. § 181.9414 (2020) (requiring an employer to “provide reasonable accommodations to an employee for health conditions related to pregnancy or childbirth if she so requests, with the advice of her licensed health care provider or certified doula, unless the employer demonstrates that the accommodation would impose an undue hardship on the operation of the employer’s business”).

256. ROSS & SOLINGER, *supra* note 64, at 188.

257. See Kukura, *supra* note 29, at 730–35.

258. *Id.*

259. ROSS & SOLINGER, *supra* note 64, at 188.

260. Luna & Luker, *supra* note 65, at 340–41.

261. ROSS & SOLINGER, *supra* note 64, at 190.



focuses on the woman's rights within the "actual conditions of birth."<sup>262</sup> It is the "right to give birth with whom, where, when, and how a person chooses"<sup>263</sup> "without pressure or aggressive nonemergency interventions."<sup>264</sup> 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."<sup>265</sup> Additionally, birth justice recognizes the "right to determine their own birth plans, use midwives and doulas if they choose, and have home births or use freestanding birthing centers if they prefer."<sup>266</sup> Again, this is a right; reproductive justice recognizes that "deciding how one gives birth is an essential part of human dignity."<sup>267</sup> This right enables a woman's "pursuit of birth as an empowering experience free from coercion for all people, regardless of identity or circumstances."<sup>268</sup>

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."<sup>269</sup> 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."<sup>270</sup> In one study, 80% of those surveyed "report[ed] feeling angry

---

262. Luna & Luker, *supra* note 65, at 340–41; *see also* Solinger, *supra* note 214, at 42 (describing reproductive justice rights to include "[t]he right to decide among birthing options and access to those services").

263. ROSS & SOLINGER, *supra* note 64, at 262.

264. *Id.* at 190.

265. *Id.*

266. *Id.* at 188

267. Kukura, *supra* note 29, at 762.

268. *Id.*

269. Cacciatore, *supra* note 40, at 135.

270. Layne, *supra* note 243, 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, Karen Kavanaugh, L. Michele Issel, Kamal Eldeirawi & Kathleen L. Meert, *Experiences of African American Parents Following Perinatal or Pediatric Death: A Literature Review*, 38 DEATH STUD. 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 suspicion that doctors did not try as hard as possible to save their children due to the parents' insurance status. *Id.*

Another factor affecting all women's satisfaction with health care during miscarriage and stillbirth is doctors' reactions. Because of the high rate of miscarriage, physicians see miscarriages very often. LAYNE, *supra* note 169, 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." Kirkley-Best & Kellner, *supra* note 144, at 426. 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." Maureen C. Kelley & Susan B. Trinidad, *Silent Loss and the Clinical Encounter: Parents'*

about their care.”<sup>271</sup> 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.”<sup>272</sup>

Just as she 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.<sup>273</sup> With stillbirth, the concern is for forced vaginal delivery—that women desire a cesarean delivery and instead are forced to give birth vaginally.<sup>274</sup>

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.”<sup>275</sup> Delivery may be immediately necessary due to maternal conditions,<sup>276</sup> but absent those conditions, a woman could safely delay delivery for a short period if she so desires, giving her more time to process.<sup>277</sup>

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

---

*and Physicians’ Experiences of Stillbirth—A Qualitative Analysis*, BMC PREGNANCY & CHILDBIRTH, Nov. 27, 2012, at 1, 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.*

271. Layne, *supra* note 243, at 595.

272. ROYAL COLL. OF OBSTETRICIANS & GYNAECOLOGISTS, LATE INTRAUTERINE FETAL DEATH AND STILLBIRTH: GREEN-TOP GUIDELINE NO. 55, at 4 (2010), [https://www.rcog.org.uk/globalassets/documents/guidelines/gtg\\_55.pdf](https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_55.pdf) [<https://perma.cc/DG6Z-GJ CZ>] [hereinafter RCOG GUIDELINE]; Layne, *supra* note 243, 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. See *Saving Babies’ Lives*, *supra* note 153 (explaining England’s government mandate that its National Health Service reduce national stillbirth rates, including a national “ambition” to reduce the rates by 20% by 2020 and reduce them by 50% by 2025).

273. See Kukura, *supra* note 29, at 730–35.

274. See *infra* notes 278–281 and accompanying text.

275. Kelley & Trinidad, *supra* note 270, at 4.

276. RCOG GUIDELINE, *supra* note 272, at 12.

277. See *id.*

medically necessary) cesarean delivery.<sup>278</sup> Sometimes, women may incorrectly think “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.”<sup>279</sup> 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.”<sup>280</sup> 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.<sup>281</sup>

Whatever the reason, some women 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 should seek “to identify and understand [the] women’s thoughts and wishes but without trying to shape them.”<sup>282</sup> “Discussions should aim to support maternal/paternal choice.”<sup>283</sup> The doctor should provide the woman accurate information on “the risks and benefits of medical procedures,” including cesarean delivery.<sup>284</sup> 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.

---

278. See V. Flenady, F. Boyle, L. Koopmans, T. Wilson, W. Stones & J. Cacciatore, *Meeting the Needs of Parents After a Stillbirth or Neonatal Death*, 121 BJOG (SPECIAL ISSUE 4) 137, 139 (2014) (“A natural parental response is sometimes to request immediate operative delivery and a recommendation to proceed with labour and vaginal delivery may be construed as insensitive.”).

279. D. Siassakos, S. Jackson, K. Gleeson, C. Chebsey, A. Ellis & C. Storey, *All Bereaved Parents Are Entitled to Good Care After Stillbirth: A Mixed-Methods Multicentre Study (INSIGHT)*, 125 BJOG 160, 166 (2018).

280. Paul Richard Cassidy, *Care Quality Following Intrauterine Death in Spanish Hospitals: Results from an Online Survey*, BMC PREGNANCY & CHILDBIRTH, Jan. 10, 2018, at 1, 9.

281. Siassakos et al., *supra* note 279, at 166.

282. RCOG GUIDELINE, *supra* note 272, at 4. ACOG’s guidelines are less comprehensive on the topic of method of delivery. They state that the method of delivery should depend on the timing in pregnancy, the woman’s medical history, and “maternal preference.” Am. Coll. of Obstetricians & Gynecologists & Soc’y for Maternal-Fetal Med., *Management of Stillbirth*, 135 OBSTETRICS & GYNECOLOGY 747.e110, 747.e122 (2020) [hereinafter *Management of Stillbirth*]. ACOG does not emphasize that importance of the woman’s feeling in control. The guidelines do state that “[s]hared decision making plays an important role in determining the optimal method for delivery in the setting of fetal demise.” *Id.* Other language, however, is deferential to the doctor’s discretion: “Health care providers should weigh the risks and benefits of each strategy in a given clinical scenario and consider available institutional expertise,” and, “[i]n general, cesarean delivery for fetal demise should be reserved for unusual circumstances because it is associated with potential maternal morbidity without any fetal benefit.” *Id.* at 747.e122–23.

283. RCOG GUIDELINE, *supra* note 272, at 4.

284. Farah Diaz-Tello & Lynn Paltrow, *Birth Justice as Reproductive Justice* 3 (Nat’l Advocs. for Pregnant Women, Working Paper, 2012).

[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 imposed.<sup>285</sup>

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 twelve-week appointment that she has miscarried although she has had no symptoms.<sup>286</sup> An inevitable miscarriage occurs if the baby's heart is still beating but it stopped developing.<sup>287</sup> In either case, numerous treatment options exist—the woman can wait and miscarry naturally,<sup>288</sup> she can take the same medication used for a medicated abortion,<sup>289</sup> or she can have a surgery called a dilation and curettage (D&C) in which the doctor

---

285. Cassidy, *supra* note 280, at 9–10; *see also* Flenady et al., *supra* note 278, at 139 (“[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.”).

286. *Signs of Miscarriage*, *supra* note 98.

287. *Id.*

288. 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.” Layne, *supra* note 243, 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.” NAT’L INST. FOR HEALTH & CARE EXCELLENCE, ECTOPIC PREGNANCY AND MISCARRIAGE: DIAGNOSIS AND INITIAL MANAGEMENT 16–17 (2019), <https://www.nice.org.uk/guidance/ng126/resources/ectopic-pregnancy-and-miscarriage-diagnosis-and-initial-management-pdf-66141662244037> [<https://perma.cc/6YUT-Y8QT>].

289. Layne, *supra* note 243, at 587. Numerous women have complained that a pharmacist has been unwilling to fill a prescription for Misoprostol because of religious beliefs, even though the woman needs the drug because of miscarriage. *See, e.g.*, Elisha Fieldstadt, *Michigan Pharmacist Denies Woman Miscarriage Medication over Religious Beliefs*, NBC NEWS, (Oct. 18, 2018, 1:55 PM), <https://www.nbcnews.com/news/us-news/meijer-pharmacist-denies-michigan-woman-miscarriage-medication-citing-religious-beliefs-n921711> [<https://perma.cc/JDV3-3PM4>]; 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> [<https://perma.cc/S3EP-NDK9>].

removes the fetal tissue from the woman's uterus.<sup>290</sup> It does not appear common practice for a doctor to advise the woman of all these options.<sup>291</sup> 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.<sup>292</sup>

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.<sup>293</sup> 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.<sup>294</sup> Numerous women report being blindsided by a bill for a D&C; expensive bills only increase the difficulty of grieving.<sup>295</sup> 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 for treatment of a miscarriage.<sup>296</sup>

#### 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. “[E]conomic hardship, racism and discrimination, lack of social and professional support, and history of

---

290. *Signs of Miscarriage*, *supra* note 98.

291. ACOG Comm. on Prac. Bulls.—Gynecology, *ACOG Practice Bulletin No. 200: Early Pregnancy Loss*, 132 *OBSTETRICS & GYNECOLOGY* e197, e199 (2018) [hereinafter *Early Pregnancy Loss*] (explaining that if no complications exist, “[p]atients should be counseled about the risks and benefits of each option”).

292. Jessica Grose, *The Cost of a Miscarriage*, *SLATE* (Mar. 26, 2015, 3:30 AM), <https://slate.com/human-interest/2015/03/the-cost-of-a-miscarriage-we-talk-about-the-emotional-pain-but-not-the-financial-hurt.html> [https://perma.cc/4CXN-AZLX].

293. Catherine Pearson, *After Miscarriage Come the Bills*, *HUFFPOST* (Apr. 4, 2019), [https://www.huffpost.com/entry/after-a-miscarriage-next-come-the-bills\\_1\\_5c950630e4b0a6329e15eb83](https://www.huffpost.com/entry/after-a-miscarriage-next-come-the-bills_1_5c950630e4b0a6329e15eb83) [https://perma.cc/S99N-CXLX].

294. Grose, *supra* note 292.

295. *Id.*

296. Ayana Lage, *The Hidden Financial Toll of Having a Miscarriage*, *WASH. POST* (Dec. 11, 2019, 10:30 AM), <https://www.washingtonpost.com/lifestyle/2019/12/11/hidden-financial-toll-having-miscarriage/> [https://perma.cc/DHB8-DCZ9] (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. *Early Pregnancy Loss*, *supra* note 291, at e199, 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 292. The ACOG bulletin also mentions a U.S. study that concluded “that medical management with misoprostol was the most cost-effective intervention.” *Early Pregnancy Loss*, *supra* note 291, at e202. The practice bulletin does not indicate that the doctor should discuss costs with the patient.

illness and death in the family”<sup>297</sup> affect a woman’s experience. A marginalized woman can easily have an emotional experience different from a white woman of higher socioeconomic status. 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.”<sup>298</sup> The “realities of everyday life add[] to the burden African Americans face[] after the loss of a child”<sup>299</sup> — 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.”<sup>300</sup>

Individual circumstances and cultural values affect grief and access to support; Black women are “more likely to experience loss,” but “have limited access to bereavement support.”<sup>301</sup> Similarly, circumstances affect the effectiveness of different types of support.<sup>302</sup> 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, which . . . were higher than levels found in Caucasian mothers 18 months post loss.”<sup>303</sup>

Yet existing guidelines for emotional and mental health support after miscarriage and stillbirth are generalized. For instance, the United Kingdom’s Royal College of Obstetricians & Gynaecologists (“RCOG”) guidelines state that “[c]ounseling should be offered to all women and their partners,” “[p]arents should be advised about support groups,”<sup>304</sup> and that “[b]ereavement officers should be appointed to coordinate services.”<sup>305</sup> 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[ning] for follow-up.”<sup>306</sup> A new American College of Obstetricians & Gynecologists guideline released in March 2020 explains that “[p]atient support should

---

297. Boyden et al., *supra* note 270, at 379.

298. *Id.* at 375.

299. *Id.* at 376.

300. *Id.*; *see also id.* at 378 (“Racism, discrimination, economic disadvantage, and health disparities greatly influence bereavement and may create a high vulnerability to further disruption, loss, and trauma for many African Americans.” (citation omitted)).

301. Layne, *supra* note 243, at 594.

302. Paulina Van & Afaf I. Meleis, *Coping with Grief After Involuntary Pregnancy Loss: Perspectives of African American Women*, 32 J. OBSTETRIC GYNECOLOGIC & NEONATAL NURSING 28, 35 (2003) (explaining that “personal relationships and religious, spiritual, and cultural beliefs are significant factors that may” affect the effectiveness of support).

303. Boyden et al., *supra* note 270, at 378 (citation omitted).

304. RCOG GUIDELINE, *supra* note 272, at 18.

305. *Id.* at 19.

306. *Id.* at 25–26.

include emotional support” and includes a list a components of bereavement care: “good communication; shared decision making; recognition of parenthood; acknowledgement of a partners’ [sic] and families’ grief . . . ongoing emotional and practical support; health professionals trained in bereavement care; and health professionals with access to self-care.”<sup>307</sup> It also explains that “[r]eferral to a bereavement counselor, peer support group, or mental health professional may be advisable for management of grief and depression.”<sup>308</sup>

Notably, the RCOG guidelines do note that “[c]arers should be aware of and responsive to possible variations in individual and cultural approaches to death.”<sup>309</sup> The new 2020 ACOG guidelines also note that “[b]ereavement care should be individualized to recognize bereaved parents’ personal, cultural, or religious needs.”<sup>310</sup> This is consistent with the reproductive justice framework, to recognize that marginalized women do experience miscarriage and stillbirth differently due to their circumstances.

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 be given the opportunity to hold their stillborn baby, a measure that researchers almost unanimously agree is beneficial for parents.<sup>311</sup> In studies, almost no parent expresses regret over holding the baby, but almost all express regret over not holding the baby.<sup>312</sup> “Holding the baby gives the mother an opportunity to nurture her baby, a chance for her to care for the baby, which can be seen as a natural biological reaction after giving birth”<sup>313</sup>—an opportunity to parent her child. In one survey, nearly all the mothers who held their baby reported feeling “tenderness, warmth and grief . . . while some also felt pride.”<sup>314</sup> Holding the baby is such an important part of grief resolution that guidelines advise

---

307. *Management of Stillbirth*, *supra* note 282, at 747.e123–24.

308. *Id.* at 747.e124.

309. RCOG GUIDELINE, *supra* note 272, at 18.

310. *Management of Stillbirth*, *supra* note 282, at 747.e123.

311. Kirkley-Best & Kellner, *supra* note 144, at 426 (describing that research shows “almost unanimous agreement that seeing and holding the infant is helpful in successful grief resolution”). Offering the stillborn baby to the parents is now part of the modern standard of care—“to offer grieving parents repeated and extended opportunities to have close contact with their baby.” PREGNANCY LOSS & INFANT DEATH ALL., *supra* note 143, at 2; *see also* Cacciatore, *supra* note 143, at 93 (“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.”); Sanger, *supra* note 143, at 283–85 (describing changes in hospitals allowing parents to spend time with the infant and preparing memory boxes for parents).

312. *See* Murphy & Cacciatore, *supra* note 144, at 130.

313. Ingela Rådestad, Karin Säflund, Regina Wredling, Erik Onelöv & Gunnar Stelneck, *Holding a Stillborn Baby: Mothers’ Feelings of Tenderness and Grief*, 17 BRIT. J. MIDWIFERY 178, 179 (2009).

314. *Id.*

medical professionals to continue to ask parents in the hours after birth as “[t]he opportunity for contact is fleeting and final.”<sup>315</sup>

But some parents may be especially hesitant to hold their stillborn baby, especially Black fathers.<sup>316</sup> Parents may need appropriate encouragement from health professionals whose words and conducts will affect a parent’s decision.<sup>317</sup> “[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 bathe, dress or sleep next to their baby, and how the passing of time will alter the baby’s temperature, appearance, and touch.”<sup>318</sup> In one study, most African American “fathers were very reluctant to hold their baby but did so with encouragement from nurses or family members.”<sup>319</sup>

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.”<sup>320</sup>

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.”<sup>321</sup> 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.<sup>322</sup>

Similarly, in a 2005 study of low-income African American parents after perinatal death, *no* participant attended a support group. “This finding

---

315. Carol Kingdon, Emer O’Donnell, Jennifer Givens & Mark Turner, *The Role of Healthcare Professionals in Encouraging Parents to See and Hold Their Stillborn Baby: A Meta-Synthesis of Qualitative Studies*, PLOS ONE, July 8, 2015, at 1, 17.

316. Karen Kavanaugh & Patricia Hershberger, *Perinatal Loss in Low-Income African American Parents*, 34 J. OBSTETRIC GYNECOLOGIC & NEONATAL NURSING 595, 603–04 (2005).

317. Kingdon et al., *supra* note 315, at 15 (“The behaviour and opinions expressed by healthcare professionals were found to be especially pertinent in the decision making processes of parents.”).

318. *Id.* at 16.

319. Kavanaugh & Hershberger, *supra* note 316, at 601.

320. Cacciatore, *supra* note 109, at 83–84.

321. Van & Meleis, *supra* note 302, at 32.

322. *Id.* (alterations in original).



suggests that traditional mechanisms for providing follow-up care for parents after a perinatal loss, such as making a referral to a hospital-based parent support group, may not be appropriate for these parents.”<sup>323</sup>

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.”<sup>324</sup> Parents with a lower socioeconomic status are likely to experience “greater despair and higher levels of depression” due to funeral and burial expenses.<sup>325</sup> Medical professionals should thus “direct[] parents to financial assistance for burial services.”<sup>326</sup> 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 deaths 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.”<sup>327</sup> 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 these parents, and the necessity of culturally sensitive healthcare and bereavement supports following the death of a child.”<sup>328</sup>

#### *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 obligates the state to provide “social supports” to help women raise their children in “safe and healthy environments.”<sup>329</sup> These necessary social supports include affordable housing and quality public education among many others.<sup>330</sup> Reproductive justice thus recognizes the connection between the state and parenting.<sup>331</sup>

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 living children by highlighting

---

323. Kavanaugh & Hershberger, *supra* note 316, at 604.

324. Boyden et al., *supra* note 270, at 378.

325. *Id.* at 376 (citation omitted).

326. *Id.* at 379.

327. Van & Meleis, *supra* note 302, 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 addressed in IPL [involuntary pregnancy loss] literature”).

328. Boyden et al., *supra* note 270, at 379.

329. ROSS & SOLINGER, *supra* note 64, at 168–69.

330. *Id.* at 170.

331. *Id.* at 169–70.

infertility,<sup>332</sup> a special concern for reproductive justice given the disparity in access. “Pursuing fertility treatments is a class privilege,” and usually one pursued by only wealthier, white women.<sup>333</sup> Notably, some studies have found a connection between the use of artificial reproductive technologies and stillbirth.<sup>334</sup> 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.”<sup>335</sup> 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 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.<sup>336</sup> 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.”<sup>337</sup> 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

---

332. Chrisler, *supra* note 80, at 13.

333. Rickie Solinger, *The Incompatibility of Neo-Liberal “Choice” and Reproductive Justice*, in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE, *supra* note 81, at 39, 39 (“Pursuing fertility treatments is a class privilege.”); Seema Mohapatra, *Fertility Preservation for Medical Reasons and Reproductive Justice*, 30 HARV. J. RACIAL & ETHNIC JUST. 193, 211–12 (2014); Madeline Curtis, Note, *Inconceivable: How Barriers to Infertility Treatment for Low-Income Women Amount to Reproductive Oppression*, 25 GEO. J. ON POVERTY L. & POL’Y 323, 341–42 (2018).

334. Notably, some studies have found a connection between the use of artificial reproductive technologies and stillbirth. See A.A. Henningsen et al., *Trends in Perinatal Health After Assisted Reproduction: A Nordic Study from the CoNARTaS Group*, 30 HUM. REPROD. 710 (2015); Jennifer L. Marino et al., *Perinatal Outcomes by Mode of Assisted Conception and Sub-Fertility in an Australian Data Linkage Cohort*, PLOS ONE, Jan. 8, 2014, at 1; K. Wisborg, H.J. Ingerslev & T.B. Henriksen, *IVF and Stillbirth: A Prospective Follow-Up Study*, 25 HUM. REPROD. 1312 (2010).

335. ROSS & SOLINGER, *supra* note 64, at 172.

336. See, e.g., Joanne Cacciatore & Suzanne Bushfield, *Stillbirth: The Mother’s Experience and Implications for Improving Care*, 3 J. SOC. WORK. END-OF-LIFE PALLIATIVE CARE, no. 3, 2007, at 59; Kelley & Trinidad, *supra* note 270; Kirkley-Best & Kellner, *supra* note 144; Joanne Cacciatore, John DeFrain & Kara L. C. Jones, *When a Baby Dies: Ambiguity and Stillbirth*, 44 MARRIAGE & FAM. REV. 439, 443 (2008); Vicki J. Flenady, Christine Carroll & Ros M. Richardson, *Support for Parents Following Stillbirth*, 197 MED. J. AUSTL. 276 (2012); Karen Kavanaugh & Teresa Moro, *Supporting Parents After Stillbirth or Newborn Death*, AM. J. NURSING, Sept. 2006, at 74; A.E.P. Heazell et al., *A Difficult Conversation? The Views and Experiences of Parents and Professionals on the Consent Process for Perinatal Postmortem After Stillbirth*, 119 BJOG 987 (2012); Suzanne Pullen, Mindi Ann Golden & Joanne Cacciatore, *“I’ll Never Forget Those Cold Words as Long as I Live”: Parent Perceptions of Death Notification for Stillbirth*, 8 J. SOC. WORK. END-OF-LIFE PALLIATIVE CARE 339 (2012).

337. Kelley & Trinidad, *supra* note 270, at 10.

baby had an enduring importance as a human being that mattered.”<sup>338</sup> Similarly, parents emphasized the importance of recognizing their “stillborn baby as a real baby, the baby’s unique identity.”<sup>339</sup> Parents explained that their baby’s identity existed both before his birth and after; “all parents gave a name to their baby.”<sup>340</sup> 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.<sup>341</sup> Mothers explained that they had a “strong ongoing relationship with their baby” before death.<sup>342</sup>

As a group, women are more likely to still identify as mothers after stillbirth than they are after miscarriage.<sup>343</sup> Studies have also shown that levels of prenatal bonding increase as the pregnancy progresses.<sup>344</sup> As many have pointed out, it is true that technology has enabled bonding earlier than in the past, but the first transabdominal ultrasound (when a baby with baby parts is first visible) still does not occur until around twenty weeks. This is not to say that some women who miscarry don’t also see themselves as mothers to their unborn children; some do.<sup>345</sup> But on the whole, women are more likely to identify themselves as mothers of their unborn children after stillbirth than are women after miscarriage.<sup>346</sup>

---

338. Daniel Nuzum, Sarah Meaney & Keelin O’Donoghue, *The Impact of Stillbirth on Bereaved Parents: A Qualitative Study*, PLOS ONE, Jan. 24, 2018, at 1, 5.

339. *Id.*

340. *Id.* at 6; see also Kelley & Trinidad, *supra* note 270, at 10 (explaining that all parents surveyed had named their (stillborn) child).

341. Nuzum et al., *supra* note 338, at 5.

342. *Id.* at 8.

343. A study published in 2017 measured self-esteem of women following miscarriage, stillbirth, and child death, explaining that self-esteem is heavily associated with identity as mother maternal identity. See Patricia Wonch Hill, Joanne Cacciatore, Karina M. Shreffler & Kayla M. Pritchard, *The Loss of Self: The Effect of Miscarriage, Stillbirth, and Child Death on Maternal Self-Esteem*, 41 DEATH STUD. 226, 226–27 (2017). The study explained that “[p]erinatal losses may differentially impact self-esteem depending on a woman’s internal ‘Becoming a Mother’ process; miscarriage may be less of an identity-relevant stressor than stillbirth, and stillbirth less so than child loss.” *Id.* at 229. The study did find that “[s]elf-esteem is lower among women who experienced the death of a baby to stillbirth or the death of a child (3.30 and 3.32) than for women with no losses or miscarriage only (3.48 and 3.51,  $p < .01$ .” *Id.* at 230. Ultimately the authors found “significant differences between women who experienced stillbirth or child death and women who experienced miscarriage or did not experience a loss.” *Id.*

344. Anna Maria Della Vedova, Francesca Dabrassi & Antonio Imbasciati, *Assessing Prenatal Attachment in a Sample of Italian Women*, 26 J. REPROD. & INFANT PSYCH. 86, 89, 95 (2008) (concluding that “prenatal attachment scores increase with the weeks of gestation”).

345. Rowe & Hawkey, *supra* note 146, at 299 (explaining that some “women attribute personhood to their foetus and are emotionally invested in their pregnancy from the earliest weeks”).

346. 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 nineteen weeks versus the woman who gives birth to her stillborn child at twenty-one weeks. A woman draws the line for herself, but the law cannot rely on each woman’s subjective line.

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,<sup>347</sup> now often called a fetal death certificate. The child's name is listed on the certificate if the parents so desire.<sup>348</sup> Some evidence also exists that states historically also issued a birth certificate for stillbirth. The birth certificate had a box to check for either live birth or stillbirth. 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."<sup>349</sup> 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.<sup>350</sup> Missouri's statutory mandate specifically defines "either or both the biological mother or father of a stillborn child" as the

---

Notably, other institutions draw a later line dividing miscarriage and stillbirth. England's dividing line between miscarriage and stillbirth is at twenty-four weeks. *Overview: Stillbirth*, NAT'L HEALTH SERV. (Feb. 8, 2018), <https://www.nhs.uk/conditions/stillbirth/> [<https://perma.cc/323Z-JASA>]. The World Health Organization's line is at twenty-eight weeks. *Maternal, Newborn, Child, and Adolescent Health: Stillbirths*, WORLD HEALTH ORG., [https://www.who.int/maternal\\_child\\_adolescent/epidemiology/stillbirth/en/](https://www.who.int/maternal_child_adolescent/epidemiology/stillbirth/en/) [<https://perma.cc/V7ZH-ZMCK>]. In the United States, abortion jurisprudence draws a line at viability, which is generally thought of as at twenty-four weeks of pregnancy. *Roe v. Wade*, 410 U.S. 113, 163 (1973) (explaining that at viability, "the fetus then presumably has the capability of 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 claims after stillbirth. See Jill Wieber Lens, *Tort Law's Devaluation of Stillbirth*, 19 NEV. L.J. 955, 1004 (2019). If anything, these examples support a line later than twenty 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.

347. MICHAEL J. SIRI & DANIEL L. CORK, VITAL STATISTICS: SUMMARY OF A WORKSHOP 90 (2009) ("Fetal deaths of 20 weeks of gestation and greater have been a reportable component of U.S. vital statistics since the 1920s."). States are free to set their own requirement of when a fetal death certificate is recorded based either on the fetus's weight or gestational age, although the large majority of states require a fetal death certificate if the fetus is at or past twenty weeks of gestation. NAT'L CTR. FOR HEALTH STAT., U.S. DEP'T OF HEALTH & HUM. SERVS., STATE DEFINITIONS AND REPORTING REQUIREMENTS FOR LIVE BIRTHS, FETAL DEATHS, AND INDUCED TERMINATIONS OF PREGNANCY 3 (1997). 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. NAT'L CTR. FOR HEALTH STAT., U.S. DEP'T OF HEALTH & HUM. SERVS., FUNERAL DIRECTORS' HANDBOOK ON DEATH REGISTRATION AND FETAL DEATH REPORTING 2 (2003) [hereinafter FUNERAL DIRECTORS' HANDBOOK]. That data could also indicate causes like "environmental and occupational exposures of parents on the fetus." *Id.* The data are also "essential in planning and evaluating prenatal care services and obstetrical programs." *Id.*

348. FUNERAL DIRECTORS' HANDBOOK, *supra* note 347, at 32.

349. *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.*

350. See, e.g., CAL. HEALTH & SAFETY CODE § 7100(a)(4) (West 2020); ARIZ. REV. STAT. ANN. § 36-831 (2020); MO. REV. STAT. § 194.200 (2020); WIS. STAT. § 69.18 (2020).

“parents” of the “stillborn child.”<sup>351</sup> Wisconsin’s statute also uses the language “parent of the stillbirth.”<sup>352</sup>

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 identical 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 are responsible for their child’s final disposition. One difference does exist between their experiences though—that first breath 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 gestational development, such a cutoff makes little sense medically and is essentially arbitrary.”<sup>353</sup>

Numerous legal measures exist that affirm the parenthood of a mother whose baby dies shortly after birth. They include state issuance of birth and death certificates,<sup>354</sup> a tax benefit,<sup>355</sup> and the availability of a wrongful death claim if the baby’s death was due to tortious conduct.<sup>356</sup>

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 already allow issuance of a stillbirth birth certificate if parents request one<sup>357</sup> and apply wrongful death tort law to stillbirth.<sup>358</sup> Only a few states, however, recognize tax benefits for parents after stillbirth; the vast majority of the states and the federal government do not.<sup>359</sup> 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.<sup>360</sup> All of these

---

351. MO. REV. STAT. § 194.200.

352. WIS. STAT. § 69.18.

353. Kelley & Trinidad, *supra* note 270, at 13.

354. See *Levin v. N.Y.C. Health & Hosps. Corp.*, 990 N.Y.S.2d 490, 492 (N.Y. App. Div. 2014) (describing that baby “lived for approximately 3½ hours, as evidenced by her . . . birth and death certificates”).

355. See *infra* Section III.E.1.

356. See *infra* Section III.E.3.

357. See *infra* Section III.E.2.

358. See *infra* Section III.E.3.

359. See *infra* Section III.E.1.

360. These suggested measures are very conservative given that the United States recognizes only limited social support for parents of healthy children (*e.g.*, no paid parental leave after birth). Other countries have very broad legal affirmations of parenthood after stillbirth. For example, in the UK, women are entitled to the same parental leave after stillbirth that they would receive after the birth of a living child. Sally Maitlis & Gianpiero Petriglieri, *Going Back to Work After a Pregnancy Loss*, HARV.

recognitive measures should be available to those women who desire them, to those women who identify as a mother to their stillborn children and desire recognition of that identification.

States' previous adoptions of some of these measures have generated controversy and opposition, mostly from pro-choice groups.<sup>361</sup> 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 antiabortion movement was legal treatment of an unborn fetus the same as a living child.<sup>362</sup>

The controversy disappears, however, when the measures are viewed through the reproductive justice lens—a lens that recognizes the equally important rights to not have a child, to have a child, and to parent that child. The reproductive justice movement recognizes that these rights are not a zero-sum game; a measure affirming the right to parent does not negate the right to not be a parent.

Each of these suggested measures—tax recognition, stillbirth birth certificates, wrongful death causes of action, and autopsies—legally affirms a woman's motherhood of her stillborn child, consistent with reproductive justice's right to parent. The reproductive justice lens also reveals the necessity of these measures especially for marginalized women, specifically those of lower economic status.

### 1. Tax Recognition After Stillbirth<sup>363</sup>

Federal tax law has long allowed a type of tax benefit for parents. Until 2018, parents were able to claim children as dependents and allowed a

---

BUS. REV. (Dec. 5, 2019), <https://hbr.org/2019/12/going-back-to-work-after-a-pregnancy-loss> [<https://perma.cc/JY3Z-459C>]. Australia recently passed a law allowing parents up to a year off work to grieve their child, guaranteeing “entitlements” that “match the leave parents of healthy babies can access.” Katina Curtis, *More Leave on Offer for Grieving Parents After Stillbirths*, SYDNEY MORNING HERALD (Sept. 3, 2020), <https://www.smh.com.au/politics/federal/more-leave-on-offer-for-grieving-parents-after-stillbirths-20200902-p555rmh.html> [<https://perma.cc/R9Y3-PB4C>]. Another example is the Children's Funeral Fund for England, which helps parents pay for the costs of a funeral after the death of a child under the age of eighteen or a baby stillborn after the twenty-fourth week of pregnancy. *See Support for Child Funeral Costs (Children's Funeral Fund for England)*, GOV.UK, <https://www.gov.uk/child-funeral-costs> [<https://perma.cc/J9QN-RJXG>] [hereinafter *Children's Funeral Fund*].

361. *See infra* notes 374, 391–403 and accompanying text.

362. De Ville & Kopelman, *supra* note 165, at 335 (explaining that 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”).

363. 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. *When to Start Buying Baby Stuff During Pregnancy (And Before It!)*, NAT. BABY LIFE, <https://naturalbabylife.com/when-should-you-start-shopping-for-baby-stuff-why-to-wait/> [<https://perma.cc/9A38-H6QB>] (explaining that most women wait until at least after the first twelve weeks of pregnancy to buy supplies due to the risk of miscarriage, the same time at which most women share their pregnancy news publicly).

personal exemption or deduction for each child.<sup>364</sup> 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.”<sup>365</sup> And thus the dependent exemption “treat[ed] the larger family more generously on ability-to-pay grounds and imposes a lower tax liability.”<sup>366</sup> The tax law changed in 2019, eliminating personal exemptions but also increasing the amount of the now refundable child tax credit.<sup>367</sup> 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 can still be claimed in the year that their child dies.<sup>368</sup> 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, federal law does not allow the parents any sort of tax benefit.<sup>369</sup> 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

---

364. JOEL SLEMROD & JON BAKIJA, *TAXING OURSELVES: A CITIZEN’S GUIDE TO THE DEBATE OVER TAXES* 92 (4th ed. 2008).

365. *Id.*

366. *Id.*

367. Matthew Frankel, *2019 Tax Changes: Everything You Need to Know*, THE MOTLEY FOOL (Aug. 7, 2019, 5:15 PM), <https://www.fool.com/taxes/2019-tax-changes-everything-you-need-to-know.aspx> [<https://perma.cc/P8PT-8MY5>] (explaining how the personal exemption was likely more beneficial for parents with many children than the expanded child tax credit).

368. *Frequently Asked Questions: Qualifying Child Rules 1*, IRS, <https://www.irs.gov/faqs/earned-income-tax-credit/qualifying-child-rules/qualifying-child-rules-1> [<https://perma.cc/434Q-GAA6>]; see also Kelly Phillips Erb, *Death and Taxes and Children*, FORBES (Dec. 19, 2011, 7:58 AM), <https://www.forbes.com/sites/kellyphillipserb/2011/12/19/death-and-taxes-and-children/#2fa1404017f5> [<https://perma.cc/P7FX-LSFQ>] (explaining that “a child who dies shortly after birth can be considered a dependent.”).

369. *Frequently Asked Questions: Qualifying Child Rules 1*, *supra* note 368; see also Erb, *supra* note 368 (explaining that “[a] child who dies before birth is not considered a dependent”).

in which the child is stillborn.<sup>370</sup> 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.<sup>371</sup> 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.<sup>372</sup>

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.”<sup>373</sup> 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.”<sup>374</sup>

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 this status: “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.”<sup>375</sup> Similarly, a bereaved mother expressing gratitude for state tax benefits explained that, to her, a tax benefit “has a much deeper meaning

---

370. ARIZ. REV. STAT. ANN. § 43-1023 (2020) (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 § 206.30 (2020) (allowing a taxpayer to “claim an additional exemption . . . in the tax year for which the taxpayer has a certificate of stillbirth”); MO. REV. STAT. § 143.161 (2020) (allowing a taxpayer to deduct \$1,200 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 § 57-38-30.3 (2020) (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”).

371. MINN. STAT. § 290.0685 (2020).

372. *Id.*

373. *Despite Bipartisan Support, Still Birth Tax Credit Bill Fails to Advance*, CAL. CATH. CONF. (May 31, 2018), <https://cacatholic.org/article/despite-bipartisan-support-still-birth-tax-credit-bill-fails-to-advance> [<https://perma.cc/Z6NM-A25K>].

374. 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 dependent tax exemptions to the stillborn’s parents in the year of the birth”).

375. Danielle Pollock, Elissa Pearson, Megan Cooper, Tahereh Ziaian, Claire Foord & Jane Warland, *Voices of the Unheard: A Qualitative Survey Exploring Bereaved Parents Experiences of Stillbirth Stigma*, 33 WOMEN & BIRTH 165, 170 (2020).



than money” by providing “acknowledgment” of her parenthood and raising “awareness.”<sup>376</sup>

Second, a tax benefit provides practical assistance and support to parents for the surprising costs of stillbirth,<sup>377</sup> 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.<sup>378</sup> This includes costs for the birth, the hospital stay, and tests.<sup>379</sup> These increased medical costs may also be higher due to any maternal health complications that contributed to the stillbirth.<sup>380</sup> 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.<sup>381</sup> Some parents in the United States turn to *GoFundMe* to try to raise money to cover their funeral costs.<sup>382</sup>

These costs add up quickly, especially for women of lower socioeconomic status. When the North Dakota legislature unanimously passed its bill creating this tax deduction, the proponents explained that this will help ease the financial burden of both childbirth and funeral costs.<sup>383</sup> 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.<sup>384</sup> They were insured, but still

---

376. 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/> [https://perma.cc/87L3-PBME].

377. 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, 9:38 AM), <https://www.vox.com/the-highlight/2019/7/23/20698480/stillborn-stillbirth-baby-costs-expensive> [https://perma.cc/7DXW-6UUR].

378. See Katherine J. Gold, Ananda Sen & Xiao Xu, *Hospital Costs Associated with Stillbirth Delivery*, 17 MATERNAL & CHILD HEALTH J. 1835 (2013).

379. *Id.*

380. *Id.*

381. Hess, *supra* note 377 (explaining that “most life insurance companies only cover children who are between 14 days and 18 years old” but that the Veterans Administration “amended their life insurance policy to include stillborns for dependent child coverage” in 2014).

382. See, e.g., *Baby Kayden’s Funeral*, GOFUNDME, <https://www.gofundme.com/f/baby-kaydens-funeral> [https://perma.cc/J25J-9CKY]; *Baby “JoJo’s” Funeral, Medical Cost*, GOFUNDME, <https://www.gofundme.com/f/babies-funeral-and-medical-cost039s> [https://perma.cc/4R9N-AZTX]. 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 18 or a baby stillborn after the 24th week of pregnancy.” *Children’s Funeral Fund*, *supra* note 360.

383. Nick Smith, *Stillborn Tax Exemption Bill Sees No Opposition*, BISMARCK TRIB. (Mar. 8, 2017), [https://bismarcktribune.com/news/local/govt-and-politics/stillborn-tax-exemption-bill-sees-no-opposition/article\\_3f98c934-b708-5505-9f7e-340481e4655a.html](https://bismarcktribune.com/news/local/govt-and-politics/stillborn-tax-exemption-bill-sees-no-opposition/article_3f98c934-b708-5505-9f7e-340481e4655a.html) [https://perma.cc/529Q-LYPQ].

384. Lee Ann Schutz, *Tax Credit Proposed to Help Parents Who Have Stillborn Child but Still Face Costs*, SESSION DAILY (Apr. 12, 2016, 2:32 PM), <https://www.house.leg.state.mn.us/sessiondaily/SDView.aspx?StoryID=10119> [https://perma.cc/8AD6-RA7T].

had “co-pays, deductibles and other expenses” and their claim for life insurance benefits for their son was denied.<sup>385</sup> 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.

A tax benefit for parents after stillbirth neither acknowledges that life begins in the womb nor does it demonstrate how prenatal life can take off on its own. Instead, consistent with reproductive justice’s right to parent, a tax credit after stillbirth acknowledges parenthood and provides financial assistance. Moreover, 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*<sup>386</sup>

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,<sup>387</sup> which makes sense given the “physiologically identical”<sup>388</sup> experiences of childbirth. At some point, however, this practice stopped. And states started requiring issuance of only death certificates—“fetal death certificates”—after stillbirth.<sup>389</sup>

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)

---

385. *Id.*

386. A birth certificate would not be appropriate for miscarriage as, generally speaking, miscarriage does not involve childbirth; miscarriage is physiologically distinct. Further, unlike stillbirth, no history of issuing birth certificates for miscarriage exists and fetal death certificates are not currently issued for miscarriage. *See, e.g.*, UTAH CODE ANN. § 26-2-2 (West 2020) (defining fetal death as a fetus after 20 weeks gestation); MD. CODE ANN., HEALTH-GEN. § 4-213 (LexisNexis 2020) (same); N.J. STAT. ANN. § 26:6-11 (West 2020) (same).

387. *See* State v. Norvell, 191 S.W. 536, 537 (Tenn. 1917) (discussing Tennessee’s 1913 Vital Statistics Law).

388. Cacciatore, *supra* note 40, at 135.

389. *See, e.g.*, UTAH CODE ANN. § 26-2-14 (West 2020); MD. CODE ANN., HEALTH-GEN. §§ 4-213 to -213.1 (LexisNexis 2020); N.J. STAT. ANN. § 26:6-11.

Foundation and began lobbying state legislatures to create something akin to a birth certificate for stillbirth. Around thirty-four states currently have some version of a Certificate of Birth Resulting in Stillbirth or a Certificate of Stillbirth available to bereaved parents.<sup>390</sup>

The fiercest opposition to birth certificates came from the reproductive rights movement. “Supporters of legal abortion have 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.”<sup>391</sup> Birth certificates would “deepen[] cultural familiarity with the idea of prenatal death as the loss of a *child*,” which fits too well in the antiabortion political strategy of getting fetuses defined as infants and children.<sup>392</sup> 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,”<sup>393</sup> would be a step toward acknowledging fetal

---

390. This is according to the M.I.S.S. Foundation’s website. *MISSing Angels Bill (MAB) Legislation - State Chart: What is the Missing Angels Bill?*, M.I.S.S. FOUND., [http://www.missingangelsbill.org/index.php?option=com\\_content&view=article&id=76&Itemid%20=61%20](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. § 382.0086 (2020). 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 practitioner . . . attends or diagnoses [the] nonviable birth” or if it occurs at a “health care facility.” *Id.* Additionally, the “Certificate of Nonviable Birth” lacks the same details as a fetal death certificate, details like the cause of death. *See id.* 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. § 71-607 (2020); *id.* 71-606. Nebraska law requires a fetal death certificate only for a stillbirth. *Id.* 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 twelve weeks. ARK. CODE ANN. § 20-18-410 (2020). Arkansas’s conflation of miscarriage and stillbirth is especially dangerous because it strengthens the (inaccurate) fatalism surrounding stillbirth. *See* Cacciatore & Lens, *supra* note 152, at 310. Notably, the M.I.S.S. Foundation opposes the issuance of any certificates for miscarriage. *See MISSing Angels Bill (MAB) Legislation - State Chart: What is the Missing Angels Bill?*, *supra*.

391. Sanger, *supra* note 143, 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 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. *Id.* at 291–305.

392. *Id.* at 305.

393. Allison Stevens, *The Politics of Stillbirth*, AM. PROSPECT (July 14, 2007), <http://prospect.org/article/politics-stillbirth> [<https://perma.cc/S2BB-DTDN>].

personhood,<sup>394</sup> would “legitimize” the life of an unborn baby,<sup>395</sup> and would “push anti-choice groups one step further in their quest to make abortion tantamount to murder.”<sup>396</sup> The slippery slope was raised: might, for example, states start issuing or even requiring birth certificates for aborted fetuses?<sup>397</sup> Former Governor of New Mexico Bill Richardson even vetoed a popular stillbirth birth certificate bill.<sup>398</sup> 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.<sup>399</sup>

But when viewed through the lens of reproductive justice instead of reproductive rights, these measures are not controversial.<sup>400</sup> The stillbirth birth certificate acknowledges the mother’s motherhood—that she has a child who both was born and died. It provides mothers some acknowledgement of their child’s birth and existence beyond his death. The reproductive justice movement broadly and appropriately recognizes both a woman’s right to legal acknowledgment that she gave birth to a stillborn child and a woman’s right to abortion.

### 3. Tort Claims<sup>401</sup>

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,

---

394. Ilene Lelechuk, *Wrenching Politics Surround Stillborns / Bereft Moms Want Birth Papers, but Abortion Complicates Issue*, SFGATE (Jan. 16, 2012, 6:52 AM), <https://www.sfgate.com/news/article/Wrenching-politics-surround-stillborns-Bereft-2565630.php> [<https://perma.cc/Z7NM-B7AP>] (“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.”).

395. Jacqueline Feldman, *Mothers of Stillborns to Get Birth, not Death, Certificates*, PITTSBURGH POST-GAZETTE (July 25, 2011, 3:00 AM), <https://www.post-gazette.com/news/state/2011/07/25/Mothers-of-stillborns-to-get-birth-not-death-certificate/stories/201107250179> [<https://perma.cc/8CSW-BH9U>] (“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 . . .”).

396. Stevens, *supra* note 393.

397. *Id.*

398. *Id.*

399. *Id.*; see also Carol Sanger, *Legislating with Affect: Emotion and Legislative Law Making*, in *PASSIONS AND EMOTIONS* 38, 63 (James E. 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”).

400. Cacciatore did what she could do to distance the M.I.S.S. Foundation from the abortion debate. See Stevens, *supra* note 393. 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 143, at 307–08 (discussing the compromises reached in state legislatures that passed stillbirth birth certificates); Stevens, *supra* note 393.

401. I have previously explained why tort wrongful death claims should be available for stillbirth, but not for miscarriage. See Lens, *supra* note 346, at 1005. 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, making it difficult for women to recover under these claims. *Id.* at 973–74.

the same claim available to parents if their living child's death is due to tortious conduct. Like stillbirth birth certificates, a majority of states recognize this type of wrongful death claim.<sup>402</sup> 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,”<sup>403</sup> strengthening the antiabortion fetal personhood argument.<sup>404</sup>

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.”<sup>405</sup> 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<sup>406</sup>

No other test is as effective as an autopsy in determining the cause of stillbirth.<sup>407</sup> Medical guidelines recommend autopsies following stillbirth,

402. *Id.* at 969.

403. Sanger, *supra* note 143, at 305.

404. I have previously argued the consistency between applying wrongful death claims to stillbirth and the reproductive rights movement. Lens, *supra* note 346, 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, Note, *Fetal Personhood After the Unborn Victims of Violence Act*, 58 RUTGERS L. REV. 553 (2006); Erica Richards, Note, *Loss of Potential Parenthood As a Statutory Solution to the Conflict Between Wrongful Death Remedies and Roe v. Wade*, 63 WASH. & LEE L. REV. 809, 810 (2006); Amy Lotierzo, Comment, *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., Special Project, *Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth*, 39 VAND. L. REV. 597 (1986).

405. Imani Gandy, *Alabama's Wrongful Death Suit for Nonviable Fetus Raises Thorny Reproductive Rights Questions*, REWIRE NEWS GRP. (Jan. 11, 2017, 2:32 PM), <https://rewire.news/article/2017/01/11/alabama-wrongful-death-fetus-reproductive-rights/> [<https://perma.cc/7J2Q-Z84N>].

406. 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, [http://www.aetna.com/cpb/medical/data/300\\_399/0348.html](http://www.aetna.com/cpb/medical/data/300_399/0348.html) [<https://perma.cc/8HFR-6YY5>]; CIGNA, *RECURRENT PREGNANCY LOSS: DIAGNOSIS AND TREATMENT (2020)*, [https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm\\_0284\\_coveragepositioncriteria\\_recurrent\\_pregnancy\\_loss.pdf](https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0284_coveragepositioncriteria_recurrent_pregnancy_loss.pdf) [<https://perma.cc/GCR4-TJ83>]. 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.

407. RCOG GUIDELINE, *supra* note 272, at 10–11.

yet current estimates are that autopsies occur in only 30–40% of stillbirths in the United States.<sup>408</sup> The main reason for this is the cost—at least \$1000, \$1500, or more.<sup>409</sup> Insurance may or may not cover the cost of an autopsy following stillbirth.<sup>410</sup> The chances of coverage are greater with private insurance.<sup>411</sup> 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% of the federal poverty level,<sup>412</sup> the same women who face a higher risk of stillbirth due to their socioeconomic status.<sup>413</sup> No state Medicaid plan covers the cost of an autopsy after a child’s stillbirth.<sup>414</sup>

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.<sup>415</sup> Parents after stillbirth, especially those women who were insured via Medicaid, will have to make choices about what costs are necessary and which are not. An autopsy that may not reveal the cause of death quickly falls into the ‘unnecessary’ column.

---

408. Sarah Muthler, *Stillbirth is More Common than You Think—And We’re Doing Little About It*, WASH. POST (May 16, 2016, 5:00 AM), <https://www.washingtonpost.com/posteverything/wp/2016/05/16/stillbirth-is-more-common-than-you-think-and-were-doing-little-about-it/> [https://perma.cc/74P3-UZW9].

409. 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.*; see also M. Human, R.D. Goldstein, C.A. Groenewald, H.C. Kinney & H.J. Odendall, *Bereaved Mothers’ Attitudes Regarding Autopsy of Their Stillborn Baby*, 23 S. AFR. J. OBSTETRICS & GYNAECOLOGY 93, 95 (2017) (explaining that “a large majority of those [parents] who are asked to provide consent” to an autopsy after stillbirth “would provide it”); Janet Realini, *Need for Perinatal Autopsies Following Stillbirth*, TEX. MED. ASS’N (July 6, 2010), <https://www.texmed.org/Template.aspx?id=4883> [https://perma.cc/86A4-5A5Y] (“Many families cannot pay for the procedure, which typically costs about \$1,000 to \$1,500 in routine cases.”); 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, 11:09 PM), <https://www.theguardian.com/australia-news/2016/jan/19/australia-failing-to-adequately-investigate-stillbirths-researcher-finds> [https://perma.cc/T4WW-QZBR].

410. Gillian Brockell, *Here Are All the Things I Didn’t Know About Stillbirth Until It Happened to Me*, WASH. POST (Oct. 15, 2019, 2:35 PM), <https://www.washingtonpost.com/lifestyle/2019/10/15/he-re-are-all-things-i-didnt-know-about-stillbirth-until-it-happened-me/> [https://perma.cc/ANU8-MUCQ].

411. *Id.*

412. See generally 42 U.S.C. § 1396a.

413. 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.” MEDICAID & CHIP PAYMENT & ACCESS COMM’N, ACCESS IN BRIEF: PREGNANT WOMEN AND MEDICAID 1 (2018).

414. See KATHY GIFFORD, JENNA WALLS, USHA RANJ, ALINA SALGANICOFF & IVETTE GOMEZ, MEDICAID COVERAGE OF PREGNANCY AND PERINATAL BENEFITS: RESULTS FROM A STATE SURVEY 15 (2017) (summarizing results of survey concerning state Medicaid pregnancy benefits); see also Realini, *supra* note 409.

415. Hess, *supra* note 377.

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.<sup>416</sup> Even knowing that the autopsy may not discover a cause, parents are “resolute that all avenues of investigation be undertaken.”<sup>417</sup> 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.”<sup>418</sup> The parents wanted to “know that [they] tried to find out and that [they] did everything that [they] could to find out.”<sup>419</sup> “Even when no definite cause of death is found, emphasis on the baby’s normality seems to alleviate a great deal of parental concern.”<sup>420</sup>

An autopsy helps the parent to 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.”<sup>421</sup> 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.”<sup>422</sup>

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 their benefits. Pregnant women insured through Medicaid, however, need insurance

---

416. Sarah Meaney, Stephen Gallagher, Jennifer E. Lutomski & Keelin O’Donoghue, *Parental Decision Making Around Perinatal Autopsy: A Qualitative Investigation*, 18 HEALTH EXPECTATIONS 3160, 3164 (2015).

417. *Id.*

418. *Id.*

419. *Id.*

420. Kirkley-Best & Kellner, *supra* note 144, at 426.

421. Realini, *supra* note 409.

422. Muthler, *supra* note 408.

coverage to be able to afford autopsies, especially given all of the other costs surrounding stillbirth.<sup>423</sup>

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.”<sup>424</sup> It is not surprising that countries with some of the lowest stillbirth rates, countries like the Netherlands, offer free autopsies for stillbirths.<sup>425</sup> As part of its recent efforts to decrease its stillbirth rate, Australia is specifically investigating ways to provide free autopsies.<sup>426</sup>

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 24,000 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.

#### 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.<sup>427</sup> 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.

---

423. Notably, a very recent study of autopsies in the UK, which are free to parents, found that “[m]others 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, Elizabeth S. Draper & Lucy K. Smith, *Impact of Sociodemographic and Clinical Factors on Offer and Parental Consent to Postmortem Following Stillbirth or Neonatal Death: A UK Population-Based Cohort Study*, 105 *FETAL & NEONATAL* F532, F532 (2020). 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.

424. Muthler, *supra* note 408.

425. *Id.*; see also Davey, *supra* note 409.

426. Stephanie Dalzell, *Government Seeks Advice on Covering Cost of Stillbirth Autopsies in Bid to Prevent Further Deaths*, ABC NEWS (July 4, 2019, 12:13 AM), <https://www.abc.net.au/news/2019-07-04/stillbirth-autopsies-government-advice-research/11276286> [<https://perma.cc/YUE7-WUG6>].

427. Shared with permission.



Reproductive justice's rejection of the individualistic notion of choice and its holistic lens provide an opportunity to finally highlight women's experiences of miscarriage and stillbirth and their 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 from how various laws affirm motherhood despite an infant's death shortly after birth. Expressly adding these rights to the reproductive justice framework properly recognizes miscarriage and stillbirth as meaningful reproductive experiences that marginalized women are especially likely to experience them.