

Medical Paternalism, Stillbirth, & Blindsided Mothers

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ABSTRACT: Pregnant women know that some things can go wrong in their pregnancies. They know of the chance of miscarriage, the reason most women do not even publicly share their happy news until after 12 weeks. They also know of the chance of certain chromosomal abnormalities, including fatal ones, as doctors' disclosure of and screening for these abnormalities has become routine in prenatal care. But empirical studies confirm that pregnant women are ignorant of the chance of stillbirth, the death of the unborn child in the woman's womb after 20 weeks of pregnancy but before birth. Women are ignorant that stillbirth means the woman will have to give birth to her dead baby. Women remain ignorant of the chance and reality of stillbirth because of medical paternalism—doctors think pregnant women do not need to and should not know of the chance of stillbirth.

This Article argues that a woman has a right to know of the chance of stillbirth before it happens to her child, a right enforceable through an informed consent medical malpractice tort claim. The application of modern informed consent law to define this right is novel, but not difficult. The risk of stillbirth is easily material, and no evidence supports the myth that disclosure will cause pregnant women anxiety. Doctors are not protecting anyone, except maybe themselves, by failing to disclose stillbirth. To the contrary, numerous countries other than the United States have reduced their stillbirth rates through initiatives that include requiring doctors to disclose the risk of stillbirth to women and to educate women on the known, simple preventative measures. A tort claim enforcing a woman's right to disclosure of stillbirth could have a similar effect in the United States.

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I. INTRODUCTION

A day before Alan and Elyse Goldenbach’s son Shalom was due to be born, he died due to a knotted umbilical cord.¹ The next day, on his due date, Elyse gave birth to their dead baby.² A death like Shalom’s is called a stillbirth, the medical term for a pregnancy loss after 20 weeks of pregnancy but before birth. Weeks later, Alan went to a bookstore and looked for any mention of stillbirth in the pregnancy and childbirth books.³ He didn’t find any.⁴ In his words: “[s]tillbirth, the culprit that destroys more than one in every [one

1. Alan Goldenbach, *Blindsided*, in *THEY WERE STILL BORN: PERSONAL STORIES ABOUT STILLBIRTH* 7, 8 (Janel C. Atlas ed., 2010) [hereinafter Goldenbach, *Blindsided*].

2. *Id.* at 7.

3. *Id.* at 7–8.

4. *Id.* at 8.

hundred and sixty] . . . pregnancies in this country, was glaringly absent from these books that are specifically intended to guide couples through their pregnancies, to prepare them for every possible twist or turn.”⁵ The Goldenbachs later asked Elyse’s doctor why she hadn’t mentioned the possibility of stillbirth.⁶ The doctor explained that “[p]regnancy is a happy time” and “[n]obody wants to hear anything about something bad.”⁷

The Goldenbachs are not alone. Over 26,000 mothers each year in the United States give birth to stillborn babies,⁸ and none of them likely heard the word stillbirth beforehand.⁹ Women are aware of the possibility of miscarriage, a pregnancy loss before 20 weeks of pregnancy.¹⁰ Most miscarriages occur before 12 weeks of pregnancy, the same reason most women do not publicly share their happy news until after the first 12 weeks.¹¹ Doctors also now inform women of the risks of certain fetal abnormalities, mainly Down Syndrome and fatal trisomies, as screening tests for these abnormalities has become routine.¹² But empirical studies confirm that pregnant women remain unaware both of the possibility and the reality of stillbirth, that reality being that the woman will have to give birth to her dead child.¹³ Not even women with high-risk pregnancies know the chance of stillbirth beforehand.¹⁴ Women remain ignorant of the possibility of stillbirth because of medical paternalism—doctors do not disclose this risk because

5. *Id.* Goldenbach explained the risk for stillbirth as one in 200 pregnancies, which is outdated and inaccurate. The Center for Disease Control’s current website puts the risk of stillbirth at one in 160 pregnancies. *What is Stillbirth?*, CDC, <https://www.cdc.gov/ncbddd/stillbirth/facts.html> [<https://perma.cc/L53Y-CSB3>] (last updated Aug. 13, 2020).

6. Goldenbach, *Blindsided*, *supra* note 1, at 8.

7. *Id.*

8. *Placental, Pregnancy Conditions Account for Most Stillbirths*, NIH (Dec. 13, 2011), <https://www.nih.gov/news-events/news-releases/placental-pregnancy-conditions-account-most-stillbirths> [<https://perma.cc/7WWH-RDTW>]. I am one of these blindsided mothers. I knew nothing about the possibility of stillbirth until after my son Caleb’s death in 2017.

9. Gordon C.S. Smith, *A Bonfire of the Tape Measures*, 377 LANCET 1307, 1307 (2011) (reviewing STILLBIRTH: PREDICTION, PREVENTION AND MANAGEMENT (Catherine Y. Spong ed., 2011)) (explaining that stillbirth “will often never have previously been mentioned in a conversation with any health professional”).

10. *Signs of Miscarriage*, AM. PREGNANCY ASS’N (Apr. 26, 2020), <http://americanpregnancy.org/pregnancy-complications/miscarriage> [<https://perma.cc/S5W9-Q6JZ>].

11. Katy Lindemann, *The 12-Week Pregnancy Rule Makes the Pain of Miscarriage Worse*, GUARDIAN (Oct. 7, 2019, 2:57 PM), <https://www.theguardian.com/commentisfree/2019/oct/07/12-week-pregnancy-rule-miscarriage-shame-failure> [<https://perma.cc/SZH3-VSWQ>] (explaining “the longstanding social convention that dictates that women mustn’t tell anyone they’re pregnant before the 12-week mark” because of the chance of miscarriage).

12. *See infra* notes 65–68, 192–95 and accompanying text.

13. *See, e.g.*, Maureen C. Kelley & Susan B. Trinidad, *Silent Loss and the Clinical Encounter: Parents’ and Physicians’ Experiences of Stillbirth—A Qualitative Analysis*, BMC PREGNANCY & CHILDBIRTH, Nov. 27, 2012, at 1, 13.

14. *Id.* at 3.

they think pregnant women don't need to and shouldn't know of their child's possible stillbirth.¹⁵

Much of recent legal scholarship concerning pregnancy focuses on the mistreatment women experience in childbirth due to medicalization.¹⁶ The term "obstetric violence" describes forced surgeries like cesareans¹⁷ and episiotomies,¹⁸ and the use of unconsented-to medical procedures like inducing labor and using vacuums and forceps in delivery.¹⁹ Numerous legal scholars explain how lingering medical paternalism and an increased focus on the fetus have enabled this mistreatment and the resulting trauma women increasingly experience in childbirth.²⁰

But legal scholarship has thus far missed the most traumatic experience in childbirth—giving birth to a dead baby. A woman may be in for a routine doctor's visit near the end of her pregnancy, and the doctor may be unable to find the baby's heartbeat. An ultrasound will later reveal that the baby's heart is no longer beating.²¹ The doctor will then tell her that she still needs to give birth to her child the same as if he were alive.²² In delivery, she will face a much higher risk of life-threatening complications than during live childbirth.²³ After delivery, she will hold her baby in her arms if she desires as she makes plans for the disposition of his body.²⁴ She plans her baby's funeral

15. See *infra* Section III.A.

16. See generally, e.g., Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721 (2018) (arguing that birthing women are abused, coerced, and disrespected during the birthing process and advocating for a change in tort law that would address women's abuse during childbirth); Mary Ziegler, *Some Form of Punishment: Penalizing Women for Abortion*, 26 WM. & MARY BILL RTS. J. 735 (2018) (interrogating the ways in which ambiguous language in feticide laws could result in women being punished for having legal abortions); Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955 (2013) [hereinafter Abrams, *Distorted and Diminished*] (arguing that fetal well-being overshadows the birthing woman in negligence law and birthing women should be centered in negligence law); Maria T.R. Borges, Note, *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, 67 DUKE L.J. 827 (2018) (explaining that courts allow physicians to forgo women's wishes to deliver their children vaginally and force them to deliver children via cesarean section, episiotomies, or with the aid of forceps when physicians feel as though the children are at risk).

17. A cesarean is "an incision in the woman's abdomen and uterus to remove the [baby]." Kukura, *supra* note 16, at 730.

18. "An episiotomy is an incision to widen the vaginal opening." *Id.* at 731.

19. *Id.* at 734.

20. See sources cited *supra* note 16.

21. Linda L. Layne, *Pregnancy and Infant Loss Support: A New, Feminist, American, Patient Movement?*, 62 SOC. SCI. & MED. 602, 610 (2006) [hereinafter Layne, *Infant Loss Support*].

22. Kelley & Trinidad, *supra* note 13, at 4.

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

24. Joanne Cacciatore & Jill Wieber Lens, *The Ultimate in Women's Labor: Rethinking Feminism Around Pregnancy, Birthing, and Grieving a Dead Baby*, in ROUTLEDGE INTERNATIONAL HANDBOOK

instead of his homecoming. She adjusts to the reality of stillbirth, a reality even harder to process because her doctor paternalistically believed it was better for the woman to not know the possibility of stillbirth before she gave birth to her own stillborn child.²⁵

This Article is the first to argue that a woman has a right to know of the risk of stillbirth before it happens to her child, a right enforceable through an informed consent medical malpractice tort claim for a doctor's failure to disclose. This right also includes the right to information on the simple preventative measures the woman can perform to help prevent her child's stillbirth—refraining from smoking, sleeping on her side, and monitoring her baby's movements.²⁶ Other countries have reduced their stillbirth rates with initiatives that include doctors educating pregnant women regarding the risk and these measures.²⁷ Tort liability in the United States incentivizing doctors to disclose and educate women about the risk of stillbirth could similarly reduce the number of stillborn babies and bereaved mothers.

The organization of the Article is as follows. Part II explains many aspects of stillbirth—its commonality, known causes and risk factors, women's ignorance of it, and preventative measures. Part III then describes informed consent doctrine, focusing mostly on the evolution of the standards for disclosure and application of the doctrine to medical treatment generally. Part IV then explains a woman's right to know of stillbirth and how such a right exists under modern informed consent doctrine, including explaining the materiality of the risk, the ability to establish causation, and the available damages. Part V describes other benefits of doctors' disclosure of the risk of stillbirth, including a reduction in malpractice claims filed and public health benefits. Part VI briefly concludes.

II. PREGNANT WOMEN'S IGNORANCE OF STILLBIRTH

One in 160 pregnancies will end in stillbirth each year in the United States.²⁸ That may seem like a small risk, but it translates to the births of at least 24,000 stillborn babies every year.²⁹ Pregnant women, however, are unaware of this risk, unaware of the possibility that their unborn baby could still die even after 20 weeks of pregnancy and that they could have to give birth to their already dead child. Far too many stillbirths occur, but they do not have to. Only around seven percent of stillbirths globally are due to

OF WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH 308, 308 (Jane M. Ussher, Joan C. Chrisler & Janette Perz eds., 2019).

25. Smith, *supra* note 9, at 1307.

26. See *infra* Section IV.B.1.

27. See *infra* Section IV.B.1.

28. *What is Stillbirth?*, *supra* note 5.

29. See *id.*

chromosomal abnormalities; the rest are preventable.³⁰ Medical research shows that when a woman sleeps on her side, closely monitors her baby's movements, and refrains from smoking, the likelihood of stillbirth decreases.³¹ Numerous countries other than the United States have already reduced their stillbirth rates by requiring doctors to disclose the risk of stillbirth to pregnant women and to teach them these simple preventative measures.³²

A. *THE VERY REAL RISK OF STILLBIRTH IN THE UNITED STATES*

In 2013, the most recent national data available, approximately 24,000 babies died due to stillbirth in the United States.³³ That's over 65 babies each day. More technically, the United States' 2013 stillbirth rate was 5.96 per 1,000 births.³⁴ The Center for Disease Control's current website says that stillbirth "affects" about one in 160 pregnancies.³⁵

These at least 24,000 United States stillbirths contribute to the 2.6 million stillbirths that occur annually world-wide.³⁶ The United States' stillbirth rate is higher "than in many other high-income countries."³⁷ Plus, the United States' rate has not continued to decrease like the rates in other high-income countries.³⁸ In a study published in *The Lancet* medical journal, of the listed 49 high-income countries, the United States' annual percentage stillbirth rate reduction from 2000–2015 was lower than all but one other country.³⁹ Specifically, the United States' reduction rate was only .40 percent,⁴⁰ whereas other high-income countries had much more success; for instance, the Netherlands reduced stillbirths 6.8 percent, Iceland 5.4 percent, Norway 3.4 percent, and the United Kingdom (the "UK") 1.4 percent.⁴¹

30. See Joy E. Lawn et al., *Stillbirths: Rates, Risk Factors, and Acceleration Towards 2030*, 387 LANCET 587, 587 (2016).

31. See *infra* Section IV.B.1.

32. See *infra* Section IV.B.1.

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

34. *Id.*

35. *What is Stillbirth?*, *supra* note 5.

36. LANCET, ENDING PREVENTABLE STILLBIRTHS: AN EXECUTIVE SUMMARY FOR THE LANCET'S SERIES 4 (2016), <http://www.thelancet.com/pb/assets/raw/Lancet/stories/series/stillbirths2016-exec-summ.pdf> [<https://perma.cc/RRV8-WWCT>].

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

38. *Id.*

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

40. *Id.*

41. *Id.*; see also Katherine Hobson, *U.S. Lags Behind Other Countries in Reducing Stillbirths*, NPR (Jan. 22, 2016, 11:13 AM), <https://www.npr.org/sections/health-shots/2016/01/22/463954283/the-u-s-lags-behind-in-reducing-stillbirths-late-in-pregnancy> [<https://perma.cc/TBH6-G7XV>]

The United States' lack of progress on its stillbirth rate contrasts sharply with its success in reducing infant mortality. The U.S. infant mortality rate decreased 11 percent between 2006 and 2013, but fetal mortality "has remained relatively stable for the past decade."⁴² "In many developed countries, while absolute rates have never been lower, late-fetal mortality is now higher than infant mortality."⁴³

Babies are more likely to die from "stillbirth than . . . all other causes of infant deaths combined."⁴⁴ "Despite improved access to prenatal care, sophisticated medical technology, and frequent obstetrical visits during the final weeks of a pregnancy, the rates of stillbirth have declined only slightly in the United States during the past 20 years."⁴⁵ Two and a half times more stillbirths occur in the United States than deaths from AIDS.⁴⁶ Stillbirths occur ten times as often as infant deaths due to Sudden Infant Death Syndrome ("SIDS"), though the risk of SIDS is widely known and discussed between doctors and their pregnant patients preparing for childbirth.⁴⁷

Some causes of stillbirth are known. A study of the Stillbirth Collaborative Research Network identified these causes: pregnancy with multiple babies; pregnancy complications like placental abruption where the placenta, which provides nutrients and oxygen to the baby, separates from the uterus; problems with the placenta like insufficient blood flow; birth defects; infection; problems with the umbilical cord, like it getting knotted, cutting off oxygen to the baby; mother's high blood pressure; and assorted medical complications in the mother, such as diabetes.⁴⁸ Of the data studied, covering over two and a half years, about one-fourth of stillbirths had no explained cause.⁴⁹

Stillbirth can happen in any pregnancy, but some risks factors are known. In high-income countries, the factors include: low socioeconomic status, maternal age over 35, smoking or marijuana use during and just before

(highlighting *The Lancet's* findings on stillbirth in the United States compared to other countries).

42. Page et al., *supra* note 37, at 336–37.

43. Robert Woods, *Long-Term Trends in Fetal Mortality: Implications for Developing Countries*, 86 BULL. WORLD HEALTH ORG. 460, 460 (2008).

44. Joanne Cacciatore & Suzanne Bushfield, *Stillbirth: A Sociopolitical Issue*, 23 J. WOMEN & SOC. WORK 378, 380 (2008).

45. *Id.*

46. Alan Goldenbach, *Stillbirth Gets Short Shrift, Even from Physicians*, WASH. POST (July 7, 2009), <https://www.washingtonpost.com/wp-dyn/content/article/2009/07/06/AR2009070602918.html> [<https://perma.cc/5MAZ-MJX5>] [hereinafter Goldenbach, *Short Shrift*].

47. Joanne Cacciatore, *Effects of Support Groups on Post Traumatic Stress Responses in Women Experiencing Stillbirth*, 55 OMEGA 71, 72 (2007) [hereinafter Cacciatore, *Support Groups*].

48. *What Are Possible Causes of Stillbirth?*, NIH, <https://www.nichd.nih.gov/health/topics/stillbirth/topicinfo/Pages/causes.aspx> [<https://perma.cc/37X2-KD4W>] (last updated Dec. 1, 2016).

49. *Id.*

pregnancy, use of illegal drugs before and during pregnancy, the pregnant woman being overweight, her having diabetes before pregnancy, her having high blood pressure before pregnancy, if it's her first pregnancy, a previous stillbirth, if the pregnant woman is carrying multiple babies, the use of assisted reproductive technology to get pregnant, and if the fetus is small for gestational age.⁵⁰ In less-developed countries, the highest risk factor for stillbirth is lack of quality prenatal care,⁵¹ which is becoming increasingly common in rural areas in the United States.⁵² The risk of stillbirth also increases as the pregnancy progresses, increasing every week the pregnancy continues past term, which is 37 weeks.⁵³ Additionally, race matters. The stillbirth rate “for non-Hispanic black women was more than twice the rate for non-Hispanic white women.”⁵⁴

B. BLINDSIDING PREGNANT WOMEN

Despite the very real risk of stillbirth, few women, if any, ever worry about stillbirth—until it happens to them. After stillbirth, parents surveyed explain that before their own child's stillbirth, they “believed that stillbirth [was] a very rare event.”⁵⁵ Most believed that good prenatal care would prevent stillbirth, and later learned they were wrong.⁵⁶ The same parents also “reported being surprised to learn the actual rates of stillbirth worldwide, or that stillbirth occurs much at all in high-income countries like the U.S.”⁵⁷ A 2011 article in *The Lancet* quotes a parent whose child was stillborn in 2010: “If stillbirth really is ten times as common as cot death, we cannot be the only

50. *What Are the Risk Factors for Stillbirth?*, NIH, <https://www.nichd.nih.gov/health/topics/stillbirth/topicinfo/risk> [<https://perma.cc/VA2S-987B>] (last updated Dec. 1, 2016).

51. *See id.* (explaining that many stillbirths in resource-limited countries “result from long and difficult labor, preeclampsia, and infections”).

52. COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, OPINION NO. 586, HEALTH DISPARITIES IN RURAL WOMEN 2 (2014), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women> [<https://perma.cc/GEZ7-FHS6>] (“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.” (footnotes omitted)).

53. Jacqui Wise, *Risk of Stillbirth Increases After 41 Weeks, Study Finds*, *BMJ*, July 2, 2019, at 1, 1 (“The risk of stillbirth increases with every week that a pregnancy continues past 37 weeks.”); *see also New Stillbirth Risk Figures Help Women’s Decisions on Timing Delivery*, *SCIENCEDAILY* (July 2, 2019), <https://www.sciencedaily.com/releases/2019/07/190702152815.htm> [<https://perma.cc/WMG7-LBE5>] (explaining that a study by Queen Mary University of London found “a small but significantly increased risk of stillbirth in mothers who continued their pregnancy to 41 weeks’ gestation . . . compared to those who delivered at 40 weeks”).

54. MacDorman & Gregory, *supra* note 33, at 4.

55. Kelley & Trinidad, *supra* note 13, at 13.

56. *Id.*

57. *Id.* at 3.

ones who had bought three sleep positioners but had never once considered the possibility of stillbirth.”⁵⁸ A stillbirth advocate in Australia described that “nine out of 10 families” were unaware of the possibility of stillbirth before it happened; those women were “told not to eat soft cheese,” but not of the possibility of stillbirth.⁵⁹

Although pregnant women are unaware of the possibility of stillbirth, they do know of other things that could go wrong in their pregnancies. For the first 20 weeks of the pregnancy, and especially in the first 12 weeks, women are concerned about miscarriage, the term for a pregnancy loss before 20 weeks of pregnancy. Medical staff may not always discuss the risk of miscarriage with pregnant women; a 2009 study showing that medical professionals did so only 48 percent in that study.⁶⁰ But miscarriages are relatively common; research shows that as many as one in four pregnancies ends in miscarriage.⁶¹ An article in *Parents* magazine lists miscarriage as one of the top 14 pregnancy fears, but does not mention stillbirth.⁶² Thus, women are at least somewhat aware of the possibility of miscarriage and when that possibility decreases.⁶³

Pregnant women are also aware of the risks of chromosomal or genetic abnormalities. In an article in *The Washington Post*, Ruth C. Fretts, an assistant professor of obstetrics and gynecology at Harvard Medical School, explained that doctors “spend . . . an hour during the first visit talking about screening for Down Syndrome.”⁶⁴ Testing early in pregnancy for Down Syndrome, which is not fatal, has become routine,⁶⁵ yet the stillbirth rate in

58. Smith, *supra* note 9, at 1307.

59. THE SENATE, COMMONWEALTH OF AUSTRALIA, SELECT COMMITTEE ON STILLBIRTH RESEARCH AND EDUCATION § 7.21 (2018) [hereinafter AUSTRALIAN SENATE COMMITTEE REPORT], https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth_Research_and_Education/Stillbirth/Report [<https://perma.cc/A3KS-WFFK>] (quoting Ms. Victoria Bowring, Chief Executive Officer, Stillbirth Foundation Australia).

60. Joann O’Leary, Jane Warland & Lynnda Parker, *Prenatal Parenthood*, 20 J. PERINATAL EDUC. 218, 219 (2011) (discussing unpublished research done by Suzanne Pullen).

61. *Signs of Miscarriage*, *supra* note 10.

62. Shaun Dreisbach, *Top 14 Pregnancy Fears (and Why You Shouldn’t Worry)*, PARENTS (July 14, 2015), <https://www.parents.com/pregnancy/complications/health-and-safety-issues/top-pregnancy-fears> [<https://perma.cc/899E-TZAT>].

63. Women may be aware of the possibility of stillbirth but are likely unaware of exactly what miscarriage looks like. Linda Layne, *A Women’s Health Model for Pregnancy Loss: A Call for a New Standard of Care*, 32 FEMINIST STUD. 573, 583–85 (2006) [hereinafter Layne, *Pregnancy Loss*]. Additionally, black women are likely unaware that their risk of miscarriage after the first trimester but before 20 weeks is double that of a white woman’s. 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, 1273 (2013).

64. Goldenbach, *Short Shrift*, *supra* note 46.

65. *Id.*; see also Cynthia M. Powell, *The Current State of Prenatal Genetic Testing in the United States*, in PRENATAL TESTING AND DISABILITY RIGHTS 44, 44–45 (Erik Parens & Adrienne Asch eds., 2000) (describing the history of prenatal testing).

the United States is “four times the incidence rate of Down syndrome.”⁶⁶ More specifically, the risk of Down Syndrome is one in 350 when the woman is 35,⁶⁷ yet she will be informed of the risk and advised to do genetic testing. Not until the woman is 39 will the risk of Down Syndrome be similar to the risk of stillbirth,⁶⁸ yet every woman will be informed of the Down Syndrome risk.

After 20 weeks, the time at which stillbirth becomes a possibility, women feel confident that their child will be born alive. Women don’t even know to worry about stillbirth because, before it happens, stillbirth “will often never have previously been mentioned in a conversation with any health professional.”⁶⁹ Even women with high risk pregnancies are uninformed; they “were concerned about delivering prematurely, not about stillbirth.”⁷⁰

Women are ignorant of the risk of stillbirth and also ignorant of the experience of stillbirth, notably that it still involves childbirth. “The most unexpected reality for parents [i]s that when a child is stillborn, a woman still has to go through labor and delivery.”⁷¹ Medical advancements, mainly the ultrasound, mean that a woman will learn before labor and delivery that her child has died in her womb.⁷² And “[a]fter receiving the devastating news that their infant has died, having to then go through the delivery experience is emotionally wrenching for parents.”⁷³

Women will learn of “stillbirth” after their child’s death, a death that will have lifelong consequences for the mother—both physical and emotional consequences. In the short term, women are physically at risk.⁷⁴ According to a study of stillbirth and live birth deliveries in California published in 2019, “[p]atients who deliver stillborn babies are nearly five times more likely to experience life-threatening complications than those who have live births.”⁷⁵ One of the study’s authors explained that research is lacking regarding whether “patients experience life-threatening complications during delivery

66. Goldenbach, *Short Shrift*, *supra* note 46.

67. *What is Down Syndrome?*, NAT’L DOWN SYNDROME SOC’Y, <https://www.ndss.org/about-down-syndrome/down-syndrome> [<https://perma.cc/EWX9-A9gJ>].

68. *Id.* (explaining that the risk of Down Syndrome is one in 150 when the woman is 39 years old).

69. Smith, *supra* note 9, at 1307; O’Leary et al., *supra* note 60, at 219 (discussing unpublished research done by Suzanne Pullen in which the women surveyed reported that medical professionals mentioned stillbirth as a possibility only 11 percent of the time).

70. Kelley & Trinidad, *supra* note 13, at 3.

71. *Id.* at 4.

72. Layne, *Infant Loss Support*, *supra* note 21, at 603 (explaining that medicalization has changed the experience of stillbirth including by enabling diagnosis before birth).

73. Kelley & Trinidad, *supra* note 13, at 4.

74. *See* Wall-Wieler et al., *supra* note 23, at 310 (noting the complications associated with stillbirth deliveries).

75. Hannah Harris Green, *We Had No Idea How Much Physical Danger Stillbirth Can Cause*, REWIRE NEWS GRP. (Aug. 14, 2019, 2:57 PM), <https://rewire.news/article/2019/08/14/we-had-no-idea-how-much-physical-danger-stillbirth-can-cause> [<https://perma.cc/T88R-RXQX>] (discussing the study cited in *supra* note 23).

. . . because of the care (or lack thereof) they're receiving, or for the same reasons that they had a stillbirth in the first place."⁷⁶ Either way, women are physically at risk.

In both the short and long term, women are also emotionally at risk. The process of giving birth to a stillborn baby increases "the mother's risk for depression, post-traumatic stress disorder (PTSD), psychosis, and other adverse psychobiological outcomes."⁷⁷ In a 2010 study of mothers after stillbirth, almost one half of the participants reported thoughts of "self-harm," usually "during the early period[] after the baby's death."⁷⁸ Her grief is further complicated by the fact that her body assumes her baby was born alive and starts to produce milk; "[t]he emotional state derived from maternal hormones is incongruent with her reality as she cannot physically bond with her baby."⁷⁹ Adding to a mother's anxiety is the lack of recognition of the baby's life and death, lack of recognition culturally, societally, and sometimes even by family members and friends.⁸⁰ Common reactions like "you can have more" or "[a]t least it wasn't one of your older children who died" only minimize the woman's loss and further traumatize her.⁸¹ Especially if they lack living children, women struggle with their role as mother.⁸² She will forever struggle with how to answer common questions like "when are you going to have children" if she lacks living children, and "how many children do you have" if she has living children.⁸³ Her grief may change, but it does not go away.

C. PREVENTING STILLBIRTH

Stillbirth doesn't have to happen so frequently. It is neither inevitable nor unpreventable, despite pervasive myths that stillbirths are "mostly due to non-preventable congenital abnormalities."⁸⁴ Only around seven percent of 2.6 million stillbirths⁸⁵ that occur yearly globally (using a 28-week definition of stillbirth) are due to congenital abnormalities, and even some of those abnormalities are actually preventable if the mother takes folic acid.⁸⁶ In short, only a very small proportion of stillbirths are due to fetal abnormalities and are thus unpreventable.

76. *Id.*

77. Joanne Cacciatore, *The Unique Experiences of Women and Their Families After the Death of a Baby*, 49 SOC. WORK HEALTH CARE 134, 136 (2010) [hereinafter Cacciatore, *Unique Experiences*].

78. *Id.* at 140.

79. *Id.* at 142.

80. *Id.* at 144.

81. *Id.*

82. *Id.* at 142.

83. Kelley & Trinidad, *supra* note 13, at 9–10.

84. Lawn et al., *supra* note 30, at 597.

85. *Id.* at 587.

86. *Id.* at 597.

Other stillbirths do not have to happen. As mentioned, other countries like Norway, Scotland, the Netherlands, Iceland, and the UK have successfully and sometimes dramatically reduced their stillbirth rates.⁸⁷ A recent study specific to stillbirths in the United States similarly concluded that “approximately one fourth of stillbirths . . . in the United States are potentially preventable.”⁸⁸ The study also clarified that it used conservative criteria and that “compelling argument[s] [exist] that many of the stillbirths [the study] did not include as potentially preventable were, in fact, preventable.”⁸⁹ This research exists, but the myth of the unpreventability of stillbirth continues to stunt medical research and prevention efforts.⁹⁰

Still, some dedicated researchers have discovered some simple measures that women can do during pregnancy to *help* prevent stillbirth. First, women cannot smoke during pregnancy.⁹¹ Second, women can sleep on their side instead of their back during pregnancy.⁹² Last, and perhaps most importantly, women can monitor their child’s movements starting around the 28th week of pregnancy. Any change in the baby’s movements can indicate a problem. Specifically, researchers have linked reduced fetal movement to stillbirth,⁹³ believing that if there is a problem, the baby starts to move slower and less

87. See *supra* text accompanying notes 36–41.

88. Page et al., *supra* note 37, 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.

89. *Id.* at 340–41.

90. See, e.g., Flenady et al., *supra* note 39, at 699 (explaining that fatalism must be reduced in order to reduce the number of stillbirths); Robert L. Goldenberg et al., *Stillbirths: The Vision for 2020*, 377 LANCET 1798, 1798 (2011) (“Inappropriate fatalism regarding stillbirths among caregivers and policy makers will virtually guarantee that no progress occurs.”).

91. See generally Takawira C. Marufu, Anand Ahankari, Tim Coleman & Sarah Lewis, *Maternal Smoking and the Risk of Still Birth: Systematic Review and Meta-Analysis*, BMC PUB. HEALTH, Mar. 13, 2015, at 1, 13 (summarizing studies and concluding “that smoking greatly increases the risk of stillbirth”).

92. See, e.g., A.E.P. Heazell et al., *Association Between Maternal Sleep Practices and Late Stillbirth—Findings from a Stillbirth Case-Control Study*, 125 BJOG 254, 260 (2017) [hereinafter Heazell et al., *Maternal Sleep Practices*]; Lesley M.E. McCowan et al., *Going to Sleep in the Supine Position Is a Modifiable Risk Factor for Late Pregnancy Stillbirth; Findings from the New Zealand Multicentre Stillbirth Case-Control Study*, PLOS ONE, June 13, 2017, at 1, 6, 12.

93. See generally, 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 [hereinafter Heazell et al., *Perceived Alterations*] (finding that stillbirth is linked to reduced fetal movements); 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 [hereinafter Heazell et al., *Alterations in Maternally Perceived Fetal Movement*] (finding that decreased fetal movements is linked to a higher risk of stillbirth); 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 22, 2009, at 1 (finding that improved management of decreased fetal movements is linked to fewer stillbirths).

forcefully to preserve energy.⁹⁴ Women who notice a change in fetal movement should visit their doctor without delay, enabling the doctor to take extreme measures if necessary to protect the baby.

Women can only know to take these measures, however, if they know about them. And women can only know of the importance of these measures to prevent *stillbirth* if their doctors explain so. Ideally, doctors would start informing their patients without outside prompting. That voluntary change, unfortunately, seems unlikely.⁹⁵ This Article explains how tort law could help mandate disclosure and ultimately save mothers and babies from stillbirth.

III. INFORMED CONSENT LAW

Courts have long recognized an intentional tort claim when a doctor performs a medical procedure on a patient to which the patient did not consent. As Justice Cardozo famously explained: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault.”⁹⁶ Courts evolved the law not just to cover the need for the patient to consent, but for the patient’s consent to be informed, recognizing the patient’s “right to important information about the nature of the medical procedure” the doctor proposes.⁹⁷ Courts thus eventually recognized a negligence-based informed consent claim based on the physician’s duty “to make adequate disclosures to the patient” to ensure that informed consent.⁹⁸

Informed consent law has evolved dramatically, both on the standards for required disclosure and on when the doctor is required to disclose information. Specific to the standards for required disclosure, courts originally required doctors to disclose the risks that they customarily disclosed—a paternalistic doctor-knows-best standard in which doctors decide what patients need to know before consenting to treatment.⁹⁹ When possible, courts have moved away from this traditional standard, instead emphasizing that patients have

94. See Lynne K. Warrander et al., *Maternal Perception of Reduced Fetal Movements Is Associated with Altered Placental Structure and Function*, PLOS ONE, Apr. 16, 2012, at 1, 1, 4 tbl.2 (“DFM is thought to represent fetal compensation to conserve energy due to insufficient oxygen and nutrient transfer resulting from placental insufficiency.”).

95. See Anthony Szczygiel, *Beyond Informed Consent*, 21 OHIO N.U. L. REV. 171, 171 (1994) (explaining that “[c]ourts played a leading role in” expanding and enforcing broader disclosure requirements for doctors).

96. *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *abrogated by* *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

97. DAN B. DOBBS, PAUL T. HAYDEN & ELLEN M. BUBLICK, *HORNBOOK ON TORTS* § 21.9, at 513 (2d ed. 2016).

98. Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL’Y 223, 237 (2009).

99. See *infra* Section III.A.

a right to self-determination.¹⁰⁰ Consistent with that right, the materiality standard requires the doctor to disclose all material risks, meaning those that a reasonable patient would want to know before consenting.¹⁰¹ The materiality standard ensures that patients are making the decisions and enables patients to partner in their health care instead of passively receiving medical care.

Courts have increasingly applied the doctor's duty to disclose risks broadly, to more than just the risks of a specific procedure. For instance, doctors need to disclose test results even when the results would not necessitate a specific procedure.¹⁰² Many of the broad applications of the informed consent doctrine have come within the context of pregnancy, most notably in the creation of a wrongful birth claim requiring disclosure of information to ensure the pregnant woman is educated regarding the condition of her unborn child.¹⁰³

A. FROM PATERNALISM TO SELF-DETERMINATION

"[T]he preeminent foundational concept in traditional medical ethics is nonmaleficence," the idea that doctors should do no harm.¹⁰⁴ As Professor Ben Rich explained, "the ethos of medical paternalism, from its inception, has been cloaked in the mantle of nonmaleficence."¹⁰⁵ It was doctors who decided what would harm patients and thus what patients needed to know regarding their health care. One somewhat recent example is a doctor's decision to withhold upsetting news from a patient—to avoid doing harm by disclosing, for instance, a cancer diagnosis or poor prognosis to a vulnerable and unsophisticated patient.¹⁰⁶ The patient is neither able to "understand important clinical information nor cope with the stress of being a participant in health care decisions."¹⁰⁷ Just over 50 years ago, 90 percent of physicians surveyed chose to withhold a cancer diagnosis consistent with the nonmaleficence ethos.¹⁰⁸

Consistent with these paternalistic roots of medicine, when courts first recognized informed consent claims, they required that doctors disclose to patients only those risks that doctors customarily disclose. The medical standard is the traditional standard, requiring doctors to disclose only information that a reasonable doctor, exercising the level of skill and

100. See *infra* Section III.A.

101. See *infra* Section III.A.

102. See *infra* Section III.B.

103. See *infra* Section III.B.

104. Ben A. Rich, *Medical Paternalism v. Respect for Patient Autonomy: The More Things Change the More They Remain the Same*, 10 MICH. ST. U. J. MED. & L. 87, 94 (2006).

105. *Id.*

106. *Id.* at 92.

107. *Id.*

108. Dennis H. Novack et al., *Changes in Physicians' Attitudes Toward Telling the Cancer Patient*, 241 J. AM. MED. ASS'N 897, 897 (1979).

knowledge consistent with the professional, would have disclosed.¹⁰⁹ “Under that standard, if medical custom requires no disclosure, the doctor . . . owes no duty to divulge information, no matter how critical it might be to the patient.”¹¹⁰

Then, starting in the 1970s, courts began to explore a different standard for disclosure: a materiality standard. The leading case announcing the new standard was *Canterbury v. Spence*.¹¹¹ The *Canterbury* court thoroughly criticized the traditional doctor-controlled standard. It first questioned whether “discernible custom[s]” of disclosure actually exist.¹¹² The court also noted that the reliance on the custom assigns “the decision on revelation to the physician alone.”¹¹³

The *Canterbury* court then emphasized that the traditional disclosure standard is inconsistent with a patient’s right to self-determination. “The root premise” of an informed consent claim “is the concept, fundamental in American jurisprudence, that ‘[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.’”¹¹⁴ The traditional, professional standard, basing the disclosure obligation on doctors’ custom “is at odds with the patient’s prerogative to decide on projected therapy himself.”¹¹⁵ This is true even though the patient lacks the doctor’s medical training or education.¹¹⁶ Consistent with the patient’s right of self-determination, the law must then set the standard for disclosure instead of allowing physicians to decide the standard.

Again relying on self-determination, the *Canterbury* court introduced the need for a standard broad enough to enable patients to make an intelligent choice.¹¹⁷ The standard was the materiality standard—“whether a particular peril must be divulged [depends on] its materiality to the patient’s decision: all risks potentially affecting the decision must be unmasked.”¹¹⁸ The court further explained “that ‘[a] risk is . . . material when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.’”¹¹⁹ This includes disclosure

109. DOBBS ET AL., *supra* note 97, § 21.10, at 516.

110. *Id.* (footnote omitted).

111. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

112. *Id.* at 783.

113. *Id.* at 784.

114. *Id.* at 780 (alteration in original) (quoting *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *abrogated by Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957)).

115. *Id.* at 786.

116. *Id.* at 781.

117. *Id.* at 786.

118. *Id.* at 786–87.

119. *Id.* at 787 (alteration in original) (quoting *Jon R. Waltz & Thomas W. Scheuneman, Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 640 (1970)).

of “inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated.”¹²⁰

The *Canterbury* court also explained the factors relevant to materiality. It specifically mentioned that materiality depends both on “the incidence of injury and the degree of the harm threatened.”¹²¹ Because the degree of harm is relevant, even “[a] very small chance of death or serious disablement may well be significant.”¹²² Ultimately, the court cautioned that “no bright line separat[es] the significant from the insignificant.”¹²³

The *Canterbury* court did recognize one exception to the materiality standard, what has become known as the therapeutic exception.¹²⁴ Under this exception, a doctor is not required to disclose even a material risk if disclosure

poses such a threat of detriment . . . as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. . . . The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient’s well-being.¹²⁵

The court, however, cautioned that this exception “must be carefully circumscribed.”¹²⁶ A broad application would allow a return to “the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs.”¹²⁷ This paternalistic attitude “presumes [the patient’s] instability or perversity” and negates “the foundation principle that the patient should and ordinarily can make the choice for himself.”¹²⁸

Since *Canterbury*, courts have tended to favor the materiality standard because it recognizes the importance of a patient’s self-determination.¹²⁹ The

120. *Id.* at 787–88.

121. *Id.* at 788.

122. *Id.*

123. *Id.*

124. *Id.* at 789.

125. *Id.* (footnotes omitted).

126. *Id.*

127. *Id.*

128. *Id.*

129. DOBBS ET AL., *supra* note 97, § 21.10, at 516–17; *see, e.g.*, *Largey v. Rothman*, 540 A.2d 504, 508–09 (N.J. 1988) (adopting the materiality standard and explaining that a number of jurisdictions had already done the same); *Logan v. Greenwich Hosp. Ass’n*, 465 A.2d 294, 300 (Conn. 1983) (explaining that *Canterbury* received “a generally favorable reception by the judiciary”). In some states, informed consent doctrine is governed by statute, meaning courts must apply whatever standard the legislature chose. *See Curran v. Buser*, 711 N.W.2d 562, 570

materiality standard “rejects a paternalistic model of patient decision-making in which the physician makes treatment decisions for the patient.”¹³⁰ Still today, “[i]deas about a patient’s right of self determination are continuing to develop, increasingly emphasizing the patient-provider relationship as a cooperative venture.”¹³¹

B. BROADER APPLICATIONS TO MEDICAL CARE

Just as courts broadened the scope of disclosure, they also broadened the scope of medical treatment to which informed consent law applies, beyond just the risks of a specific medical procedure.¹³² An important, yet clearly logical, expansion occurred in *Truman v. Thomas*, in which the California Supreme Court mandated that doctors disclose the risks of a medical procedure and the risks of forgoing that procedure.¹³³ But some courts have also gone even further, applying informed consent principles even when no specific procedure is at issue.¹³⁴ For instance, informed consent principles may require a doctor “to disclose some information even if there is no immediate medical procedure to be performed, specifically a diagnosis of or test result showing that the plaintiff has a disease.”¹³⁵

Pregnancy cases have played an important role in this expansion given the somewhat unique medical situation in that “[n]o progressive and threatening disease drives the patient to undergo medical treatment.”¹³⁶ This context more easily enables expansion of the doctrine. For instance, in *Nold ex rel. Nold v. Binyon*, the Kansas Supreme Court held that “[w]here a communicable disease has been diagnosed in a pregnant woman who desires to continue her pregnancy to term and deliver a healthy baby,” the doctor is

–71 (Neb. 2006) (discussing that Nebraska statute requires the professional standard disclosure standard).

130. Manian, *supra* note 98, at 235.

131. Szczygiel, *supra* note 95, at 171.

132. Numerous legal scholars have argued for an expansion of informed consent doctrine to even further recognize patient autonomy. See generally Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985) (explaining the need for an expansion of patient autonomy); Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313 (2002) (advocating for the increased involvement of patients in their medicinal decision making).

133. *Truman v. Thomas*, 611 P.2d 902, 906 (Cal. 1980) (en banc); Brietta Clark, *Using Law to Fight A Silent Epidemic: The Role of Health Literacy in Health Care Access, Quality, & Cost*, 20 ANNALS HEALTH L. 253, 286 (2011) (“*Truman* is considered significant for expanding the scope of disclosure beyond simply ensuring informed consent for a procedure or test that a patient does choose; it required giving information about the risks of doing nothing.”).

134. DOBBS ET AL., *supra* note 97, § 21.11, at 519.

135. *Id.*

136. See Shultz, *supra* note 132, at 264 (explaining that pregnancy informed consent cases are a bit different because “[n]o progressive and threatening disease drives the patient to undergo medical treatment” and instead “[t]he patient seeks some affirmative outcome instead of warding off an encroaching evil”).

legally required to inform the woman of that diagnosis.¹³⁷ In *Nold*, the mother was diagnosed with hepatitis B, which meant her child should be given an injection and a hepatitis B vaccine after birth.¹³⁸ This test result did not involve any specific procedure to which the woman consented, but the court affirmed the woman's broad right to be informed.¹³⁹

Likely the best example of an informed consent claim broadly applied in the pregnancy context is a wrongful birth claim. It is a woman's claim against her doctor if the doctor fails to disclose the unborn baby's birth defects.¹⁴⁰ That failure to disclose then deprives the woman of the ability to decide whether to terminate the pregnancy.¹⁴¹ Since *Roe v. Wade* established the constitutional right to choose abortion, almost all courts considering the existence of a wrongful birth claim have recognized it.¹⁴²

Like an informed consent claim, a wrongful birth claim "is predicated on the patient's right to self-determination."¹⁴³ It recognizes "the parents' lost opportunity to make the personal decision of whether or not to give birth to a child who might have birth defects."¹⁴⁴ The informed consent/wrongful birth claim has gained more prominence with the increased regularity of prenatal testing,¹⁴⁵ testing that can reveal conditions in the fetus that will cause the baby to die before or shortly after birth, or cause serious long-term physical or mental developmental issues.¹⁴⁶ Numerous successful informed consent claims have already been based on a doctor's failure to explain the

137. *Nold ex rel. Nold v. Binyon*, 31 P.3d 274, 286 (Kan. 2001); *see also* *Gates v. Jensen*, 595 P.2d 919, 924 (Wash. 1979) (en banc) (requiring a doctor to disclose to the patient that she had "borderline glaucoma," unconnected to any specific procedure); *Jamison v. Lindsay*, 166 Cal. Rptr. 443, 447 (Ct. App. 1980) (suggesting a doctor's duty to disclose information concerning "whether to seek additional treatment following surgery" (emphasis added)). Professor Marjorie Maguire Shultz suggests that these broader applications of informed consent doctrine enable the patient to "meaningful[ly] participat[e] in medical decisionmaking." Shultz, *supra* note 132, at 247.

138. *Nold*, 31 P.3d at 281.

139. *Id.* at 289.

140. DOBBS ET AL., *supra* note 97, § 27.4, at 678.

141. *Id.*

142. *Id.*; *see* Maggie Fox, *This Doctor Just Explained Late-Term Abortion—on Twitter*, NBC NEWS (Jan. 30, 2018, 8:28 PM), <https://www.nbcnews.com/health/health-news/doctor-just-explained-late-term-abortion-twitter-n842611> [<https://perma.cc/G29Y6W9A>].

143. *Canesi ex rel. Canesi v. Wilson*, 730 A.2d 805, 812 (N.J. 1999).

144. *Id.* at 810.

145. *Plowman v. Fort Madison Cmty. Hosp.*, 896 N.W.2d 393, 400 (Iowa 2017) (explaining "prenatal testing is 'extremely prevalent and is widely accepted,' and 'will likely become more common in the future'" (quoting Cailin Harris, *Statutory Prohibitions on Wrongful Birth Claims & Their Dangerous Effects on Parents*, 34 B.C. J.L. & SOC. JUST. 365, 370–71 (2014))).

146. *See infra* notes 192–93 and accompanying text (discussing screening for trisomies).

mother's risks of the conditions,¹⁴⁷ failure to recommend prenatal testing options,¹⁴⁸ and failure to recommend further tests.¹⁴⁹

The wrongful birth claim may appear tied to an affirmative medical procedure—an abortion. But the medical decision that the woman made without informed consent was not about a procedure; it was her decision to maintain her pregnancy. Because of the doctor's negligence, the woman didn't even know that abortion was something she may want to consider. She was thus deprived of the ability to make an informed decision regarding treatment of her medical condition, her pregnancy.

A Connecticut court specifically rejected the argument that “treatment of a pregnant patient in the course of care during a pregnancy does not constitute affirmative treatment” as required in an informed consent claim.¹⁵⁰ *Quinn v. Blau* concerned the doctor's failure to disclose test results that the baby had an increased risk of Down's Syndrome.¹⁵¹ There, the doctor argued he owed no duty to disclose the test results because informed consent claims are based only on “affirmative treatment of the patient's person, such as an invasive test or surgical procedure.”¹⁵² The doctor also argued that he lacked a duty to disclose because “the alleged undisclosed information relate[d] to the condition of pregnancy and not the affirmative treatment of the pregnancy.”¹⁵³ The *Quinn* court rejected all of these arguments. Affirmative treatment or not, the doctor owed a duty to disclose the test results. The non-disclosure “deprived [pregnant women] of the opportunity to make an informed choice regarding further treatment or what that treatment might be, i.e., further testing, continuing, or terminating the pregnancy.”¹⁵⁴

Even if the existence of affirmative treatment was still paramount, pregnancy is a medical condition that involves numerous possible affirmative treatments. As Justice Breyer recently described,

prenatal care often involves testing for anemia, infections, measles, chicken pox, genetic disorders, diabetes, pneumonia, urinary tract infections, preeclampsia, and hosts of other medical conditions. Childbirth itself, directly or through pain management, risks harms

147. *Azzolino v. Dingfelder*, 322 S.E.2d 567, 585 (N.C. Ct. App. 1984), *aff'd in part, rev'd in part*, 337 S.E.2d 528 (N.C. 1985).

148. *Canesi*, 730 A.2d at 810–11.

149. *Schirmer v. Mt. Auburn Obstetrics & Gynecologic Assocs., Inc.*, 844 N.E.2d 1160, 1163 (Ohio 2006).

150. *Quinn v. Blau*, No. CV96325691S, 1997 WL 781874, at *4 (Conn. Super. Ct. Dec. 12, 1997).

151. *Id.* at *1.

152. *Id.* at *4.

153. *Id.*

154. *Id.* at *6; *see also* *Berman v. Allan*, 404 A.2d 8, 14 (N.J. 1979) (recognizing a claim based on the doctor's failure to disclose the availability of an amniocentesis, “impermissibly den[ying] a meaningful opportunity to make” the decision about abortion), *abrogated by* *Hummel v. Reiss*, 608 A.2d 1341 (N.J. 1992).

of various kinds, some connected with caesarean or surgery-related deliveries, some related to more ordinary methods of delivery.¹⁵⁵

Informed consent doctrine and the resulting right to information has in some ways just become part of proper medical care.¹⁵⁶ The American College of Obstetricians and Gynecologists (“ACOG”) adopted informed consent as an ethical principle. In an ethics opinion, ACOG’s Committee on Ethics explained that obtaining “informed consent expresses respect for the patient as a person,” particularly by “respect[ing] a patient’s moral right to bodily

155. *Nat’l Inst. of Fam. & Life Advocs. v. Becerra*, 138 S. Ct. 2361, 2386 (2018) (Breyer, J., dissenting). Writing for the majority, Justice Thomas took a narrower view of informed consent applied to procedures in pregnancy. He explained that a California law requiring crisis pregnancy centers, centers known to discourage women from seeking abortions, to post a notice “that California provides free or low-cost services, including abortions, and give them a phone number to call” was consistent with informed consent doctrine. *Id.* at 2368, 2373 (majority opinion). He explained that the notice requirement “does not facilitate informed consent to a medical procedure. In fact, it is not tied to a procedure at all. It applies to all interactions between a covered facility and its clients, regardless of whether a medical procedure is ever sought, offered, or performed.” *Id.* at 2373. The information is tied to the woman’s pregnancy, however, the reason for all of the woman’s visits to the facility. And the sign is a way to provide to her additional information regarding her medical condition and her options, including abortion. Notably, Justice Breyer’s dissent responded to Justice Thomas’ dismissal of pregnancy and informed consent with one word: “Really?” *Id.* at 2386 (Breyer, J., dissenting). Justice Breyer also commented on Justice Thomas’ unworkable juxtaposition of requiring and emphasizing informed consent for abortion, but not for carrying a pregnancy to term. “Indeed, nationwide ‘childbirth is 14 times more likely than abortion to result in’ the woman’s death. Health considerations do not favor disclosure of alternatives and risks associated with the latter but not those associated with the former.” *Id.* (citations omitted).

156. A broad application of informed consent doctrine blurs the traditional dividing line between a malpractice claim and an informed consent specific malpractice claim. Traditionally, the basis of a malpractice claim was that the doctor acted improperly in providing medical care, like he made a mistake in providing medical care. *See, e.g., Bienz v. Cent. Suffolk Hosp.*, 557 N.Y.S.2d 139, 139 (App. Div. 1990) (“A medical malpractice cause of action may be based on allegations that a physician negligently gave advice to his patient as to what course of treatment to pursue.”). Today though, part of providing that medical care is also providing information consistent with informed consent doctrine. The facts of *Montgomery v. Lanarkshire Health Board* illustrate the overlap. In that case, the patient sued for her doctor’s failure to disclose the risks associated with the recommended vaginal childbirth. *Montgomery v. Lanarkshire Health Bd.* [2015] UKSC 11, [2], [2015] 1 AC 1430 (appeal taken from Scot.). Ms. Montgomery had Type I diabetes, which can cause complications in vaginal childbirth due to the child’s likely large weight. *Id.* at [7]. Ms. Montgomery alleged and established that her doctor should have disclosed those risks associated with vaginal childbirth and had her doctor done so, she would have chosen a cesarean delivery and her child likely would not have gotten cerebral palsy. *Id.* at [18]. Ms. Montgomery likely also had a relatively easy claim for malpractice—that the doctor’s insistence on that vaginal delivery was malpractice, especially since the doctor ceased doing ultrasounds to monitor the size of the baby. The decided treatment can be the basis for a traditional malpractice claim, but the doctor’s failure to explain that decided treatment is the basis of the very related informed consent claim. Some states do very much maintain a distinction in that evidence of that patient’s informed consent to the procedure is not a defense to traditional malpractice claim. *See Brady v. Urbas*, 111 A.3d 1155, 1162 (Pa. 2015) (“[T]here is no assumption-of-the-risk defense available to a defendant physician which would vitiate his duty to provide treatment according to the ordinary standard of care.”).

integrity, [and] to self-determination.”¹⁵⁷ The decision explains two components of the ethical concept of informed consent—enabling a patient’s comprehension and her free consent.¹⁵⁸ The comprehension element “includes the patient’s awareness and understanding of her situation and possibilities.”¹⁵⁹ This comprehension is important because it enables the patient to participate and partner in her healthcare; it “makes possible the patient’s active involvement in her medical planning and care.”¹⁶⁰ The ACOG ethics opinion also explains the importance of the patient’s “active participation in decisions about the management of one’s medical care.”¹⁶¹ According to the Committee, “[c]onsent in this sense requires not only external freedom and freedom from inner compulsion, but also . . . freedom from *ignorance*.”¹⁶²

Both courts’ expanded application of informed consent doctrine and medical organizations’ adoption of it as an ethical principle change the patient’s role in her medical care. She is entitled to information regarding her medical condition regardless of whether a procedure is possibly impending. She is also increasingly an active participant in her health care instead of a passive recipient.

IV. A TORT CLAIM FOR A DOCTOR’S FAILURE TO DISCLOSE THE RISK OF STILLBIRTH

Pregnant women are unaware of risk of stillbirth because of their doctors’ failure to disclose it. Ideally, doctors would begin to disclose this very real risk on their own, but that seems unlikely. For years the Star Legacy Foundation, an organization devoted to increasing stillbirth research, education, and family support, has attempted to work with medical and professional associations, state health departments, and hospital organizations to convince

157. COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, OPINION NO. 439, INFORMED CONSENT 1 (2009), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2009/08/informed-consent.pdf> [<https://perma.cc/4L4Y-2UJQ>].

158. *Id.*

159. *Id.* at 3.

160. *Id.* at 1.

161. *Id.* at 5.

162. *Id.* (emphasis added). ACOG’s ethics opinion does not adopt a required standard for disclosure. But the emphasis on self-determination also implies the materiality standard is preferable “for permanently overriding the obligation to seek informed consent.” *Id.* at 7. Even if ACOG agreed to the materiality standard, “the actual attitudes—and behavior—of physicians in practice are often at odds with the ‘ethical best practices’ advocated by their national membership bodies.” LINDA C. FENTIMAN, *BLAMING MOTHERS: AMERICAN LAW AND THE RISKS TO CHILDREN’S HEALTH* 87 (2017). The commitment to informed consent may thus be more aspirational than actual. See Michelle Oberman, *Mothers and Doctors’ Orders: Unmasking the Doctor’s Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 466 (2000) (discussing “[t]he American Medical Association’s ethical and policy guidelines” that “embrace[] the notion of an autonomy right for patients,” “[a]t least at the aspirational level”).

doctors to voluntarily make this change—to educate pregnant women about stillbirth.¹⁶³ Unfortunately, doctors remain steadfast that women don't need to and shouldn't know of the risk of stillbirth.¹⁶⁴

Just as a change in tort law was necessary to get doctors to start disclosing material risks of medical procedures,¹⁶⁵ the recognition of an informed consent claim based on the failure to disclose the chances of stillbirth—the risk that is present in every pregnancy and the measures that can help prevent it—is likely necessary to prompt disclosure.¹⁶⁶

The application of informed consent doctrine to disclosure of stillbirth is novel, but not difficult. The risk of stillbirth is material to any pregnant woman desiring her pregnancy. The materiality standard rejects the medical paternalism lurking behind the common reasons for non-disclosure, a silence that is only endangering both the mother and her child. Establishing causation is also easier than it may appear. Given the current state of medical research and the relatively low preponderance of evidence burden of proof in tort law, a woman can prove that had her doctor disclosed the risk of stillbirth, her child more likely than not would not have been stillborn. Last, the damages for such a claim would be based on the parents' loss, the same as in a wrongful death claim based on stillbirth.

A. THE MATERIALITY OF THE RISK OF STILLBIRTH

Currently, doctors are deciding that women both don't need to and shouldn't know of the risk of stillbirth. The three main reasons for their non-disclosure are that the risk is low, stillbirth is (supposedly) unpreventable, and disclosing will cause the woman anxiety.¹⁶⁷ These three reasons may have been

163. Telephone Interview with Lindsey Wimmer, RN, MSN, CPNP, CPLC, Founder & Exec. Dir., Star Legacy Found. (Oct. 25, 2019).

164. See *supra* Section II.B.

165. See Szczygiel, *supra* note 95, at 171 (explaining that “courts played a leading role” in expanding and enforcing broader disclosure requirements for doctors).

166. Very few cases can be found involving stillbirth and informed consent. One case that actually focused on the risk is a 1999 UK case in which a woman sued her doctor after he failed to disclose the risk of stillbirth when advising her to wait for childbirth to occur naturally even though it was after her due date. The case is discussed in Section IV.A.1. Otherwise, the risk of stillbirth seems to only come up in informed consent cases concerning the woman's decision for vaginal or cesarean delivery. For example, in a Louisiana case, a diabetic mother whose child was stillborn claimed that her consent to a vaginal delivery was not informed. *Descant v. Adm'rs of the Tulane Educ. Fund*, 706 So. 2d 618, 621 (La. Ct. App. 1998). But the doctor testified at trial that he did disclose the risk of stillbirth, explaining it “as the death of the baby before it is born.” *Id.* at 633–34. Journalist Jennifer Block believes that doctors frequently bring up stillbirth in advising women on childbirth methods—invoking the “dead baby card” to get women to agree to cesareans. JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE 92 (2007). Elizabeth Kukura criticizes this as doctors using “language intended to shock and frighten, rather than to inform and assist in effective decision making.” Kukura, *supra* note 16, at 752.

167. See *infra* Sections IV.A.1–3.

consistent with the traditional doctor-focused informed consent disclosure standard, but none of them renders stillbirth immaterial.

First, even if the risk of stillbirth is low for an individual woman, the gravity of the injury is high for both the mother and child, making the risk material.¹⁶⁸ Next, some stillbirths are preventable. Successful and dramatic reductions of the stillbirth rates in other countries demonstrate this preventability.¹⁶⁹ “Unpreventability” is thus no excuse for doctors’ silence. Last, although common, there is no truth to the narrative of the emotional and irrational pregnant woman.¹⁷⁰ Doctors are presuming instability to all pregnant women, a presumption the materiality standard prohibits.¹⁷¹ Doctors’ silence, which unfortunately may be motivated by billing practices,¹⁷² does not protect the woman; it instead endangers both the woman and her unborn child.

1. Low Frequency, Yet Severe Injury

One reason that doctors do not disclose the risk of stillbirth to their patients is the low risk.¹⁷³ Additionally, in one survey of doctors, the physicians experienced “discomfort” in raising the topic because stillbirth “is typically a clinically unexpected and sudden event.”¹⁷⁴

Low risk was one of the reasons the doctor did not disclose the chance of stillbirth in *Pearce v. United Bristol Healthcare NHS Trust*.¹⁷⁵ Mrs. Pearce was two weeks past her due date with her child and “begged” her doctor to either have labor “induced or have a Caesarean section” delivery.¹⁷⁶ The doctor, however, believed that allowing labor to begin naturally was the proper course of treatment.¹⁷⁷ Mrs. Pearce left her doctor’s office and gave birth to her stillborn child about one week later.¹⁷⁸ Mrs. Pearce later filed an informed consent claim, alleging that the doctor should have disclosed the risk of stillbirth to her.¹⁷⁹ The doctor said one reason he did not disclose the risk of stillbirth because the likelihood was low.¹⁸⁰

168. See *infra* Section IV.A.1.

169. See *infra* Section IV.A.2.

170. See *infra* Section IV.A.3.

171. See *infra* Section IV.A.3.

172. See *infra* Section IV.A.3.

173. Telephone Interview with Lindsey Wimmer, *supra* note 163.

174. Kelley & Trinidad, *supra* note 13, at 4.

175. *Pearce v. United Bristol Healthcare NHS Tr.* [1999] AC 167 at 167–68 (appeal taken from Eng.).

176. *Id.* at 169.

177. *Id.*

178. *Id.* at 170.

179. *Id.*

180. *Id.* at 174.

The UK court agreed with the doctor's non-disclosure and applied a disclosure standard that depended only on the size of the risk—disclosure was required if it was significant enough that it “would affect the judgment of a reasonable patient.”¹⁸¹ This focus on the size of the risk reflects the traditional doctor-focused standard. The risk of stillbirth for Mrs. Pearce was “something like 0.1 to 0.2 [percent],” which the court did not consider “significant”¹⁸² and characterized as “very, very small.”¹⁸³ The court explained that “it would not be proper for the courts to interfere with the clinical opinion of the expert medical man responsible for treating Mrs[.] Pearce.”¹⁸⁴

Had the *Pearce* court applied the materiality standard, it would have discussed both the low risk and the gravity of the injury—that Mrs. Pearce's child, whom she named Jacqueline, could die. The court would have explained that, despite the low risk, stillbirth is the most severe consequence possible for a woman past 20 weeks of pregnancy. That woman is planning for the baby, decorating a nursery, and singing to the baby in her womb. Theories of prenatal attachment demonstrate that the mother-child bond develops well before birth.¹⁸⁵ Plus, her child's stillbirth dramatically increases life-threatening complications for the woman during delivery and a possible lifelong psychological distress.¹⁸⁶ Any reasonable woman at that point in pregnancy would want to know, even if the risk of death is low.

If anything, the *Pearce* court implied that the Pearces' loss of their child was not that grave. The court does acknowledge that the child's stillbirth “was obviously extremely distressing,” and its opinion includes Jacqueline's name.¹⁸⁷ But the court also noted that “Mrs. Pearce is already the mother of five children. Jacqueline would have been her sixth child. Since the events to which I am about to refer, she has given birth successfully to another child, so

181. *Id.*

182. *Id.*

183. *Id.* at 175. For reasons unexplained in the opinion, the court dismisses the possibility of inducing labor. *Id.* at 169–70 (explaining that the “medical evidence before the judge was overwhelming that it would indeed be risky to induce the birth . . . [and] [b]ecause of that, the question of the baby being induced at that stage falls out of consideration”). The court thus instead evaluates the risk of stillbirth versus the risks associated with a c-section delivery. *Id.* at 170–71.

184. *Id.* at 175. The court also did not receive accurate information regarding the chances of stillbirth. For instance, the court mentioned that the risk of stillbirth was greater earlier in the pregnancy. *Id.* That is not true; the risk of stillbirth increases as pregnancy progresses. *See supra* note 53. The court also mentioned that the baby's not large size reduced the chances of stillbirth. *Pearce* [1999] AC at 175. Again, not true; low birth weight is a risk factor for stillbirth. *See supra* text accompanying note 50.

185. Julie F. Pallant, Helen M. Haines, Ingegerd Hildingsson, Maddalena Cross & Christine Rubertsson, *Psychometric Evaluation and Refinement of the Prenatal Attachment Inventory*, 32 J. REPROD. & INFANT PSYCH. 112, 112 (2014) (“The relationship between a mother and child does not begin at birth, but develops throughout the pregnancy.”).

186. *See supra* text accompanying notes 74–82.

187. *Pearce* [1999] AC at 168.

she has a family of six children.”¹⁸⁸ The court’s mention of these facts implies that Jacqueline’s death was distressing, but not that distressing. Mrs. Pearce already had a large family before Jacqueline’s death, and she had even already had another sixth child, even though Jacqueline was her sixth child.¹⁸⁹ Regardless, this discussion implies that the Pearces’ injury, Jacqueline’s stillbirth, was not that severe. And a not-that-severe injury combined with a low risk easily translates to the doctor’s not needing to disclose the risk of stillbirth.

Years later, UK courts more fully adopted the materiality standard in informed consent cases, explaining: “The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk.”¹⁹⁰ The significance of the risk is based not on its size, but on whether it would be significant to a reasonable person in the patient’s position. As a court further clarified:

the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.¹⁹¹

Thus, even a very low risk of stillbirth does not render the risk of stillbirth immaterial. The gravity of one’s child’s death, the rest of one’s life as a bereaved mother, and the desire for one’s child to be born alive also matter.

Last, any argument of the lack of need to disclose stillbirth because of its small risk is illogical given that doctors do routinely disclose even smaller risks of the unborn baby’s death. Around 12 weeks of pregnancy, women now commonly undergo genetic testing to see if the fetus is at risk for a genetic or chromosomal complication.¹⁹² These complications include Down Syndrome,

188. *Id.* at 169.

189. The replacement-child strategy is a common cultural reaction to stillbirth, and courts similarly frequently cite the existence or possibility of other children as a reason to reduce parents’ damages after stillbirth in wrongful death cases. See Jill Wieber Lens, *Tort Law’s Devaluation of Stillbirth*, 19 NEV. L.J. 955, 992–99 (2019) [hereinafter Lens, *Devaluation of Stillbirth*].

190. *Montgomery v. Lanarkshire Health Bd.* [2015] UKSC 11, [87], [2015] 1 AC 1430 (appeal taken from Scot.).

191. *Id.* at [89].

192. *Prenatal Genetic Screening Tests*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/patient-resources/faqs/pregnancy/prenatal-genetic-screening-tests> [https://perma.cc/6A75-EZLV] (last updated Oct. 2020) (explaining that cell-free DNA testing can occur as early as ten weeks of pregnancy and can indicate whether the fetus is at increased risk for Trisomy 21 (Down Syndrome), Trisomy 13 (Patau Syndrome), and Trisomy 18 (Edwards Syndrome)).

Trisomy 13, and Trisomy 18.¹⁹³ Trisomy 13 and 18 are likely fatal for the baby.¹⁹⁴ The risks of giving birth to a baby with chromosomal abnormalities increase as the woman ages, but most of these risks remain under one percent even if the woman is as old as 38.¹⁹⁵ If doctors used the same “too small of a risk” paternalistic approach with these screening tests that they do with stillbirth, doctors would not disclose the risk when discussing the possibility of the testing with a pregnant patient. But that’s not the case. Doctors *do* disclose these (very, very small) risks that something could be seriously wrong, possibly fatal, with the fetus, enabling the woman to make an informed decision whether she feels it necessary to do the testing. Any idea that doctors need not disclose the risk of stillbirth with pregnant woman is inconsistent with informed consent law and defies logic given that doctors do routinely disclose risks that something could be wrong with the unborn child that are much smaller than the risk of stillbirth.

2. The Fatalism Myth

Another reason doctors explain their failure to disclose the risk of stillbirth is that they lack any advice for women on how to avoid their baby’s possible stillbirth.¹⁹⁶ Doctors feel helpless—they could warn women of the risk of stillbirth, but decline to do so because they (supposedly) have no advice for women on how to avoid it.

As an initial matter, informed consent law has never required disclosure only of risks that the doctor can fix. Otherwise, a doctor would never be obligated to disclose that medical procedure includes a risk that the patient may die, a result that a doctor obviously cannot fix. To the contrary, the whole point of informed consent law is to ensure that the doctor discloses the existing risks so that a patient can make an informed decision, including medical risks or resulting conditions that doctors cannot fix.

The best response to the fatalistic view that doctors are helpless, however, is that it is not true. Research concludes that stillbirth is neither inevitable nor unpreventable despite pervasive myths that stillbirths are “mostly due to non-preventable congenital abnormalities.”¹⁹⁷ Only about seven percent of 2.6 million stillbirths that occur yearly globally (using a 28-week definition

193. *Id.*

194. *Trisomy 18 and 13*, BOS. CHILD.’S HOSP., <http://www.childrenshospital.org/conditions-and-treatments/conditions/t/trisomy-18-and-13> [https://perma.cc/B8SA-2NKJ].

195. *Maternal Age Related Risk for Chromosome Abnormalities*, GENETIC & RARE DISEASES INFO. CTR., <https://rarediseases.info.nih.gov/GlossaryDescription/8/0> [https://perma.cc/P3ZX-L96E].

196. Telephone Interview with Lindsey Wimmer, *supra* note 163; Goldenbach, *Short Shrift*, *supra* note 46 (“Several doctors told us that they don’t see any point in discussing stillbirth, that it’s a catch-all term for an event, and one that is frequently unexplained. If doctors knew the causes of stillbirth or its telltale signs, they say, they’d warn parents—and take preventive action.”).

197. Lawn et al., *supra* note 30, at 597.

of stillbirth) are due to congenital abnormalities. Even some of those abnormalities are actually preventable if the mother takes folic acid.¹⁹⁸ The rest of stillbirths, however, are potentially preventable.

The preventability of those rest of stillbirths is definitively established by the fact that numerous countries have reduced, sometimes substantially, their stillbirth rates. In recent testimony before an Australian Senate Committee, 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 percent reduction of stillbirths over the next 14 years.¹⁹⁹ 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 percent over the next four years.²⁰⁰ England decreased its stillbirth rate by 19 percent in the last decade.²⁰¹ These countries' statistics definitively establish that some stillbirths are preventable. In the words of Scotland's Chief Medical Officer Catherine Calderwood: "Don't let them tell you it can't be done. It can."²⁰²

Despite its rate being higher "than in many other high-income countries, and rates continu[ing] to decrease in other high-income countries,"²⁰³ the United States hasn't implemented any efforts to decrease its stillbirth rate. But research specific to the United States suggests improvement is possible. A recent study specific to stillbirths in the United States similarly concluded that "approximately one fourth of stillbirths that occur in the United States are potentially preventable,"²⁰⁴ and also clarified that its conclusion was conservative. More specifically, the study identified stillbirths occurring during childbirth, within pregnancies with multiples, and those due to maternal medical conditions, hypertensive disorders during pregnancy, and placental insufficiency as potentially preventable.²⁰⁵ The study also clarified that it used conservative criteria and that "compelling argument[s] [exist] that many of the stillbirths [the study] did not include as potentially preventable were, in fact, preventable."²⁰⁶

198. *Id.*

199. AUSTRALIAN SENATE COMMITTEE REPORT, *supra* note 59, § 7.29, at 113.

200. *Id.*

201. *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-record-low> [<https://perma.cc/G2EL-NQ2A>].

202. Catherine Calderwood, Chief Med. Officer for Scot., Presentation at the Star Legacy Foundation Stillbirth Summit (June 22, 2019).

203. Page et al., *supra* note 37, at 337.

204. *Id.* at 340.

205. *Id.* at 336. The study labeled stillbirths at less than 24 weeks of gestation, before the baby is viable, and those due to major fetal abnormalities and genetic conditions as unpreventable. *Id.* at 336, 341.

206. *Id.* at 341.

Admittedly, far too much medical uncertainty exists about the causes of and ability to prevent stillbirth. “Although medical uncertainty heightens the need for professional *advice*, it also strengthens the case for lay *choice*.”²⁰⁷ If there is uncertainty, “the patient should receive information about divergent views and be allowed to arrive at her own decision.”²⁰⁸ Thus, even if a doctor (inaccurately) believes stillbirth to be unpreventable, this actually increases the need for disclosure as opposed to excusing non-disclosure.

Last, just like the “the risk is too low” reason that doctors do not commonly disclose stillbirth, not disclosing stillbirth because it is (supposedly) unpreventable is also inconsistent with doctors’ routine disclosure of the risks of fatal fetal abnormalities. There is no “fix” for a fatal abnormality; an abortion is hardly a fix for parents desiring the baby. Yet doctors still routinely disclose these risks.

3. The Anxiety Myth

Another common reason that doctors do not disclose the risk of stillbirth to pregnant women is that doctors do not want to scare moms.²⁰⁹ Presumably, mentioning the possibility of stillbirth would cause a woman great anxiety. In one study, a doctor explained he does not mention stillbirth before it happens due to “concern that it may frighten the patient unnecessarily.”²¹⁰ Specifically, he doesn’t “use the actual word” stillbirth because “[i]t scares people.”²¹¹ The woman’s emotional state was also one reason the doctor didn’t disclose the risk of stillbirth in the UK *Pearce* case mentioned above. Two weeks past her due date, Mrs. Pearce was “distressed” when she visited her doctor, and she became even further distressed when her doctor told her to “not behave like a child.”²¹² The court relied on her distress, which the doctor helped cause, in agreeing with the doctor’s non-disclosure—“[p]articularly when one bears in mind Mrs Pearce’s distressed condition, one cannot criticise [the doctor’s] decision not to inform Mrs Pearce of that very, very small additional risk.”²¹³

This idea that a pregnant woman is fragile, irrational, or emotional and thus unable to make a decision or in need of protection is not new. This type of characterization is present in both childbirth and abortion cases. Professor Jamie Abrams reviewed cases in which women desired vaginal births despite doctors’ insistence on cesarean deliveries and overwhelmingly found courts

207. Shultz, *supra* note 132, at 271–72.

208. *Id.* at 270.

209. Telephone Interview with Lindsey Wimmer, *supra* note 163; Goldenbach, *Short Shrift*, *supra* note 46 (explaining that talking to women about stillbirth is “going to frighten a lot of people”).

210. Kelley & Trinidad, *supra* note 13, at 4.

211. *Id.*

212. *Pearce v. United Bristol Healthcare NHS Tr.* [1999] AC 167 at 170 (appeal taken from Eng.).

213. *Id.* at 175.

characterizing mothers “as stubborn, perhaps reckless,”²¹⁴ and “making decisions in the abstract, out of emotion, or irrationally.”²¹⁵ Similarly, in abortion cases, courts often portray the pregnant woman as “stupid[] and irrational[]” and engaged in “unnecessary risk-taking and careless decision making.”²¹⁶

The irrational pregnant woman narrative could trigger the therapeutic exception to the materiality standard, which negates disclosure of material risks if it would cause a patient to “become so . . . emotionally distraught . . . as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient.”²¹⁷ Although the *Canterbury* court recognized the therapeutic exception, it also quickly clarified that it must be applied narrowly.²¹⁸ If applied too broadly, it would allow a return to the paternalistic “doctor knows best” standard. *Canterbury* also clarified that the therapeutic exception must not allow the doctor to “presume[] instability or perversity.”²¹⁹

These restrictions on the therapeutic exception demonstrate its inapplicability to the disclosure of the risk of stillbirth. Doctors currently conclude that *all* pregnant women are likely to become emotionally distraught or experience psychological damage if told of the risk of stillbirth. That it is not a narrow application; it is impossible to both apply this exception narrowly as *Canterbury* requires and yet also apply it to all pregnant women.

Moreover, the presumption illogically assumes that disclosure of the risk of stillbirth is necessarily bad news—that a pregnant woman hearing that any risk of stillbirth exists will become hysterical. But while the chance of stillbirth exists, it is a very small chance. It makes little sense to assume that a pregnant woman will be driven to hysteria upon learning of the one percent chance her baby won’t be born alive. The woman already successfully avoided miscarriage in the first 20 weeks, where she had as much as a 25 percent chance of losing her baby. Nevertheless, the presumption persists that a woman could not handle news of a very low chance of losing her baby.

The presumption is also illogical given that doctors routinely disclose the risk of fatal chromosomal abnormalities. Testing around ten weeks of

214. Abrams, *Distorted and Diminished*, *supra* note 16, at 1994 (discussing *Ortego v. Jurgelsky*, 732 So. 2d 683 (La. Ct. App. 1999) and *Blevins v. Clark*, 740 N.E.2d 1235 (Ind. Ct. App. 2000)).

215. *Id.* at 1995.

216. See Jody Lyneé Madeira, *Woman Scorned?: Resurrecting Infertile Women’s Decision-Making Autonomy*, 71 MD. L. REV. 339, 357 (2012).

217. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972).

218. *Id.* at 780.

219. *Id.* at 789. Plus, courts rarely apply the therapeutic exception in modern jurisprudence. Bradford Wixen, *Therapeutic Deception: A Comparison of Halacha and American Law*, 13 J. LEGAL MED. 77, 86–87 (1992) (“Because the therapeutic exception conflicts with the common-law value of self determination and is only debatably constitutional, the exception is one that defendants are reluctant to assert and courts are hesitant to enforce.”).

pregnancy for Down Syndrome and the fatal Trisomy 18 and Trisomy 13 has become standard, even though the risks are lower than the risk of stillbirth.²²⁰ For any pregnant woman, the word “trisomy” should scare her and cause her psychological damage as much as the word “stillbirth,” yet doctors routinely disclose these risks.

Simply put, no evidence supports the presumption. Doctors are paternalistically presuming instability without any evidence of instability. As a Wisconsin court forcefully stated, “[t]here is nothing about pregnancy or the onset of the labor process that automatically renders a woman incapable of rational thought or unable to participate in competent decision-making with respect to which medically viable treatment will be followed.”²²¹ Lady Hale of the UK Supreme Court similarly explained “[g]one are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.”²²²

Medical research supports the lack of evidence for any presumption of instability. Stillbirth researcher Danielle Pollock recently published a study of Australian women in which she asked participants “how you would feel if your health care provider discussed with you about stillbirth alongside with some tools (fetal movements monitoring) to possibly detect that your baby was unwell.”²²³ The participants responded:

44.5%	They would feel “very calm” or “slightly calmer” ²²⁴
23.9%	They would feel “neither anxious nor calmer” ²²⁵
27.1%	They would feel “slightly anxious” ²²⁶
4.6%	They would feel “very anxious” ²²⁷

Again, only 4.6 percent of women answered that the conversation would make them feel “very anxious” as doctors’ prevailing narrative depicts.²²⁸ In another study conducted by Pollock, a participant explained that

I would have preferred to have readily available information and having a little fear in me and knowing about the warning signs and

220. The risk varies depending on the woman’s age. *See supra* text accompanying notes 192–95.

221. *Schreiber v. Physicians Ins. Co. of Wis.*, 579 N.W.2d 730, 735 (Wis. Ct. App. 1998), *aff’d*, 588 N.W.2d 26 (Wis. 1999).

222. *Montgomery v. Lanarkshire Health Bd.* [2015] UKSC 11, [116], [2015] 1 AC 1430 (appeal taken from Scot.).

223. Danielle Pollock, Tahereh Ziaian, Elissa Pearson, Megan Cooper & Jane Warland, *Breaking Through the Silence in Antenatal Care: Fetal Movement and Stillbirth Education*, 33 *WOMEN & BIRTH* 77, 82 (2020) [hereinafter Pollock et al., *Breaking Through the Silence*].

224. *Id.*

225. *Id.*

226. *Id.*

227. *Id.*

228. *Id.*

maybe just maybe many parents wouldn't have to walk from a birthing suite [with] empty arms, heart aching, and having to prepare a funeral for their baby.²²⁹

When testifying recently before an Australian governmental committee, Pollock explained that “no evidence” exists for “the anxiety myth” and that other countries have realized this.²³⁰ Similarly, another stillbirth researcher dismissed the anxiety presumption by analogizing to “airline safety briefings,” which “are presented to passengers on every flight, even though the risk of a crash occurring is extremely low. ‘Most passengers don’t run off the plane screaming in fear that because it was discussed, it’s going to happen. But we *assume* that women will do that if stillbirth is discussed.’”²³¹ Another submission to the same committee hearing analogized disclosure of the stillbirth risk to disclosure of sudden infant death syndrome (“SIDS”). Although SIDS is also “[a] terrifying thought for any . . . parent,” increasing awareness did “not cause[] mass hysteria or anxiety;” rather, “it has reduced rates.”²³²

Doctors are protecting neither the mother nor her baby when they fail to disclose the risk of stillbirth. That makes stillbirth factually distinct from the childbirth and abortion cases in which, as mentioned briefly above, the narrative of the irrational pregnant woman is also common.²³³ These cases did not involve the therapeutic exception to the materiality standard, but instead concern attempts to directly or indirectly override the pregnant woman’s medical decision. In childbirth cases, the doctor goes to court to force a cesarean delivery despite the mother’s desire for a vaginal one.²³⁴ And courts frequently agree with the doctor, enabling the doctor “to compel their patients to heed medical advice” regarding childbirth, “a startling exception to the nearly universal consensus that patients, not doctors, should control determinations about whether and when to undergo medical treatment.”²³⁵ In the abortion cases, the Supreme Court has expressly affirmed the

229. Danielle Pollock et al., *Voices of the Unheard: A Qualitative Survey Exploring Bereaved Parents Experiences of Stillbirth Stigma*, 33 *WOMEN & BIRTH* 165, 171 (2020) [hereinafter Pollock et al., *Voices of the Unheard*].

230. AUSTRALIAN SENATE COMMITTEE REPORT, *supra* note 59, § 7.28, at 113.

231. *Id.* § 7.7, at 108 (emphasis added) (quoting stillbirth researcher Natasha Donnelly).

232. *Id.* § 7.13, at 109.

233. See *supra* text accompanying notes 214–16.

234. See, e.g., *Pemberton v. Tallahassee Mem’l Reg’l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1249–50 (N.D. Fla. 1999); *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457, 458 (Ga. 1981).

235. Jamie R. Abrams, *The Illusion of Autonomy in Women’s Medical Decision-Making*, 42 *FLA. ST. U. L. REV.* 17, 49 (2014) (quoting Oberman, *supra* note 162, at 469). Abrams also explains VBAC conflict is likely even more common than it appears, but that “women often acquiesce to medical expertise[,] . . . align[ing] with a longstanding historical shift to the primacy of doctors in reproductive decision-making.” *Id.* at 35–36. The acquiescence is partly due to women’s desires to be “good mothers” who use good doctors and listen to those doctors, and partly due to a lack of access to information. *Id.* at 37, 49.

constitutionality of state attempts to dissuade the woman from choosing abortion to protect her psychological well-being,²³⁶ a ruling that “assume[s] that women lack[] the judgment to make ‘mature and informed’ abortion decisions on their own, without pressure from the State, as other patients do with respect to other important medical decisions.”²³⁷ The Court even upheld a federal ban on a second-trimester abortion procedure because of how it could affect the woman’s psychological well-being.²³⁸ As Professor Maya Manian explains, this reasoning assumes pregnant women are “‘hysterical’ and childlike,”²³⁹ “emotionally unstable,”²⁴⁰ and incapable “of deciding how best to protect [their] own mental health.”²⁴¹

The pregnant woman’s emotional state is only one reason that courts have found for doctors and the State in these cases. Another reason is the purported maternal-fetal conflict in those situations. As Abrams explains, “[c]esarean sections today are often distinctly utilized to minimize fetal risks, while they simultaneously increase maternal risks.”²⁴² The mother is portrayed as acting in her own interests, while the doctor is the one looking out for the unborn child. The purported maternal-fetal conflict in the abortion context

236. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882–83 (1992) (ruling that the state could also express its “preference for childbirth over abortion” within its attempt to ensure the woman gives informed consent “to ensure that a woman apprehend[s] the full consequences of her decision . . . reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed”).

237. Manian, *supra* note 98, at 251; see also *Casey*, 505 U.S. at 918 (Stevens, J., concurring in part) (explaining that the plurality opinion “rest[s] on outmoded and unacceptable assumptions about the decisionmaking capacity of women”).

238. *Gonzales v. Carhart*, 550 U.S. 124, 159–60 (2007). But see CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST-CENTURY AMERICA 132 (2017) (explaining that in “*Carhart*, the Court decided that it is better for everyone to ban the whole thing rather than to force a confrontation through disclosure ahead of time”).

239. Manian, *supra* note 98, at 258.

240. *Id.*

241. *Id.*; see *Gonzales*, 550 U.S. at 183–84 (Ginsburg, J., dissenting) (criticizing that the majority’s opinion affirming the constitutionality of Congress’ ban on the intact D&E abortion procedure was based on stereotypes of women in a “fragile emotional state”); see also Susan Frelich Appleton, *Reproduction and Regret*, 23 YALE J.L. & FEMINISM 255, 268 (2011) (explaining that the *Carhart* opinion “reli[es] on gender stereotypes that characterize women as ignorant, naive, and unable to elicit pertinent information from health care providers, as well as emotionally fragile if not psychologically unfit”); Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1615 (2008) (“Abortion disclosure laws separate women deciding about abortion from people deciding about other kinds of medical interventions.”); Jack M. Balkin, *Original Meaning and Constitutional Redemption*, 24 CONST. COMMENT. 427, 530–31 (2007) (explaining that legislators “assume that pregnant women lack decisionmaking capabilities to choose abortion in ways that legislatures do not assume about women’s choices for other surgical procedures” and that legislators assume women who would choose abortion “are misinformed, emotionally distraught, or mentally confused”).

242. Abrams, *Distorted and Diminished*, *supra* note 16, at 1973–74.

is more obvious. Again, the woman is portrayed as acting in her own interests and not thinking of the fetus.²⁴³

These maternal-fetal conflicts make little sense factually; the woman is not necessarily acting in only her interests in either situation. With respect to childbirth, the mother wants the child to be born alive and healthy; her interest is much greater than the doctor's, making the "maternal-fetal" label strange.²⁴⁴ And in the abortion context, Professor Jamie Abrams recently discussed how the portrayal of the woman thinking only of herself undercuts the complexity of a woman's decision to abort, which often involves consideration of how another child would affect her existing children.²⁴⁵

Feminist legal scholars have also thoroughly criticized the maternal-fetal conflict label itself. As Professor Michelle Oberman elegantly explains, these purported maternal-fetal conflicts actually "result from doctors' seemingly well-motivated efforts to promote maternal or fetal well-being by imposing their perception of appropriate medical care on their pregnant patients. Hence, these are not maternal-fetal conflicts at all, but rather maternal-doctor conflicts."²⁴⁶ In the abortion context, these are maternal-*state* conflicts, with the state imposing its perception of appropriate medical care—that the woman should have the child instead of terminating.

But there's little support for an argument that the doctor is acting in the unborn child's best interest in failing to disclose stillbirth. In fact, the non-disclosure is actually *contrary* to the unborn child's best interests. As more fully detailed later, if the mother knew of the risk of stillbirth, she would be more likely to do the measures that can help prevent it—not smoking, sleeping on her side, and paying close attention to the baby's movements.²⁴⁷ Without knowledge, the mother lacks the power to best protect her unborn child. This is both inconsistent with the child's best interests and the mother's best interest. The mother has a greater interest than anyone in ensuring that the child is born alive. And the non-disclosure deprives her of important and necessary information, rendering her unable to participate in both her and her child's healthcare.

243. Jamie R. Abrams, *The Polarization of Reproductive and Parental Decision-Making*, 44 FLA. ST. U. L. REV. 1281, 1302–03 (2017) [hereinafter Abrams, *Parental Decision-Making*].

244. Kukura, *supra* note 16, at 794–95 (“[A] woman who has decided to carry a pregnancy to term is making decisions with the fetus in mind—and arguably is the most motivated party to make the best possible decision to protect the fetus’ health and well-being.”).

245. See Abrams, *Parental Decision-Making*, *supra* note 243, at 1298 (“Women actually make decisions focused on their children and families and in consultation with doctors.”).

246. Oberman, *supra* note 162, at 454. Professor Oberman explains that Professor Timothy Murphy actually came up with the “maternal-doctor” label and that she doesn’t actually like the use of word maternal “because ‘mother’ carries with it connotations of loving altruism, the notion of a conflict between mother and fetus implies that, by refusing to follow medical advice, the mother has cruelly betrayed the sacred trust between mother and child.” *Id.* at 454 n.13.

247. See *infra* Section IV.B.1.

It seems the only person possibly served by the current non-disclosure of the risk of stillbirth is the doctor, ostensibly because of billing incentives. Some doctors use “global billing,” a one-time charge for routine prenatal care and related services, including childbirth.²⁴⁸ If women became irrationally anxious about stillbirth as the narrative depicts, they may be inclined to arrange additional doctor’s visits to ensure that the developing baby is okay. Under global billing, doctors would likely not be compensated for any additional visits that a woman may desire to ensure that her child is still okay.²⁴⁹ Perhaps doctors continue to not disclose stillbirth because of this economic disincentive.

The idea that doctors could be affected by economic incentives is not new. Many suspect that billing practices have contributed to the alarming increase in cesarean deliveries in the United States. They cost more, and have higher reimbursement rates, “provid[ing] incentives to [doctors to]

248. For example, the reimbursement policy for UnitedHealthcare mandates that the “global OB package code” must be used when the same provider or group of providers provides all of “the antepartum care, delivery and postpartum care.” UNITEDHEALTHCARE, OBSTETRICAL POLICY, PROFESSIONAL (2020), <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Obstetrical-Policy.pdf> [<https://perma.cc/S9QC-QZBA>]. Four global package codes exist depending on the type of delivery. *Id.* All of these global obstetric packages include payment for “[a]ll routine prenatal visits until delivery (approximately 13 for uncomplicated cases).” *Id.*; *Maternity—Global vs. Non-Global Billing*, HERITAGE HEALTH: NEB. TOTAL CARE (Jan. 11, 2019), <https://www.nebraskatotalcare.com/newsroom/maternity-global-vs-non-global-billing.html> [<https://perma.cc/QFY6-R3RM>] (“The global maternity allowance is a complete, one-time billing which includes all professional services for routine antepartum care, delivery services, and postpartum care. . . . If the member is seen four or more times prior to delivery for prenatal care and the provider performs the delivery, and performs the postpartum care[,] then the provider must bill the Global OB code.”). Similarly, a survey of states’ Medicaid policies, which cover as high as half of pregnant women in the United States, explained: “Maternity care is typically reimbursed with a global fee that covers all care for pregnant women through the postpartum period.” KATHY GIFFORD, JENNA WALLS, USHA RANJIL, ALINA SALGANICOFF & IVETTE GOMEZ, HENRY J. KAISER FAM. FOUND., MEDICAID COVERAGE OF PREGNANCY AND PERINATAL BENEFITS: RESULTS FROM A STATE SURVEY 3, 15 (2017), <http://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-and-Perinatal-Benefits> [<https://perma.cc/LE98-4KHS>].

249. UnitedHealthcare’s reimbursement policy states that insurance “will not separately reimburse” for routine visits if “reported separately from the global OB code.” UNITEDHEALTHCARE, *supra* note 248. Under a section entitled “High Risk/Complications,” the policy states patient may have more than 13 prenatal visits “due to high risk or complications,” which can be billed separately. *Id.* An extra visit to double check on the baby likely does not make the pregnancy high risk nor is the visit due to a complication. Regardless, the policy prohibits reimbursement if the doctor does not discover a problem in that extra visit. *Id.* (“[I]f a patient sees an obstetrician for extra visits to monitor a potential problem and no problem actually develops, the physician is not to report the additional visits”); *see, e.g.*, IOWA DEP’T OF HUM. SERVS., MATERNITY BILLING (2010), https://dhs.iowa.gov/sites/default/files/CCI_MaternityBillingGuidelines2010.pdf [<https://perma.cc/FV38-TR72>] (“The number of antepartum visits may vary from patient to patient, however, if global ob care (more than 3 antepartum visits, delivery and postpartum care) is provided, ALL pregnancy related visits . . . should be billed under the global OB code.”).

recommend cesareans even when medical necessity is lacking.”²⁵⁰ The “respon[se] to economic incentives with changes in clinical practices does not prove that [doctors] act[] intentionally in immoral ways— . . . considerations of financial benefit and convenience may occur subconsciously, shifting behavior without health care providers being aware of the impact of economic concerns on their decision making.”²⁵¹ Intentional or not, though, concern already exists that obstetricians are advising their patients about medical procedures based on billing incentives. This same concern also applies to current non-disclosure of stillbirth.

But evidence shows that doctors’ fears of extra visits, like the anxiety myth itself, are unfounded. After Norway introduced efforts to educate women on the importance of reduced fetal movement, “[t]he number of women presenting with [decreased fetal movement] remained unchanged during intervention” and “[t]he rate of unplanned repeat visits for [decreased fetal movement] was consistently very low, but increased” .2 percent.²⁵² Plus, any increase in unplanned visits may very well be appropriate if the unborn child is at risk.

Regardless, billing practices are irrelevant to the materiality of a risk. And the doctor’s desire to not be further bothered by the irrational pregnant woman is not a valid reason to continue to deprive women of important information regarding their health care and that of their unborn child.

B. “MORE LIKELY THAN NOT” BORN ALIVE

Closely related to the fatalism myth, causation is a difficult question in any stillbirth because of how much is still unknown regarding the causes of stillbirth. In this proposed informed consent claim, the mother would need to prove that her child would not have been stillborn had the doctor disclosed the risk.

But medical research supports a mother’s claim of causation. As already discussed, most stillbirths are not inevitable; they can be prevented. And, as many countries other than the United States recognize, empowered mothers play a crucial role in that prevention. But mothers can only be empowered if doctors both disclose the risk of stillbirth *and* inform them of the preventative measures. A mother’s empowerment and participation in her health care is a

250. Kukura, *supra* note 16, at 767; see CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 59–60 (2008), <https://www.milbank.org/wp-content/uploads/2016/04/0809MaternityCare.pdf> [<https://perma.cc/D7XM-AFqj>] (explaining how the current payment system “for maternity care provides strong incentives for inappropriate care of healthy childbearing women”); Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice Between Vaginal Delivery and Cesarean Section*, 71 MILBANK Q. 365, 374 (1993); Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. ECON. 99, 99 (1996).

251. Kukura, *supra* note 16, at 768.

252. Tveit et al., *supra* note 93, at 4.

crucial part of stillbirth prevention; mothers know their children best and only mothers can notice a change and seek medical attention.

A woman is also likely able to prove causation because of the relatively low burden of proof in tort claims. That burden is only a preponderance of evidence—more likely than not. The woman need only prove that had her doctor properly educated her, then, more likely than not, her child would not have been stillborn. A jury can have doubts regarding causation, even reasonable ones, yet still agree that the woman established causation. This relatively low burden of proof explains the many jury determinations finding causation even when science is less than definitive. Stillbirth is no different.

Importantly, jury determinations of causation in stillbirth cases also have the additional benefit of further helping to chip away at the fatalism myth surrounding stillbirth, just as many tort law cases have increased public awareness of the causation connection between products or chemicals and illnesses.²⁵³ This is important because researchers believe the fatalism myth has stunted further medical research on stillbirth. Tort law can then play the important role of hopefully creating more interest in the United States.

1. Empowering Women and Saving Babies

As mentioned, pregnancy and childbirth have become increasingly medicalized. Many have noted that ultrasounds and medical technology have “altered medical practice, substituting doctors’ traditional reliance on the mother for information” because the doctor can instead “see, examine and invade the fetus and its environment.”²⁵⁴ The doctor has emerged as the expert on the fetus, and he is the one who will ensure that the baby is born healthy and alive. Notably less covered is how medicalization has changed the experience of stillbirth, first causing women to believe stillbirth no longer occurs,²⁵⁵ and later enabling women to learn of their child’s death before birth and know that her child will not cry after he is born.²⁵⁶

Many have rightfully criticized medicalization as it further entrenches paternalistic “power dynamics between a patient and physician, as medical intervention removes the woman as an agent in her own childbirth

253. See *infra* notes 317–19 and accompanying text.

254. Oberman, *supra* note 162, at 472 (quoting F.A. Manning, *Reflections on Future Directions of Perinatal Medicine*, 13 SEMINARS PERINATOLOGY 342, 343 (1989)).

255. LINDA L. LAYNE, MOTHERHOOD LOST: A FEMINIST ACCOUNT OF PREGNANCY LOSS IN AMERICA 95 (2003) [hereinafter LAYNE, MOTHERHOOD LOST] (discussing the “widespread belief that if there is a problem during a pregnancy, doctors will be able to fix it”).

256. Layne has explained how medicalization has also changed the experience of pregnancy “loss in numerous, unanticipated, and unexamined ways.” Layne, *Infant Loss Support*, *supra* note 21, at 603. For stillbirth, that includes diagnosis before birth and “labor and delivery in a hospital or surgical extraction.” *Id.*

experience.”²⁵⁷ But medicalization may have also helped reduce the United States’ stillbirth rate. Between 1970 and 1998, the United States’ stillbirth rate decreased by 52 percent.²⁵⁸ Researchers attribute this reduction “to improvements in general socioeconomic conditions, including higher maternal education levels, better access to and improvements in general prenatal and intrapartum care, declining rates of smoking and substance use during pregnancy, and improvements in medical care.”²⁵⁹ The same study noted that one particular medicalization of childbirth, induction of labor, which increased “from 9.5% to 19.4% between 1990 and 1998, may have played an important role in the declining stillbirth rate.”²⁶⁰ The most commonly criticized medical intervention is the cesarean delivery.²⁶¹ And successful efforts in the UK to reduce stillbirth also saw an increase in their cesarean rates.²⁶² Notably, the data does not specify whether these were emergency and thus necessary cesarean deliveries.

Medicalization’s possible effect of reducing the United States’ stillbirth rate, however, appears complete. The rate declined slowly but steadily from 1990 to 2003, but has barely changed since 2003.²⁶³ Medical research specific to stillbirth prevention is lacking. A recent article in the *Washington Post* explained the lack of research on pregnancy compared to “much less common conditions.”²⁶⁴ Research regarding the placenta is specifically

257. Kukura, *supra* note 16, at 769–70. Linda Layne has extensively explored how the goals of the women’s health movement “restore to women the autonomy and control that had been wrested from them by biomedicine” and “reinforces the notion that positive birth outcomes are something women can control.” 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, 1886–89 (2003). This both alienates women whose pregnancies don’t have a happy ending and implies the woman was at fault given her control.

258. Cande V. Ananth, Shiliang Liu, Wendy L. Kinzler & Michael S. Kramer, *Stillbirths in the United States, 1981–2000: An Age, Period, and Cohort Analysis*, 95 AM. J. PUB. HEALTH 2213, 2213 (2005).

259. *Id.* at 2215.

260. *Id.* (footnote omitted); Mette Hedegaard, Øjvind Lidegaard, Charlotte Wessel Skovlund, Lina Steinrud Mørch & Morten Hedegaard, *Reduction in Stillbirths at Term After New Birth Induction Paradigm: Results of a National Intervention*, BMJ OPEN, Aug. 14, 2014, at 1, 8. *But see* LAYNE, MOTHERHOOD LOST, *supra* note 255, at 95 (explaining “there is no indication that there has been any significant decline in the frequency of miscarriage and stillbirth as a result of medical intervention”).

261. See Joyce A. Martin, Brady E. Hamilton, Michelle J.K. Osterman, Anne K. Driscoll & T.J. Mathews, *Births: Final Data for 2015*, NAT’L VITAL STAT. REPS., Jan. 5, 2017, at 1, 9–10. The cesarean rate peaked in 2009 at 32.9 percent, having increased every year since 1996 when it was 20.7 percent. *Id.*

262. See Jane E. Norman et al., *Awareness of Fetal Movements and Care Package to Reduce Fetal Mortality (AFFIRM): A Stepped Wedge, Cluster-Randomised Trial*, 392 LANCET 1629, 1634 (2018) (discussing that “[i]nduction of labour and caesarean section . . . were more common during the intervention period”).

263. Robert M. Silver, *Causes of Death Among Stillbirths*, 306 JAMA 2459, 2459 (2011).

264. Carolyn Y. Johnson, *Long Overlooked by Science, Pregnancy is Finally Getting Attention It Deserves*, WASH. POST (Mar. 6, 2019, 8:00 AM), <https://www.washingtonpost.com/national/>

lacking; some pregnancy experts call the placenta “the Rodney Dangerfield of the human body because it gets ‘no respect.’”²⁶⁵ Notably, the placenta plays a role in numerous known reasons for stillbirth, including placental abruption and placental deterioration,²⁶⁶ and doctors are far from experts on it.

Although the doctor is not an expert at how medicalization could help prevent stillbirth, he is still an expert at the known preventative measures. His lack of disclosure, like medicalization generally, creates a power imbalance. “By not informing pregnant women about stillbirth during their [pr]enatal care, this creates a power imbalance, in which the health care provider is using their power to consciously or unconsciously withhold information.”²⁶⁷ The power imbalance, resulting both from medicalization and non-disclosure of the risk of stillbirth, has overwhelmed “the mother’s special awareness of her unborn baby that no one else knows or can truly understand” and “the crucial role mothers have in protecting their unborn baby.”²⁶⁸

Medical research indicates three simple measures that can help prevent stillbirth, measures that only pregnant women can do. They are: not smoking,²⁶⁹ sleeping on their sides,²⁷⁰ and monitoring the baby’s movements and seeking medical attention if the movements change.²⁷¹ The importance of monitoring the baby’s movements—their strength, pattern and frequency—cannot be overstated. Researchers have linked reduced fetal movement to stillbirth, believing that if there is a problem, the baby starts to move more slowly and less forcefully to preserve energy.²⁷² More recent research also suggests that a reduction in movements followed by a violent increase in activity can indicate an impending stillbirth.²⁷³

health-science/long-overlooked-by-science-pregnancy-is-finally-getting-attention-it-deserves/2019/03/06/a29a9bcb-3556-11e9-af5b-b51b7ff322e9_story.html [https://perma.cc/VB56-E6M3].

265. *Id.*

266. *See supra* text accompanying note 48 (discussing some known causes of stillbirth).

267. Pollock et al., *Voices of the Unheard*, *supra* note 229, at 171.

268. O’Leary et al., *supra* note 60, at 218.

269. *See* Marufu et al., *supra* note 91, at 13 (summarizing studies and concluding “that smoking greatly increases the risk of stillbirth”).

270. *See, e.g.*, Heazell et al., *Maternal Sleep Practices*, *supra* note 92, at 258; McCowan et al., *supra* note 92, at 9 tbl.3.

271. *See generally, e.g.*, Heazell et al., *Perceived Alterations*, *supra* note 93 (“This study aimed to evaluate women’s experiences of fetal movements and how these relate to stillbirth.”); Heazell et al., *Alterations in Maternally Perceived Fetal Movement*, *supra* note 93 (“[M]aternal perception of changes in activity can indicate fetal compromise; the most commonly reported change is a reduction in fetal movement.”); Tveit et al., *supra* note 93 (“Maternal perception of fetal movements (FM) is a universally implemented self-screening, administered and interpreted individually by all pregnant women, with or without guidance from health care professionals.”).

272. Warrander et al., *supra* note 94, at 1.

273. Alexander E.P. Heazell, Tomasina Stacey, Louise M. O’Brien, Edwin A. Mitchell & Jane Warland, *Excessive Fetal Movements Are a Sign of Fetal Compromise Which Merits Further Examination*,

Only the mother is able to monitor her unborn child all day, every day. Only she can notice if the movements are less regular or weaker than the day before.²⁷⁴ The focus of prenatal visits should thus not be on “caregivers’ providing knowledge”; rather, it should be on “parents’ sharing with their providers what they are learning about their baby.”²⁷⁵ This is especially true given that the medical provider is inconsistent; if the obstetrician is in a group practice, a pregnant woman will likely see a different doctor every visit,²⁷⁶ meaning the only consistent participant in that prenatal care is the woman. After the mother shares her knowledge of her baby, “[t]echnology and the provider’s knowledge could then reinforce the parents’ intuitive knowing.”²⁷⁷

The woman is more than a vessel for the unborn child; pregnant women are more than “passive recipients of the care of the medical profession.”²⁷⁸ “[A] woman who has decided to carry a pregnancy to term is making decisions with the fetus in mind—and arguably is the most motivated party to make the best possible decision to protect the fetus’ health and well-being.”²⁷⁹ But a woman can only partner in her health care and make these best possible decisions for her baby if she is empowered with knowledge. “Noticing changes from the baby’s normal patterns of movements, including either slowing down or frenetic movement, can help parents know their baby as an individual. If the baby’s pattern changes, the parents are empowered by their own knowledge of their baby to seek help.”²⁸⁰ But again, this empowerment is only possible if the woman knows of the risk of stillbirth.

Admittedly, it will be easier for some mothers than others to establish causation. For instance, if the child was stillborn due to a placental abruption without warning, a doctor’s telling the mother to monitor fetal movement because of the possibility of stillbirth may not have prevented that child’s

111 MED. HYPOTHESES 19, 19 (2018) (describing a possible “association between a single episode of excessive fetal movements and late stillbirth”).

274. See Szczygiel, *supra* note 95, at 234 (“[N]o matter how elegant the science behind the treatment, results will be disappointing if the patient does not follow the therapy regimen or decides to stop taking the prescribed medications.”).

275. O’Leary et al., *supra* note 60, at 219.

276. Heidi Murkoff, *How to Choose a Practitioner You’ll Love for Your Pregnancy*, WHAT TO EXPECT (Oct. 22, 2018), <https://www.whattoexpect.com/pregnancy/choosing-doctor/> [https://perma.cc/qJVP-NKPD] (explaining that in a partnership or group medical practice, “[a] rotating team of OB-GYNs and family doctors will attend to you throughout your pregnancy”); see also Szczygiel, *supra* note 95, at 236 (explaining that “[t]he independent practitioner of medicine is becoming a rarity”).

277. O’Leary et al., *supra* note 60, at 219.

278. Montgomery v. Lanarkshire Health Bd. [2015] UKSC 11, [75], [2015] 1 AC 1430 (appeal taken from Scot.).

279. Kukura, *supra* note 16, at 794–95; Nold *ex rel.* Nold v. Binyon, 31 P.3d 274, 286 (Kan. 2001) (“To the extent a pregnant woman desires to continue her pregnancy and deliver a healthy baby at its conclusion, her interest in receiving adequate health care is inevitably intertwined with any interest or potential interest of her fetus.”).

280. O’Leary et al., *supra* note 60, at 220.

death; decreased movement may not necessarily precede an abruption.²⁸¹ But, if due to other reasons, the mother very well may have noticed reduced fetal movement as studies have documented a connection between reduced fetal movement and stillbirth.²⁸² Had she been properly warned about the risk of stillbirth as indicated by decreased fetal movement, she would have realized the danger, sought medical attention and the child could have been born and avoided stillbirth.

Notably, the initiatives that have reduced stillbirth rates in other countries have included education of pregnant women both about the risk of stillbirth and the measures to help prevent it. Again, when an Australian senate committee met to develop its own initiatives, testimony addressed international models. One model was from Scotland, which actually based its programs on those in the Netherlands. Through its Maternity Care Quality Improvement Collaborative, Scotland started a cultural change regarding stillbirth in the medical community.²⁸³ The Collaborative included, among other measures: (1) a patient education program “that stillbirth can happen to anyone and some are preventable;” (2) a program to reduce smoking in pregnancy; and (3) a patient education program raising awareness of the importance of monitoring fetal movements.²⁸⁴ In 2016, the National Health Service of England introduced the “Saving Babies’ Lives Care Bundle”²⁸⁵ in certain hospitals. The bundle includes four emphases: (1) “[r]educing smoking in pregnancy”; (2) “[r]isk assessment and surveillance for fetal growth restriction”; (3) “[r]aising awareness of reduced fetal movement”; and (4) “[e]ffective fetal monitoring during labour.”²⁸⁶ The stillbirth rate fell by 20 percent in the hospitals in which the safer bundle was adopted, meaning England is well on its way of meeting its goals to cut its stillbirth rate in half by 2025 and by 20 percent by 2020.²⁸⁷ A study in Norway suggested a 30 percent reduction of stillbirth due to educating pregnant women on the risk

281. *Information About Placental Abruption*, TOMMY’S (Sept. 1, 2016), <https://www.tommys.org/pregnancy-information/pregnancy-complications/information-about-placental-abruption> [<https://perma.cc/F24W-96V5>] (omitting decreased fetal movement as a symptom of abruption).

282. Warrander et al., *supra* note 94, at 1.

283. AUSTRALIAN SENATE COMMITTEE REPORT, *supra* note 59, § 7.27, at 113.

284. *Id.* § 7.29, at 113.

285. DAN O’CONNOR, NHS ENG., SAVING BABIES’ LIVES: A CARE BUNDLE FOR REDUCING STILLBIRTH 11 (2016), <https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf> [<https://perma.cc/LU7K-E7Z4>].

286. *Id.* at 12. After learning about the NHS program, an obstetrician in Rochester, New York started implementing it in her own practice. She believes that the practice has already saved eight babies. *Local Doctor Working to Raise Awareness About Stillborn Prevention*, SPECTRUM NEWS (Oct. 29, 2019, 4:03 PM), <https://spectrumlocalnews.com/nys/rochester/health/2019/10/29/stillborn-prevention-program-introduced-in-rochester-> [<https://perma.cc/BNR6-FBHQ>].

287. *Saving Babies’ Lives Care Bundle*, NHS, <https://www.england.nhs.uk/mat-transformation/saving-babies> [<https://perma.cc/N2FV-Y8L2>].

of stillbirth and the importance of monitoring fetal movement.²⁸⁸ More recently, Australia began the process of implementing measures to reduce its stillbirth rate. Testimony before the Australian government estimated that

the rate of stillbirth in Australia could be reduced by one-third if two of the biggest risk factors were common knowledge amongst pregnant women, clinicians and other health professionals. Research indicates that, if two of the stillbirth risk factors that we are currently aware of—decreased fetal movement and maternal sleep position—were common knowledge among the pregnant population and health clinicians there is potential to reduce the number of stillbirths by up to 30 per cent²⁸⁹

Ultimately, “[t]he committee recommend[ed] that the Australian government develop[] and implement[] a national stillbirth public awareness campaign . . . which aims to demystify stillbirth, educates parents and the general public about the risks of stillbirth, and encourages public conversations about stillbirth as a public health issue.”²⁹⁰ The committee also recommended that the government develop an education kit to teach health professionals how to “discuss risks of and strategies for preventing stillbirth with pregnant women.”²⁹¹

Closer to home, a grassroots group of bereaved mothers in Iowa started an initiative called “Count the Kicks.”²⁹² It seeks to educate women on the importance of fetal movement and now includes an app that pregnant women can use to monitor how many times their babies kick.²⁹³ In the first five years after the group’s creation, Iowa’s stillbirth rate has decreased by almost 30 percent.²⁹⁴

As these measures recognize, to inform about the risk of stillbirth, the doctor must actually use the word “stillbirth” when discussing risk and prevention with the pregnant woman. In one study, a doctor explained that he tells women to come in if the baby is moving less, but, in his words:

288. Tveit et al., *supra* note 93, at 4.

289. AUSTRALIAN SENATE COMMITTEE REPORT, *supra* note 59, § 7.22, at 111–12.

290. *Id.* § 7.97, at 129.

291. *Id.* § 7.100, at 129–30.

292. 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://perma.cc/3XSE-X8NY>].

293. *Id.*

294. 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/PY5W-R4NK>].

"I don't say the word 'stillbirth,' but what I mean is, if things are not going well and you are not noticing the baby moving well, I want you to come in and get evaluated in the hope of picking up something early so that you potentially prevent a stillbirth, but I don't use the actual word."²⁹⁵

Similarly, another doctor explained "that he tended to avoid directly mentioning stillbirth to his patients."²⁹⁶ When he discusses the importance of fetal movements, he will "refer in bleak terms to it being safer for the baby."²⁹⁷ He "is reluctant to use the word" stillbirth due to its taboo.²⁹⁸

Informed consent doctrine mandates provision not just of instructions, but also of warnings. And it requires that those warnings are specific and clear. Just as a warning of a possible "loss of function of body organs" does not sufficiently convey to the patient "that he or she is asked to encounter the specific material risk of being rendered permanently incontinent through loss of bladder control,"²⁹⁹ any message about stillbirth is insufficient unless it includes mention of the specific material risk of stillbirth.

Analogous products liability warning law has more fully developed the distinction between inadequate instructions and an adequate warning. This law requires manufacturers to provide adequate warnings of the risks of their products,³⁰⁰ one reason for which is to enable informed consent.³⁰¹ It "focuses on protecting a user's individual rights—specifically, the user's right of self-determination, the right to 'determine his own fate.'"³⁰² The manufacturer must inform and empower the user "to make his own choice as to whether the product's utility or benefits justify exposing himself to the risk of harm."³⁰³ Thus, a warning must provide more than just instructions on how to safely use the product.³⁰⁴ It must also warn of the danger that will result from a failure

295. Kelley & Trinidad, *supra* note 13, at 4.

296. AUSTRALIAN SENATE COMMITTEE REPORT, *supra* note 59, § 7.23, at 112.

297. *Id.*

298. *Id.*

299. Clark, *supra* note 133, at 289 (quoting *Hidding v. Williams*, 578 So. 2d 1192, 1196 (La. Ct. App. 1991)).

300. Jill Wieber Lens, *Warning: A Post-Sale Duty to Warn Targets Small Manufacturers*, 2014 UTAH L. REV. 1013, 1041-42.

301. *Id.*

302. DAVID G. OWEN, PRODUCTS LIABILITY LAW § 9.1, at 585 (2d ed. 2008) (citing *Pavlidis v. Galveston Yacht Basin, Inc.*, 727 F.2d 330, 338 (5th Cir. 1984)).

303. *Borel v. Fibreboard Paper Prods. Corp.*, 493 F.2d 1076, 1089 (5th Cir. 1973); *see also Liriano v. Hobart Corp.*, 170 F.3d 264, 270 (2d Cir. 1999) ("[A] warning can do more than exhort its audience to be careful. It can also affect what activities the people warned choose to engage in.").

304. *Fiorentino v. A.E. Staley Mfg. Co.*, 416 N.E.2d 998, 1003 (Mass. App. Ct. 1981) ("Furnishing instructions designed to make the product's use more efficient will not necessarily discharge the duty to warn . . ."); *Brown v. Sears, Roebuck & Co.*, 667 P.2d 750, 758 (Ariz. Ct. App. 1983) ("[P]roviding instructions for the safe use of the product is not a functional

to follow the instructions.³⁰⁵ And the warning must “convey a fair indication of the nature and extent of the danger to the mind of a reasonably prudent person.”³⁰⁶ The more serious the possible injury, the more intense and explicit the language must be.³⁰⁷

Doctors may tell a woman to not smoke, to sleep on her side, or to monitor her baby’s movements, but these are only instructions. Instructions alone return us to a paternalistic framework where the woman is supposed to take these measures simply because the doctor said so. To exercise her right to self-determination, the woman must be educated that a failure to take these measures may put her child at a higher risk of dying due to stillbirth. Only then can she understand the gravity of the situation and be “aware of the significance of changes in [her] baby’s movements.”³⁰⁸ A delay in seeking medical attention after reduced fetal movement is associated with an increased risk of stillbirth.³⁰⁹ Clear language is especially important given the pervasiveness of the myth that babies move less later in pregnancy due to their growth.³¹⁰ This myth teaches women that reduced movement is expected,

equivalent or appropriate substitute for adequate warnings of dangers that might be encountered if the instructions given are not followed.”); *Downing v. Overhead Door Corp.*, 707 P.2d 1027, 1032 (Colo. App. 1985) (explaining the distinction between instructions and warnings).

305. *Fiorentino*, 416 N.E.2d at 1003 (explaining that “the manufacturer still must call attention to the dangers to be avoided”).

306. *Bituminous Cas. Corp. v. Black & Decker Mfg. Co.*, 518 S.W.2d 868, 873 (Tex. Civ. App. 1974).

307. See *Fiorentino*, 416 N.E.2d at 1003; *Lancaster Silo & Block Co. v. N. Propane Gas Co.*, 427 N.Y.S.2d 1009, 1015 (App. Div. 1980) (“The degree of danger is a crucial factor in determining the specificity required in a warning.”).

308. Pollock et al., *Breaking Through the Silence*, *supra* note 223, at 78; see also *id.* (“Health care providers play an important role in providing information and empowering women through their antenatal care, and this includes when to act if they perceive a change in their baby’s activity.”). Frighteningly, some research suggests that when women do report reduced fetal movement, they are not taken seriously. A recent report from the UK noted that mothers reported reduced fetal movement prior to a stillbirth and “a significant proportion (57 %) felt that they were not listened to by their care providers. That many participants reported that their care provider reassured them about the change in their baby’s behaviour without taking further action is also concerning.” Jane Warland, Louise M. O’Brien, Alexander E.P. Heazell & Edwin A. Mitchell, *An International Internet Survey of the Experiences of 1,714 Mothers with a Late Stillbirth: The STARS Cohort Study*, *BMC PREGNANCY & CHILDBIRTH*, Aug. 15, 2015, at 1, 7 (footnote omitted). This type of dismissal by the doctor could easily be the basis of a traditional medical malpractice claim.

309. See Pollock et al., *Breaking Through the Silence*, *supra* note 223, at 78; see also Anders Linde et al., *Fetal Movement in Late Pregnancy—A Content Analysis of Women’s Experiences of How Their Unborn Baby Moved Less or Differently*, *BMC PREGNANCY & CHILDBIRTH*, June 1, 2016, at 1, 1–2 (“The character of the movements changes when the pregnancy approaches delivery due to limited space in the uterus, but the frequency and intensity will not normally decrease.”); *Baby Movements in Pregnancy*, TOMMY’S (Oct. 3, 2018), <https://www.tommys.org/pregnancy/symptom-checker/baby-fetal-movements> [<https://perma.cc/YQK9-LYCZ>] (explaining “[i]t is NOT TRUE that babies move less towards the end of pregnancy” and that a woman “should CONTINUE to feel your baby move right up to the time you go into labour and during labour”).

310. Pollock et al., *Breaking Through the Silence*, *supra* note 223, at 80.

when it in fact indicates a problem. Women can only make these informed decisions and understand the need to do these measures when doctors actually use the scary word “stillbirth.” Without that word, a woman remains uninformed and unable to partner in her healthcare.

As mentioned, other countries with centralized health care systems have mandated this type of empowerment. In England, the National Health Service uses educational information produced by the charity Tommy’s. The information on reduced fetal movement includes this information: “Why are my baby’s movements important? A reduction in a baby’s movements can sometimes be an important warning sign that a baby is unwell. Around half of women who had a *stillbirth* noticed their baby’s movements had slowed down or stopped.”³¹¹ It also states “You must NOT WAIT until the next day to seek advice if you are worried about your baby’s movements.”³¹² Similarly, a brochure distributed in Australian medical facilities, produced by the group Still Aware, specifically explains that “[a] reduction or a sudden increase in a baby’s movements can sometimes be an important warning sign that [your] baby is unwell. . . . Around half of the women who had a stillbirth noticed their baby’s movements had slowed down or stopped.”³¹³

It is not possible to attribute successes in reducing stillbirth rates solely to education of pregnant women; after all, education was just one of numerous initiatives in those countries that prioritize stillbirth awareness. At the same time, education certainly has contributed to those countries’ successes. When women can partner in their health care, they are able to work with their doctors to increase the chances that their babies are born alive and healthy.³¹⁴

311. TOMMY’S, NHS, FEELING YOUR BABY MOVE IS A SIGN THAT THEY ARE WELL (2019), https://www.tommys.org/sites/default/files/RFM%20leaflet%20Mar%202019_2.pdf [<https://perma.cc/TX9K-2THD>] (emphasis added).

312. *Id.*

313. STILL AWARE, YOUR PREGNANCY, <https://indd.adobe.com/view/2ac3e98e-7c57-4840-a2f7-2fe375a2c2d6>.

314. Countries that have mandated education for pregnant women have also expressed concern that the education will increase the blame placed on women if her child is stillborn—that if she had paid more attention to fetal movement, her child would have survived. See AUSTRALIAN SENATE COMMITTEE REPORT, *supra* note 59, § 7.13, at 109 (explaining that one common reason for not informing women of the risk of stillbirth “is [the] feeling of not wanting to put too much responsibility on mothers since many cases are unavoidable”); Robert M. Silver, *Maternal Going to Sleep Position and Late Stillbirth: Time to Act but with Care*, ECLINICALMEDICINE, Apr. 10, 2019, at 6, 6 (2019) (acknowledging research that shows that sleeping on side can reduce stillbirth, but advising caution before beginning a public health campaign to avoid “causing harm” given that “all women with stillbirth suffer some sense of self-blame”). But self-blame is already prevalent after stillbirth—with mothers “meticulously [reviewing] the events of [their] pregnanc[ies]” and blaming themselves. Elizabeth Kirkley-Best & Kenneth R. Kellner, *The Forgotten Grief: A Review of the Psychology of Stillbirth*, 52 AM. J. ORTHOPSYCHIATRY 420, 422 (1982). One study showed “that nearly all mothers of stillborn babies report intense behavioral and characterological self-blame following the baby’s death.” 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).

2. Easier Burden of Proof

The burden of proof in a tort claim is only a *preponderance of evidence*—“more likely than not.”³¹⁵ Thus, the mother need only demonstrate that had her doctor properly warned her of the risk of stillbirth, then, more likely than not, her child would not have been stillborn. A jury could still have some doubts whether the child would have survived, which is entirely possible given how much is still unknown regarding what specifically causes stillbirth. But doubts, even if reasonable, are still consistent with a finding that, more likely than not, the child would have been born alive if the doctor had simply warned the mother of the risk of stillbirth.

Determining causation with respect to stillbirth is no more speculative than in any other tort case. Every tort causation question involves speculation. For instance, if a university had suspended a student, would he still have raped another student? The jury cannot know for sure because the university didn't suspend the student. But the jury must pretend a world in which the university did suspend the student and then decide whether that student would have still raped the other student. This is pure speculation. And it is how the jury determines causation in every tort case.

The speculation includes cases where science is relatively undetermined. Recent examples include million-dollar verdicts to plaintiffs claiming that certain products caused their cancer. At best, the science is mixed regarding whether Bayer Round-Up causes cancer or Johnson & Johnson talcum powder causes cancer.³¹⁶ Still in numerous tort lawsuits, plaintiffs have successfully proven that Bayer Round-Up caused them cancer,³¹⁷ and other plaintiffs have successfully proven that Johnson & Johnson talcum powder caused them cancer.³¹⁸ These plaintiffs have been able to prove the causal link between the products and cancer despite the lack of scientific consensus because their

To minimize self-blame, any doctor should be informing the woman that sleeping on her side and monitoring fetal movement can *help* prevent stillbirth but are not guaranteed to prevent it. Plus, if a woman is informed ahead of time and does all she can to help prevent stillbirth—she refrains from smoking, from being around secondhand smoking, she sleeps on her side, and she monitors her child's movements—she may actually blame herself less because, when she reviews her pregnancy, she'll know that she did all she could to prevent her child's death. Her blame and distress may be lesser than if she later learns she could have done something to help prevent her child's stillbirth, and she failed to do it (because her doctor never told her about it).

315. DOBBS ET AL., *supra* note 97, § 3.3, at 39.

316. Holly Yan, *The EPA Says Glyphosate, the Main Ingredient in Roundup, Doesn't Cause Cancer. Others Aren't So Sure*, CNN: HEALTH (May 3, 2019, 5:39 AM), <https://www.cnn.com/2019/05/01/health/epa-says-glyphosate-is-safe/index.html> [<https://perma.cc/7P5D-S3GY>]; Jen Christensen, *Johnson & Johnson Hit with \$29.4 Million Verdict in Talcum Powder Case*, CNN: HEALTH (Mar. 14, 2019, 1:05 PM), <https://www.cnn.com/2019/03/14/health/johnson-and-johnson-baby-powder-cancer-verdict/index.html> [<https://perma.cc/L3Q9-R35R>].

317. Yan, *supra* note 316.

318. Christensen, *supra* note 316.

burden of proof was only preponderance of evidence. The plaintiffs didn't need to show that the products for sure caused their cancers, only that the products more likely than not caused the cancers.

A disconnect has always existed between causation determinations in tort law and science due to tort law's preponderance of the evidence standard. Even when science is undetermined, tort liability is possible.³¹⁹ The same is true for stillbirth cases. Even if science is unsure of the exact causes of stillbirth, a jury can still easily determine that tortious conduct caused a stillbirth. We should be no less comfortable with a jury determining that a doctor's educating a mother would have prevented her child's stillbirth than any other tort case in which the jury evaluates undetermined science.

Another possibility for adjudging causation in a stillbirth informed consent claim is to use something akin to loss of chance doctrine. The loss of chance doctrine, a rule recognized in medical malpractice claims, allows a plaintiff to demonstrate that the doctor caused an increased risk of an injury and received damages based on that increased risk.³²⁰ Suppose a plaintiff had an 80 percent chance of dying before the malpractice, and the malpractice increased that chance to 100 percent. If the plaintiff can prove that her doctor caused that 20 percent increased chance, the plaintiff can recover damages based on that increased 20 percent, usually calculated by determining the damages for death and awarding 20 percent of those damages. Applied to stillbirth, the woman need not show that the doctor's failure to disclose the risk caused her child's stillbirth, but that the doctor's non-disclosure increased the stillbirth risk.

Any jury determinations that the doctor's non-disclosure of the risk of stillbirth caused the child's stillbirth can have important and powerful effects on the pervasive fatalism myth. Many believe that fatalism has stunted medical research and prevention efforts as there's little point in devoting resources to preventing the unpreventable.³²¹ Civil jury determinations that stillbirths could have been prevented can help chip away at the fatalism myth surrounding stillbirth, just as tort law helped establish and educate the public regarding the causal connections between cigarettes and cancer,³²² asbestos

319. See, e.g., *id.* (describing that juries have concluded that talcum powder caused cancer even though "[t]he debate over a link between talcum powder and cancer has been growing in the scientific community" as "[s]ome studies have found an increased cancer risk, but others do not" and "[m]ost suggest that more research is needed").

320. See, e.g., *Matsuyama v. Birbaum*, 890 N.E.2d 819, 831–33 (Mass. 2008).

321. Flenady et al., *supra* note 39, at 692; J. Frederik Frøen et al., *Stillbirths: Why They Matter*, 377 LANCET 1353, 1355 (2011) (discussing the many missed opportunities to further study stillbirth and how the lack of investigations after contributes to the fatalism myth); Goldenberg et al., *supra* note 90, at 1798 ("Inappropriate fatalism regarding stillbirths among caregivers and policy makers will virtually guarantee that no progress occurs.").

322. See Allison Torres Burtka, *The Tobacco Cases: Taking on Big Tobacco*, AM. MUSEUM TORT L. (June 13, 2016), <https://www.tortmuseum.org/the-tobacco-cases> [<https://perma.cc/A6NJ-HASQ>]

and cancer,³²³ and diethylstilbestrol and cancer.³²⁴ Tort law can once again be a catalyst for further scientific and governmental research as it has numerous times in the past.

A jury's determination that the doctor's conduct *more likely than not* caused a child's stillbirth is much, much less controversial than a prosecutor attempting to show, *beyond a reasonable doubt*, that a woman's conduct caused her child's stillbirth, as prosecutors have attempted to show in a few high-profile criminal prosecutions. Criminal prosecutions after stillbirth are part of the recent proliferation of fetal protection laws, laws like "drug policies, statutes criminalizing maternal conduct, and statutes authorizing the confinement of pregnant women to protect the health of fetuses."³²⁵ In recent years, a few women have been prosecuted under such laws for causing their children's stillbirths. First, a South Carolina woman, Regina McKnight, was convicted for "homicide by child abuse" after giving birth to a stillborn baby,³²⁶ and was sentenced to 20 years in prison,³²⁷ a conviction and sentence later upheld by the South Carolina Supreme Court.³²⁸ Second, a Mississippi teenager named Rennie Gibbs, who struggled with cocaine addiction, was arrested after giving birth to her stillborn child in the 36th week of her pregnancy.³²⁹ Cocaine use has been linked to placental abruptions, which can lead to stillbirth.³³⁰ Regina's baby, however, was born with the umbilical cord wrapped around the neck and no cocaine was found in the baby's blood.³³¹ Still, Gibbs was arrested for "depraved heart murder" of her stillborn child and prosecutors argued that the stillbirth was due to Gibbs' cocaine use.³³²

(explaining how tort cases helped "shed light on the dangers of smoking and on the tobacco manufacturers' conspiracy to deceive the public").

323. *Dangerous Exposure: Borel v. Fibreboard Paper Products Corp.*, 1973, AM. MUSEUM TORT L., <https://www.tortmuseum.org/online-tour/dangerous-exposure> [<https://perma.cc/LYW7-VM6L>].

324. See Glen O. Robinson, *Multiple Causation in Tort Law: Reflections on the DES Cases*, 68 VA. L. REV. 713, 718–22 (1982).

325. Professor Michele Goodwin has written extensively about the proliferation of "fetal protection laws." Michele Goodwin, *Fetal Protection Laws: Moral Panic and the New Constitutional Battlefield*, 102 CALIF. L. REV. 781, 787 (2014). Supposedly, "fetal protection laws are intended to promote the health and safety of fetuses by criminalizing actual or intended harm to the unborn." *Id.*

326. *State v. McKnight*, 576 S.E.2d 168, 171 (S.C. 2003).

327. See *id.*

328. See *id.* at 179. But see *McKnight v. State*, 661 S.E.2d 354, 360 (S.C. 2008) (reversing conviction due to ineffective assistance of counsel).

329. Nina Martin, *A Stillborn Child, a Charge of Murder and the Disputed Case Law on 'Fetal Harm'*, PROPUBLICA (Mar. 18, 2014, 12:00 PM), <https://www.propublica.org/article/stillborn-child-charge-of-murder-and-disputed-case-law-on-fetal-harm> [<https://perma.cc/8V7T-LJQC>].

330. *Id.*

331. *Id.*

332. *Id.*

Gibbs faced life in prison if convicted.³³³ A Mississippi judge later dismissed her murder charge.³³⁴

Fetal protection laws and these types of criminal prosecutions are problematic for many reasons, only one of which is the question of causation. Given the beyond a reasonable doubt burden of proof in criminal law, one would think “that prosecutors . . . often face an uphill battle proving” that the mother’s drug use caused the child’s stillbirth.³³⁵ Beyond a reasonable doubt is the highest and most difficult burden of proof in law—much higher than the tort law preponderance of the evidence standard. And it’s likely that any “medical evidence that the mother’s drug use caused the adverse event is thin, if it exists at all.”³³⁶ Still,

[d]espite the multiplicity of factors that lead to fetal loss and the great difficulty of proving a cause-and-effect relationship between maternal behavior and a particular adverse outcome, many prosecutors have been quick to seize upon a pregnant woman’s drug use as the *sole* cause of a stillbirth or infant death and to initiate criminal proceedings whenever a pregnant woman has used drugs.³³⁷

In these criminal proceedings, prosecutors and courts “erroneously assume[] . . . that, absent depraved conduct on the part of pregnant women, stillbirths do not occur and that all pregnancies produce healthy babies except if the mother’s conduct threatens fetal health.”³³⁸ Plus, prosecutors can “win” without ever proving causation—by forcing a plea bargain in which the woman pleads guilty to avoid a harsher sentence.³³⁹

If tried, however, the prosecutor will likely be able to find at least one medical expert claiming that drug use caused the stillbirth “to a reasonable [degree of] medical certainty.”³⁴⁰ And for many reasons, the jury “may be tempted to disregard evidence that suggests other causes of stillbirth, or even that no cause has been established beyond a reasonable doubt, since the cause

333. *Id.*

334. Nina Martin, *Judge Throws Out Murder Charge in Mississippi Fetal Harm Case*, PROPUBLICA (Apr. 4, 2014, 2:00 PM), <https://www.propublica.org/article/judge-throws-out-murder-charge-in-mississippi-fetal-harm-case> [https://perma.cc/YCE2-NYGU].

335. FENTIMAN, *supra* note 162, at 145.

336. *Id.* at 125.

337. *Id.*

338. MICHELE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* 42 (2020) [hereinafter GOODWIN, *POLICING THE WOMB*].

339. FENTIMAN, *supra* note 162, at 135; *see also* GOODWIN, *POLICING THE WOMB*, *supra* note 338, at 40 (explaining that women often take a plea deal when prosecuted for an offense related to drug use while pregnant because of how inflammatory the case would be in front of a politically conservative jury). Evidence of racial disparities exists in crimes charged and plea bargains offered. FENTIMAN, *supra* note 162, at 135.

340. *Id.* at 146.

of stillbirth is unknown in nearly half of all cases.”³⁴¹ One of those reasons is that the jury is unlikely to sympathize with a woman who used drugs during her pregnancy.³⁴² Another is that almost all of women prosecuted “are poor and/or racial or ethnic minorities,”³⁴³ two systematic risks of stillbirth. Given their economic status, the defense is unlikely to be able to present too much evidence on causation either (not that it has the burden) as these women lack the resources to hire “skilled lawyers and highly paid expert witnesses to challenge the prosecution’s case on causation.”³⁴⁴ Both the woman’s economic status and race may also trip the jury’s unconscious biases when evaluating the woman’s culpability. The jury may also be affected by “fundamental attribution error, the natural human tendency . . . to assume that when bad things happen to others . . . they are the result of their bad choices and character flaws, while when they happen to us they are the result of external circumstances beyond our control.”³⁴⁵ This woman’s stillbirth was the result of her bad choice, whereas other stillbirths are unexplainable. And thus, despite the strength of the fatalism myth and the lack of research on the causes of stillbirth, a jury may agree with the prosecutor that, *beyond a reasonable doubt*, the woman’s drug use caused her child’s stillbirth.

This is troubling—that we would be so quick to set aside the supposed unexplainability of stillbirth and identify the woman as the villain beyond a reasonable doubt. At the same time, a jury determination that, more likely than not, a woman’s educated ability to monitor her unborn child would have prevented her child’s stillbirth, is not similarly troubling. Simply, the burdens of proof in a criminal prosecution and an informed consent tort claim differ dramatically. Those burdens can and do differ because the consequences of the two differ; a criminal conviction can involve the loss of freedom, whereas liability in tort creates only the need to pay the plaintiff damages. Given that burden of proof and the generally speculative nature of the causation inquiry in tort law, a jury could easily and properly conclude that the woman could have heroically saved her child’s life had she known the risk of stillbirth—that, more likely than not, the doctor’s failure to disclose the risk caused that child’s stillbirth.

341. *Id.*; see also GOODWIN, POLICING THE WOMB, *supra* note 338, at 42–43 (explaining how the causes of many stillbirths are unknown to researchers).

342. FENTIMAN, *supra* note 162, at 131–32.

343. *Id.* at 114; see also Layne, *Pregnancy Loss*, *supra* note 63, at 594 (“Not only are women of color more likely to experience loss and have limited access to bereavement support . . . they are also more likely to be criminally charged for their losses.”).

344. FENTIMAN, *supra* note 162, at 146.

345. *Id.* at 103.

C. DAMAGES FOR THE CHILD'S STILLBIRTH

A mother could then recover damages for her injury, her child's stillbirth. Yes, these damages are difficult to measure and are noneconomic.³⁴⁶ They are also, however, almost the same damages awarded in any wrongful death or negligence claim after stillbirth, one of which almost all states recognize.³⁴⁷

I've addressed compensatory damages for stillbirth extensively in prior work.³⁴⁸ In short, the damages will be based on the mother's emotional distress at losing her child and the loss of that relationship,³⁴⁹ distress likely exacerbated by her later learning that she could have done simple measures to help prevent her child's stillbirth. In order to ensure as full of compensation as possible, courts must be careful not to refer to the mother's stillborn baby as a "fetus"³⁵⁰ and to ensure that the jury does not undervalue the mother's loss because she has additional children.³⁵¹

V. SECONDARY BENEFITS OF EDUCATING WOMEN

The primary benefit of educating women about the risk of stillbirth is the possible decrease in stillbirths. But there are other benefits, too. First, increasing communication between the doctor and the pregnant woman will likely decrease the chances of the woman filing a legal claim against the doctor. Second, informing women of the chances of stillbirth beforehand may help alleviate some of the shock if her child is stillborn. Third, doctors' informing women may help reduce some of the stigma surrounding stillbirth.

A. BENEFICIAL EFFECTS ON MALPRACTICE LIABILITY

In a study, "[s]everal physicians reported that they worry about being blamed for stillbirth, particularly when there is an otherwise healthy pregnancy and then the baby dies for either known . . . or unknown reasons."³⁵² One physician explained that it is difficult to gage how a particular

346. Lens, *Devaluation of Stillbirth*, *supra* note 189, at 999–1000.

347. *Id.* at 969–70.

348. See generally *id.* (arguing that wrongful death claims should be available regardless of viability); Jill Wieber Lens, *Children, Wrongful Death, and Punitive Damages*, 100 B.U. L. REV. 437 (2020) (explaining the problems of awarding compensatory damages for wrongful death of children cases and advocating for the use of punitive damages).

349. Ideally, both damages for emotional distress and loss of consortium (loss of relationship) would be recoverable as both are necessary to fully compensate the mother. Lens, *Devaluation of Stillbirth*, *supra* note 189, at 1011. Loss of consortium damages are available in a wrongful death claim, however, because the claim is statutory and the legislature specifically allowed those type of damages. *Id.* at 981. An informed consent claim is a common law tort claim, and arguably, courts lack the ability to award loss of consortium damages in such a claim.

350. *Id.* at 1003.

351. *Id.* at 993–98.

352. Kelley & Trinidad, *supra* note 13, at 5.

patient is going to react—with blame, or desiring comfort, and that malpractice is in the back of his mind.³⁵³ Doctors' concerns about being blamed are likely not off base. Numerous studies of parents after stillbirth show that parents sometimes blame their child's stillbirth on their doctor.³⁵⁴ Blame may reflect that a doctor is actually at fault. Or it may reflect the doctor's care of the parents after the stillbirth, as researchers suspect that blame "could reflect that maternal concerns in the antenatal or intrapartum period were not addressed or indicate a lack of thorough debriefing and counselling after the stillbirth."³⁵⁵

While it is true that "[w]hen compared with colleagues in other medical specialties, obstetricians are sued more often and thus face higher malpractice insurance premiums,"³⁵⁶ not every parent who blames a doctor for their child's stillbirth will file a malpractice suit.³⁵⁷ Certain factors are known to increase that likelihood. Specifically, patients sue because of "poor communication and lack of trust," because they "are frustrated with brief, rushed appointments and who believe their physicians show insufficient attention," and they "perceive their physicians to be patronizing them by providing insufficient detail or glossing over medical explanations,"³⁵⁸ factors overlapping with whether parents blame the doctor in the first place.

A doctor's warning of the risk of stillbirth beforehand may help minimize these factors. A doctor who takes the time to explain the risk of stillbirth and the preventative measures likely has good communication with the parents, is providing sufficient attention, and is providing as sufficient detail to the parents as possible. Similarly, a patient who is not blindsided may feel less urge to blame the doctor in the first place. In *Montgomery*, the UK court likewise explained that a lawsuit may be less likely under the materiality standard:

[A]n approach which results in patients being aware that the outcome of treatment is uncertain and potentially dangerous, and in their taking responsibility for the ultimate choice to undergo that treatment, may be less likely to encourage recriminations and litigation, in the event of an adverse outcome, than an approach which requires patients to rely on their doctors to determine

353. *Id.*

354. JOHN DEFRAIN, LEONA MARTENS, JAN STORK & WARREN STORK, STILLBORN: THE INVISIBLE DEATH 29 (1986); see also Warland et al., *supra* note 308, at 9 (noting the "concern[ing] . . . number of participants ($n = 138$; 8.1 %) who believed that their care provider played a role in their baby's death").

355. Warland et al., *supra* note 308, at 9 (footnote omitted).

356. Kukura, *supra* note 16, at 771.

357. Parents may also have trouble finding attorneys to take a stillbirth case due to damage caps on noneconomic damages. See Lens, *Devaluation of Stillbirth*, *supra* note 189, at 999–1001.

358. Kukura, *supra* note 16, at 772.

whether a risk inherent in a particular form of treatment should be incurred.³⁵⁹

This research demonstrates an incentive for doctors to disclose the risk of stillbirth—it may actually help a doctor avoid a lawsuit if the child is stillborn.

B. REDUCING THE SHOCK AFTER

Grief is personal; each mother who loses a child to stillbirth can have a different experience. Studies already demonstrate that one factor affecting a mother's grief is how the doctor communicates and interacts with the mother after her child has died.³⁶⁰ In numerous studies, mothers have complained that their doctors and nurses were “cold or indifferent to them during their bereavement.”³⁶¹ Similarly, mothers have expressed their dissatisfaction “with the information offered them about the stillbirth, and with the manner in which the information was communicated.”³⁶²

Studies in other medical contexts explain that “[h]ow bad, sad, or difficult information is received depends on many factors, including expectations, previous experiences, and general personality disposition.”³⁶³ Research about parents of sick children found that “[n]o families want[] to be protected from bad news.”³⁶⁴ Something as simple as a “warning shot,” providing a heads-up that bad news is possible, is helpful and empowering for parents.³⁶⁵ Another study of parents of sick children explained that the parents “wanted advice about what symptoms to expect, believing with hindsight that having been forewarned of the symptoms had helped them cope with the unknown future.”³⁶⁶

Applying the research regarding the disclosure of bad news to stillbirth, if the mother has *zero* expectation of stillbirth versus some knowledge of its possibility, that will affect how she receives the bad news that her child died in the womb. At the very least, a warning ahead of time may eliminate or

359. *Montgomery v. Lanarkshire Health Bd.* [2015] UKSC 11, [93], [2015] 1 AC 1430 (appeal taken from Scot.).

360. Kirkley-Best & Kellner, *supra* note 314, at 425 (“When a mother gives birth to a stillborn infant, *the reaction of others*, especially doctors, nurses, and family members, may influence the processes of grief.”).

361. *Id.* at 426.

362. *Id.*

363. Lesley Fallowfield & Valerie Jenkins, *Communicating Sad, Bad, and Difficult News in Medicine*, 363 LANCET 312, 313 (2004).

364. Charles J. Schubert & Patricia Chambers, *Building the Skill of Delivering Bad News*, 6 CLINICAL PEDIATRIC EMERGENCY MED. 165, 168 (2005); see also H. Woolley, A. Stein, G.C. Forrest & J.D. Baum, *Imparting the Diagnosis of Life Threatening Illness in Children*, 298 BMJ 1623, 1624 (1989) (explaining that of parents studied, “on looking back no parent had wanted to be protected from bad news”).

365. Schubert & Chambers, *supra* note 364, at 168.

366. Woolley et al., *supra* note 364, at 1624.

alleviate the parents' first need to understand that stillbirth still happens before they can begin to process that it happened to their child.

A warning ahead of time benefits a patient even when nothing can be done to prevent the undesirable medical outcome. For instance, even though healthcare professionals may be tempted to “ censor their information giving to patients in an attempt to protect them from potentially hurtful, sad or bad news,” in a study of cancer patients, over 87 percent of those surveyed “ wanted all possible information, be it good or bad news.”³⁶⁷ The same study further explained that “ little evidence ” exists for the idea that patients will “ become overwhelmed with an immobilizing depression and not enjoy their remaining time ” if told of unpreventable bad news.³⁶⁸ The study ultimately concludes that, at least in palliative care, “[a]voidance of communication about the reality of a patient’s situation does not protect them from experiencing considerable psychological distress.”³⁶⁹

These findings apply to stillbirth. Parents do not want to be shielded from bad information. To the contrary, knowing the bad information—the potentiality of stillbirth—better prepares them. And that is true even if the undesirable medical consequence, in this case stillbirth, is unavoidable. Plus, importantly, the “ bad news ” of the possibility of stillbirth will not send mothers into psychological distress. This is especially true when the alleged “ bad news ” is simply that the stillbirth risk exists. Yes, the baby could still die in the womb even after 20 weeks of pregnancy, but the risk is very, very low. If anything, this news should be comforting to parents, while at the same time serving as a “ warning shot ” in case the child does die due to stillbirth.

C. REDUCING THE STIGMA

Mothers are traumatized by stillbirth. Their children have died. They are then further traumatized once they later learn that their child’s death is a cultural taboo. Despite its frequency, stillbirth remains hidden culturally.³⁷⁰ Researchers have described it as an invisible death; the mother was well aware of her child’s life and death, but the outside world saw neither.³⁷¹ And death before life is simply unacknowledged. “[T]he unique difficulty for women lies in the private, intimate nature of these types of losses whereby the baby is really known only to the mother, and often recognized and mourned solely

367. L.J. Fallowfield, V.A. Jenkins & H.A. Beveridge, *Truth May Hurt but Deceit Hurts More: Communication in Palliative Care*, 16 PALLIATIVE MED. 297, 297–98 (2002); see also Morris, *supra* note 132, at 315 (“ In 1961, at a time when the doctrine of informed consent was in its infancy, most doctors did not inform patients that the doctor had diagnosed a life-threatening disease, such as cancer.”).

368. Fallowfield et al., *supra* note 367, at 301.

369. *Id.* at 302.

370. See Frøen et al., *supra* note 321, at 1355.

371. See DEFRAIN ET AL., *supra* note 354, at 83.

by the parents.”³⁷² Mothers feel disenfranchised by the fact that their child’s death “may be considered by much of society as a non-event.”³⁷³ The child’s death may not even be acknowledged privately. Very often, the mother’s social support system falters.³⁷⁴ Even “[f]amily and friends may . . . act as if the birth and death had simply never happened in the first instance.”³⁷⁵ This lack of acknowledgement marginalizes mothers and further traumatizes them.³⁷⁶ Many mothers opt not to discuss their child because it makes others feel awkward and uncomfortable.³⁷⁷ “The lack of . . . acknowledgment . . . stigmatizes and retraumatizes families by minimizing the strength of their attachment and the significance of the relationship lost, particularly the mother-child relationship.”³⁷⁸ Currently, “[t]he tragedy of [a] stillbirth is a quiet tragedy.”³⁷⁹

A 2019 study suggests that the silence of health care providers is perpetuating the stigma surrounding stillbirth; it “found evidence that bereaved parents were not informed about the possibility of stillbirth in their [pre]natal care, and subsequently, this exacerbated the feeling of silence and

372. Cacciatore, *Unique Experiences*, *supra* note 77, at 137.

373. *Id.* at 135; *see also* LANCET, *supra* note 36, at 5 (explaining that “[d]isenfranchised grief is common” after stillbirth, meaning that “parents’ grief after the death of their child is not legitimised or accepted by health professionals, their family, or society” and that “[m]any parents suppress their grief in public”).

374. *See* Cacciatore, *Unique Experiences*, *supra* note 77, at 135.

375. JANE LITTLEWOOD, ASPECTS OF GRIEF: BEREAVEMENT IN ADULT LIFE 124 (1992); *see also* DEFRAIN ET AL., *supra* note 354, at 83 (“Most family members who do not talk about the baby, we presume, avoid doing so because they feel it will hurt the parents to talk about death, or because death makes them feel uncomfortable. . . . A conspiracy of silence envelops the grieving parents and makes it more difficult for them to heal rather than less.”); Danielle Pollock, Tahereh Ziaian, Elissa Pearson, Megan Cooper & Jane Warland, *Understanding Stillbirth Stigma: A Scoping Literature Review*, 33 WOMEN & BIRTH 207, 208 (2020) [hereinafter Pollock et al., *Understanding Stillbirth Stigma*] (explaining “that grief after stillbirth is often disenfranchised because parents feel they are unable to discuss their experience or baby with their family or members of their community”).

376. *See* Cacciatore & Lens, *supra* note 24, at 312; *see also* Samantha Murphy & Joanne Cacciatore, *The Psychological, Social, and Economic Impact of Stillbirth on Families*, 22 SEMINARS FETAL & NEONATAL MED. 129, 131 (2017) (noting that “stillbirth is a loss often unacknowledged and invalidated by society”).

377. *See* Kelley & Trinidad, *supra* note 13, at 9; Pollock et al., *Voices of the Unheard*, *supra* note 229, at 170 (discussing that some parents “conceal” their stillborn child’s existence when asked how many children they have, and the parents then feel guilty for that concealment); Pollock et al., *Understanding Stillbirth Stigma*, *supra* note 375, at 209 (“The most identified examples of public stigma were minimisation, loss of friendships and family support and silencing when wanting to discuss their stillborn baby.”).

378. Cacciatore & Lens, *supra* note 24, at 312; *see also* Pollock et al., *Understanding Stillbirth Stigma*, *supra* note 375, at 213–15 (explaining that the stigma of stillbirth challenges a woman’s identity as a mother, a patient of medical care, a full citizen, and the baby’s identity).

379. Kirkley-Best & Kellner, *supra* note 314, at 420; LANCET, *supra* note 36, at 5 (“Women whose babies have been stillborn especially feel stigmatised, socially isolated, and less valued by society and, in some cases, are subject to abuse and violence.”).

blame.”³⁸⁰ Similarly, another study found that “the consequences of health care providers not informing pregnant women about the possibility of stillbirth[] meant that the bereaved parent felt it was not an acceptable topic to discuss within their respective communities, subsequently[] silencing them further.”³⁸¹

If doctors’ silence is a source of the stigma surrounding stillbirth, doctors beginning to discuss the risk of stillbirth can start to alleviate that stigma. Educating mothers could increase societal and cultural awareness, which could also start to alleviate the stigma. Even with more awareness, talking about death, especially the death of an unborn baby, will still be hard. Stillbirth will not suddenly lose its taboo status. At the very least, however, women should feel less stigmatized by their own doctors if warned about stillbirth beforehand.

VI. CONCLUSION

In 1999, Nadine Montgomery gave birth to a baby boy with cerebral palsy due to oxygen deprivation during vaginal childbirth.³⁸² Her doctor knew of the risk of oxygen deprivation due to Ms. Montgomery’s Type I diabetes.³⁸³ But she didn’t tell Ms. Montgomery. Her doctor didn’t warn her because “the risk of serious injury to the baby was very slight.”³⁸⁴ The doctor even stopped doing ultrasounds to estimate the baby’s size “because she felt that Mrs Montgomery was becoming anxious.”³⁸⁵ Had her doctor properly informed her, Ms. Montgomery would have consented only to a caesarean section delivery.³⁸⁶ But Ms. Montgomery never got the chance.

Medical paternalism prevented Ms. Montgomery from saving her child from cerebral palsy,³⁸⁷ just as it is preventing mothers from attempting to save their children from death due to stillbirth. Doctors are protecting neither the pregnant woman nor her unborn baby by remaining silent. To the contrary, as other countries have already realized, the doctor’s educating and empowering a pregnant woman with information about the risk of stillbirth and the simple preventative measures can help reduce the risk her baby is

380. Pollock et al., *Voices of the Unheard*, *supra* note 229, at 172; *see also* Pollock et al., *Understanding Stillbirth Stigma*, *supra* note 375, at 215 (discussing the research regarding how health care professionals’ silence regarding stillbirth before and after stigmatizes women).

381. Pollock et al., *Voices of the Unheard*, *supra* note 229, at 171.

382. *Montgomery v. Lanarkshire Health Bd.* [2015] UKSC 11, [1], [2015] 1 AC 1430 (appeal taken from Scot.).

383. *See id.* at [7] (explaining that the doctor knew of the risk of oxygen deprivation to Montgomery’s baby due to Montgomery’s diabetes and the baby’s size, but does not normally disclose the risk to patients because the risk of injury to the baby is small).

384. *Id.* at [17].

385. *Id.* at [14].

386. *Id.* at [18].

387. *See id.* at [22]. The UK Supreme Court adopted materiality standard in this case. *See id.* at [87].

stillborn. As she should, the mother can plan her baby's homecoming instead of his funeral.