

Informed Consent Law’s Role in Stillbirth Prevention: Response to Meghan Boone, Brietta Clark, and Nadia Sawicki

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ABSTRACT: Stillbirth—fetal death after 20 weeks of pregnancy but before birth—is one of the more common pregnancy outcomes, yet doctors rarely if ever discuss its possibility before the child’s death in the womb. Medical Paternalism, Stillbirth, & Blindsided Mothers argues that pregnant people have a right to know of this risk, a right enforceable through informed consent law. This Response replies to some of the criticisms of the argument raised by Professors Meghan Boone, Brietta Clark, and Nadia Sawicki. First, it weighs the risks of increased blame and criminalization of stillbirth against the possible benefits of preventing stillbirths. Second, it addresses the role of informed consent within Black women’s experiences of stillbirth. Third, it argues that tort law can play an important part in addressing the United States’ relatively high and stagnant stillbirth rate.

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I. INTRODUCTION

I am grateful to the editors of the *Iowa Law Review* for this opportunity to engage with scholars as gifted as Professors Meghan Boone,¹ Brietta Clark², and Nadia Sawicki.³ I admire all of their work and am grateful that they took the time to engage with my article *Medical Paternalism, Stillbirth, & Blindsided Mothers*. Stillbirth is pregnancy loss after twenty weeks of pregnancy, but before birth. It is a neglected issue, and I am professionally and personally grateful to the editors of the *Iowa Law Review* for this opportunity to bring more attention to it.

Approximately 24,000 stillbirths occur each year in the United States.⁴ Stillbirth not only means that the baby dies in the womb, sometimes just before the baby was due to be born, it also means physiologically identical childbirth except that the baby is dead.⁵ Only about one in 160 pregnancies end in stillbirth, but this is the overall risk.⁶ Black women and poor women face double the risk of stillbirth compared to white women and women with more economic means.⁷ It does not have to be like this. “The United States’ stillbirth rate is [much] higher ‘than [the rates] in other high-income countries.’”⁸ And while our stillbirth rate has remained basically stagnant for decades, those same other countries have successfully reduced their rates by 20 percent and more.⁹

The purpose of *Medical Paternalism* is to creatively attempt to change one fact about current medical practices—that doctors do not mention the word

1. Meghan Boone, *Considering the Risks of Medical Paternalism and Tort Liability for Reproductive Harms: A Conversation with Jill Wieber Lens*, 106 IOWA L. REV. ONLINE 37 (2021).

2. Brietta R. Clark, *Centering Black Pregnancy: A Response to Medical Paternalism, Stillbirth, & Blindsided Mothers*, 106 IOWA L. REV. ONLINE 85 (2021).

3. Nadia N. Sawicki, *A Malpractice-Based Duty to Disclose the Risk of Stillbirth: A Response to Lens*, 106 IOWA L. REV. ONLINE 69 (2021).

4. Jill Wieber Lens, *Medical Paternalism, Stillbirth, & Blindsided Mothers*, 106 IOWA L. REV. 665, 670 (2021) (hereinafter *Lens, Medical Paternalism*). The number of stillbirths is likely to increase in 2020 and 2021 due to COVID-19. See Erika Edwards, *Hard-Hit States Add Another Concern: Stillbirths in Unvaccinated Women*, NBC NEWS (Sept. 10, 2021, 11:34 AM), <https://www.nbcnews.com/health/health-news/hard-hit-states-add-another-concern-stillbirths-unvaccinated-women-rcn1a1952> [<https://perma.cc/N7WR-CKN6>]. Numerous anecdotal reports of increased stillbirths due to COVID-19 exist. See Carlie Porterfield, *‘A Real Tragedy’: Mississippi Stillbirths Double During Coronavirus Pandemic*, FORBES (Sept. 9, 2021, 7:24 PM), <https://www.forbes.com/sites/carlieporterfield/2021/09/09/a-real-tragedy-mississippi-stillbirths-double-during-coronavirus-pandemic/?sh=7df13cfc10a4> [<https://perma.cc/3RVW-SAHH>]. The risk of stillbirth, however, is rarely, if ever, featured in public messaging regarding COVID-19 vaccination.

5. Lens, *Medical Paternalism*, supra note 4, at 674.

6. *Id.* at 669.

7. *Id.* at 672.

8. *Id.* at 670 (quoting Jessica M. Page et al., *Potentially Preventable Stillbirth in a Diverse U.S. Cohort*, 131 *Obstetrics & Gynecology* 336, 337 (2018)).

9. See *id.* at 670, 691.

“stillbirth” to pregnant patients¹⁰ until after it happens. My son Caleb was stillborn at 37 weeks of pregnancy believed due to a placental abruption. The morning after I gave birth to him, my doctor told me that she was aware that placental abruption and stillbirth at term could happen, and she worried about it in her own pregnancies. She knew of this very rare risk. But I didn’t.¹¹ I did not know that my first son could still die in my womb just two weeks before we were scheduled to induce labor. Even on that morning, the law-professor part of my brain was apparently still functioning as my immediate thought was informed consent doctrine.

Tort law’s informed consent doctrine concerns the information a doctor must disclose to a patient so that a patient can make an informed decision whether to undertake a medical procedure.¹² The law on what must be disclosed has shifted dramatically—from a standard originally focusing only on what doctors normally disclose, to a standard now requiring that a doctor disclose all material information that a reasonable patient would want to know, including information not necessarily related to a specific medical procedure.¹³ Stillbirth is easily material. And two of the three reasons doctors do not currently disclose the risk of stillbirth reflects the very reasons courts shifted to the materiality standard.¹⁴ The first reason for nondisclosure is “that the risk is [so] low.”¹⁵ A low risk might be a reason for customary nondisclosure, but a low risk can still be material if severe, and stillbirth is the gravest consequence to parents preparing for the birth of their child.¹⁶ The second reason was paternalistic, that hearing of stillbirth would make women unnecessarily anxious.¹⁷ This reliance on the stereotype of the irrational and emotional pregnant woman reverts back to a doctor knows best standard, inconsistent with materiality.¹⁸ Also, practically, doctors may have a financial disincentive because the emotional woman may also desire additional check-

10. I thank Professor Clark for pointing out in her response the need, to the extent possible, to use nongendered terms. I am trying to do the same in this Response. I often use the term “mother” because of my self-identification and its consistency with experiences I have heard in support groups. I prefer to not use “pregnant person” to someone who has given birth to a stillborn child because it does not cover the entirety of the experience; it covers pregnancy and childbirth, but not the continuing parenthood that can exist after stillbirth. At least in this Response, I have chosen to use “birthing parent” when appropriate to capture both pregnancy and parenthood. I will continue to use “mothers” or “women” when referring to the results of stillbirth research if the studies do so because I do not want to assume application of those results onto others.

11. I do not blame my doctor for my son’s stillbirth. I use this anecdote only to illustrate the imbalance of knowledge.

12. Lens, *Medical Paternalism*, *supra* note 4, at 677.

13. *Id.* at 678–81.

14. The third reason is the inaccurate belief that all stillbirths are unpreventable. *Id.* at 690–92.

15. *Id.* at 686.

16. *Id.* at 687–90.

17. *See id.* at 692–94.

18. *Id.* at 692–93.

ups to ensure the baby is okay, additional check-ups for which a doctor may not get compensated due to global billing practices.¹⁹

I argue that informed consent requires a doctor to disclose the risk of stillbirth and the simple ways that pregnant patients can lower that risk²⁰—by “not smoking, sleeping on [their] side, and [monitoring fetal] movement[.]”²¹ Countries that have reduced their risk of stillbirth have done so with initiatives that include this education.²² I also argue that doctors’ acknowledgement of stillbirth has other potential benefits, including “reducing the shock” for parents when stillbirth does happen,²³ and reducing stigma given that studies show that doctors’ non-acknowledgment contributes to that stigma.²⁴ Another potential benefit is that acknowledgment of stillbirth may actually reduce the likelihood of malpractice lawsuits even when stillbirth does happen because patients are less likely to sue when they are satisfied with the doctor’s communication and feel they received sufficient detail and attention.²⁵

Again, I am grateful to Professors Boone, Clark, and Sawicki for their responses (and especially for them taking the time to write these during a pandemic). And I appreciate this opportunity to respond to three issues raised in those commentaries.

In Part II, I address concerns regarding whether increased education for how to prevent stillbirth will also increase blame—and the possibility of criminal consequences—on birthing parents when stillbirth does happen. We unfortunately know that this increased blame and potential criminal liability will fall hardest on marginalized populations, mainly Black birthing parents and poor birthing parents. While this concern is valid, the solution should be to prevent these prosecutions, not to prevent stillbirth prevention efforts.

In Part III, I address a second very-related issue—that my description of the stereotype of the emotional and irrational pregnant woman assumes white women much more so than Black women. Studies demonstrate that marginalized women, Black women, and poor women, experience stillbirth differently than white women and wealthy women. Those differing experiences are the subject of another Article I recently published, *Miscarriage, Stillbirth & Reproductive Justice*,²⁶ in which I argue for the explicit integration of pregnancy loss into the reproductive justice framework. I argue that the integration is especially appropriate given Black women and poor women’s increased risks of pregnancy loss. I welcome this additional opportunity to further address Black women’s experiences of stillbirth,

19. *Id.* at 698–99.

20. *Id.* at 686.

21. *Id.* at 697.

22. *Id.* at 704.

23. *Id.* at 716–17.

24. *Id.* at 717–18.

25. *Id.* at 714–15.

26. Jill Wieber Lens, *Miscarriage, Stillbirth, & Reproductive Justice*, 98 WASH. U. L. REV. 1059 (2021) (hereinafter Lens, *Reproductive Justice*).

including how stereotypes and adversarial relationships with doctors affect those experiences.

Last, in Part IV, I address the role of tort law. Specifically, I address certain doctrinal problems with using informed consent to effect this change. I also address whether tort law is the best option for effecting this change. Although I do believe in the possibility of empowerment through tort law, especially when the injury involves burying one's child,²⁷ my goal in *Medical Paternalism* was not to provoke thousands of lawsuits. Instead, my goal was to use the possibility of lawsuits to motivate changes in medical practices. For years, stillbirth advocacy groups have pushed for prevention efforts within prenatal care, as such efforts are rarely if ever included in broader reform efforts within the United States. My proposal was simply a way to effect this change through already established law.

II. INCREASING THE POTENTIAL FOR BLAME

Both Professors Clark and Boone address the possibility that increased blame and criminalization that could result from greater education that women's conduct—not smoking, sleeping on their side, and monitoring fetal movement—can help prevent stillbirth.²⁸ My emphasis in *Medical Paternalism* was certainly one focused on empowering the individual pregnant person to take actions that could decrease the chance of stillbirth (although I would also argue that this strategy creates needed structural change to currently stubborn medical practices). Professors Boone and Clark are correct to bring up the potential unintended consequences of this individual focus.

Pregnancy loss prevention efforts, just like many other issues in this country, have too often focused on “personal responsibility rather than communal solutions.”²⁹ Personal responsibility messages often try “to persuade women by implying that those who failed to comply . . . were unloving mothers.”³⁰ This focus on personal responsibility pervades reproductive health issues—that the person was irresponsible to get pregnant in the first place, that they were irresponsible in not getting in an abortion in a timely fashion, that a pregnancy loss must have been the result of conduct, etc.

The reproductive justice movement, created by Black women and emphasizing marginalized women's experiences, rejects this focus on the individual and instead recognizes that the ability “to determine [one's] reproductive destiny is linked directly to the conditions in [their]

27. See Jill Wieber Lens, *Children, Wrongful Death, and Punitive Damages*, 100 B.U.L. REV. 437, 480–81 (2020).

28. See Clark, *supra* note 2, at 90–94; Boone, *supra* note 1, at 42.

29. LARA FREIDENFELDS, *THE MYTH OF THE PERFECT PREGNANCY: A HISTORY OF MISCARRIAGE IN AMERICA* 105 (2020) (explaining that public health efforts in the 1980s and 1990s emphasized personal responsibility instead of “communal solutions such as political action to clean up health hazards in the environment”).

30. *Id.*

community.”³¹ I similarly argue for a de-emphasis on the individual within my *Miscarriage, Stillbirth, & Reproductive Justice* article. I argue that the “same conditions in her community and legal and structural impediments affect a woman’s ability to keep a pregnancy and give birth to a living child at its end.”³² I also describe studies that suggest non-individualized, societal reasons for racial and class disparities in the stillbirth risk.³³ As I argue, explicitly incorporating stillbirth (and miscarriage) prevention into the reproductive justice movement would bring attention to the broader structural and institutional causes of stillbirth. Certainly, preventable pregnancy loss cannot be solved with personal responsibility alone.

Medical Paternalism does, however, focus on what pregnant people can do to prevent their child’s stillbirth, acknowledging that some conduct during pregnancy can affect the fetus.³⁴ Do we risk increased blame after stillbirth if doctors start acknowledging its existence and explaining what can be done to possibly prevent it? Maybe. But I would argue that resisting this education for fear of blame is also motivated by paternalism—the idea that we should keep important information about stillbirth from birthing parents to protect them from self-blame if stillbirth does happen.

Fear of increased blame also ignores the reality that blame after stillbirth, both self-blame and external blame, is already widespread.³⁵ Mothers report feeling guilty that they didn’t prevent their baby’s death even when they could not have done so, blaming themselves for not having “a prescient experience forewarning them of the impending death.”³⁶ Even if more education about stillbirth prevention could increase this already widespread blame, it would be a difference in degree, not kind. That is not to say that the concern is invalid, but to point out that it underestimates how much blame already exists.

More concerning though is when blame is transformed into criminal prosecutions. As both Professors Boone and Clark point out, criminal

31. Loretta Ross, *What is Reproductive Justice?*, in REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE 4, 4 (2007), <https://www.protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf> [https://perma.cc/HVPg-DXML].

32. Lens, *Reproductive Justice*, *supra* note 26, at 1082.

33. *Id.* at 1083–84.

34. Lens, *Medical Paternalism*, *supra* note 4, at 671–72.

35. Joanne Cacciatore, *The Unique Experiences of Women and Their Families After the Death of a Baby*, 49 SOC. WORK HEALTH CARE 134, 140 (2010) (all but one participant in a survey expressed regret and guilt and “the words *guilt, kill, regret, wish, and should have*” and “[a]most one-half of participants . . . reported thoughts of self-harm”); Elizabeth Kirkley-Best & Kenneth R. Kellner, *The Forgotten Grief: A Review of the Psychology of Stillbirth*, 52 AM. J. ORTHOPSYCHIATRY 420, 422 (1982) (“The guilt involved can be overwhelming, as the mother goes meticulously over the events of her pregnancy, trying to discover etiological factors.”); 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).

36. Cacciatore, *supra* note 35, at 140; *see also* Katherine J. Gold, Ananda Sen & Irving Leon, *Whose Fault is it Anyway? Guilt, Blame, and Death Attribution by Mothers After Stillbirth or Infant Death*, 26 ILLNESS, CRISIS & LOSS 40, 42 (2018) (explaining that guilt is common because “[p]arents feel it is their job to care for and protect their children, thus feeling they have failed if their child should die”).

prosecutions for conduct during pregnancy are on the rise.³⁷ Overwhelmingly, these prosecutions involve pregnancies that still end with the birth of a healthy baby.³⁸ They are based on (technically legal) drug use³⁹ during pregnancy that did not actually harm the baby.⁴⁰ But just as some pregnancies without any drug use end in stillbirth, some pregnancies that include drug use also end in stillbirth. There is little to no scientific evidence connecting drug use and stillbirth,⁴¹ but some eager prosecutors have found it appropriate to charge women with murder for their child's stillbirth. Those eager prosecutors are also overwhelmingly likely to target their prosecutions on women of color and poor women consistent with stereotypes about bad versus good mothers.⁴² Both Professors Boone and Clark warn that my advocacy for increased education in *Medical Paternalism* could decrease stillbirths while increasing the chances of criminal prosecution when a baby is stillborn.⁴³

This is an important concern, and I take it very seriously. Prosecutions will only further traumatize women who have already had their child die in their womb, given birth to him, and likely blamed themselves, only to then have the State reinforce that self-blame. And again, marginalized women who likely lack access to mental health care are the most likely to be prosecuted.

At the same time, I don't believe the solution to the criminalization of stillbirth is to maintain a studied silence on stillbirth and the ways to help prevent it. The solution to criminalization should be to prevent prosecutions after stillbirth (and all prosecutions for conduct during pregnancy). As Professor Boone's own important work demonstrates, criminal prosecutions don't reduce stillbirths but actually increase stillbirths.⁴⁴ The threat of criminal consequences deters the pregnant person from seeking prenatal

37. Boone, *supra* note 1, at 43; Clark, *supra* note 2, at 92–93; see also MICHELE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* 31–34 (2020).

38. Meghan Boone & Benjamin J. McMichael, *State-Created Fetal Harm*, 109 GEO. L.J. 475, 487 (2021) (“The majority of children born to women who use drugs while pregnant have zero long-term negative effects as a result.”) (footnote omitted); see also *id.* (“Neonatal Abstinence Syndrome (NAS) can cause startling symptoms in newborns, it is a treatable condition and there is no reliable research on how—or whether—it affects children in the long run. In fact, there is some research suggesting that the symptoms of a pregnant woman's *withdrawal* from drug use while pregnant actually present the most immediate danger to the health of a fetus.”) (footnotes omitted); Cortney Lollar, *Criminalizing Pregnancy*, 92 IND. L.J. 947, 951 (2017) (discussing studies showing that “exposure to drugs in utero does not result in the negative long-term effects legislators, and most of us, presume”) (footnote omitted).

39. Lynn M. Paltrow, *Pregnant Drug Users, Fetal Persons, and the Threat to Roe v. Wade*, 62 ALB. L. REV. 999, 1021 (1999) (“Virtually no state, however, punishes drug use per se.”) (footnote omitted).

40. Boone & McMichael, *supra* note 38, at 487.

41. *Id.* (“The science behind prenatal drug use and its effects on children's health, however, is surprisingly uncertain.”).

42. *Id.* at 489.

43. Boone, *supra* note 1, at 45; Clark, *supra* note 2, at 92.

44. Boone & McMichael, *supra* note 38, at 505.

care,⁴⁵ and study after study links inadequate prenatal care to stillbirth.⁴⁶ And thus, preventing prosecutions should also decrease stillbirths in this country.

Plus, as demonstrated by the great successes other countries have had in reducing their stillbirth rates, there is a very real possibility that increased education will actually prevent some of the preventable stillbirths. Stillbirths not happening in the first place should be our goal.

III. BLACK PREGNANCIES

Professor Clark entitled her response to my piece “Centering Black Pregnancy,” and argued for a broader lens to examine the problem and potential solutions of stillbirth.⁴⁷ As I noted, she is right to focus on Black women’s experiences of stillbirth, and I did the same in *Miscarriage, Stillbirth, & Reproductive Justice*. More specifically, I explained that studies suggest that the racial disparity in the stillbirth rate may be due to the quality of medical care that Black women receive,⁴⁸ and that women of color are more likely to have their “birth justice rights” violated.⁴⁹ I also devoted a section to the emotional and mental health consequences of stillbirth for Black women, including that negative experiences with health care providers, socioeconomic stressors, and everyday racism all worsen the trauma.⁵⁰ And I recounted studies showing that Black women are less likely to obtain counseling and do not benefit from support groups, the default suggestion for care.⁵¹

Returning to the need for prenatal care to include a discussion of stillbirth, I explained in *Medical Paternalism* that one reason doctors currently do not do so is that they don’t want to cause unnecessary anxiety.⁵² This is a stereotypical idea of pregnant women as fragile and emotional, unable to handle the news of a less than one percent chance of their child dying in the

45. *Id.* at 487–88.

46. See e.g., Tomasina Stacey et al., *Antenatal Care, Identification of Suboptimal Fetal Growth and Risk of Late Stillbirth: Findings from the Auckland Stillbirth Study*, 52 AUSTL. & N.Z. J. OBSTETRICS & GYNAECOLOGY 242, 242 (2012); Kaisa Raatikainen, Nonna Heiskanen & Seppo Heinonen, *Under-Attending Free Antenatal Care is Associated with Adverse Pregnancy Outcomes*, BMC PUB. HEALTH, 1, 4 (2007) (study linking a lack of prenatal care to poor pregnancy outcomes, including that the risk of stillbirth was “found to be statistically higher than in the general obstetric population who attended routine [prenatal] care”); Diana Y. Huang et al., *Determinants of Unexplained Antepartum Fetal Deaths*, 95 J. OBSTETRICS & GYNECOLOGY 215, 215 (2000) (finding that a connection between unexplained fetal deaths and “fewer than four antenatal visits in women whose fetuses died at 37 weeks or later”). See also generally Elizabeth M. McClure, Sarah Saleem, Omrana Pasha & Robert L. Goldenberg, *Stillbirth in Developing Countries: A Review of Causes, Risk Factors and Prevention Strategies*, 22 J. MATERNAL-FETAL & NEONATAL MED. 183 (2009) (linking stillbirths in developing countries to the lack of appropriate obstetric care).

47. See Clark, *supra* note 2, at 88.

48. Lens, *Reproductive Justice*, *supra* note 26, at 1085.

49. *Id.* at 1090.

50. *Id.* at 1095–96.

51. *Id.* at 1098–99.

52. Lens, *Medical Paternalism*, *supra* note 4, at 692.

womb after 20 weeks of pregnancy.⁵³ More practically, this anxious pregnant person may want additional prenatal doctors' visits for reassurance, additional visits for which the doctor may not be compensated under current billing procedures.⁵⁴

Professor Clark points out correctly that this stereotype of the fragile and emotional pregnant woman does not necessarily fit Black women.⁵⁵ She instead points to stereotypes of Black women as “bad mothers,” either irresponsible or neglectful and a threat to their unborn child.⁵⁶ She also explains that doctors' nondisclosure to Black women is not to protect them from unnecessary emotional distress, but is instead based on “discrimination and a lack of physician confidence in the patient's judgment.”⁵⁷ Not only are Black women likely to experience information withholding, they are also more likely to not trust their doctors enough to share relevant information in return.⁵⁸ This nondisclosure is still a form of medical paternalism—a doctor's decision that a patient doesn't need to or shouldn't know certain information. But it's rooted in racist stereotypes of Black women and better labeled obstetric racism to expose the underlying racist stereotypes. Relatedly, Professor Colleen Campbell also recently commented on the historical medical exploitation of Black women and how that history is contributing to the overmedicalization of Black women today.⁵⁹ She pointed to the alarming rate of c-section deliveries for Black pregnant women as evidence.⁶⁰

Studies of parents after stillbirth demonstrate that distrust is rampant within doctor-patient relationships. Stillbirth's unexpected nature alone immediately breeds distrust. In one study, parents reported that “[d]isorientation, shock, and a perceived lack of communication” made their experiences with medical providers.⁶¹ Other parents specifically suspect “that physicians purposely were not telling them why their baby had died.”⁶² The same study also explained that doctors can become adversarial because of fear

53. *Id.* at 692–93.

54. *Id.* at 698–99.

55. Clark, *supra* note 2, at 104–08.

56. *Id.* at 98–99.

57. *Id.* at 104. I do want to point out that a doctor's lack of confidence in the patient is not a logical reason for withholding information regarding the risk of stillbirth. If doctors perceive Black women as threats to their unborn children, the logical response wouldn't be to withhold information about the stillbirth risk and prevention methods. Perhaps instead doctors see stillbirth as inevitable for Black women, making education on prevention efforts futile. Or, maybe the stereotypes of irresponsible and neglectful mean Black women would not undertake simple prevention efforts, so the doctor sees no reason to bother disclosing the risk. Regardless, seeing Black women as a threat to the fetus does not logically explain the lack of disclosure.

58. *Id.* at 107.

59. See Colleen Campbell, *Medical Violence, Obstetric Racism, and the Limits of Informed Consent for Black Women*, 26 MICH. J. RACE & L. (SPECIAL ISSUE) 47, 67 (2021).

60. *Id.* at 62–63.

61. Maureen C. Kelley & Susan B. Trinidad, *Silent Loss and the Clinical Encounter: Parents' and Physicians' Experiences of Stillbirth—A Qualitative Analysis*, 12 BMC PREGNANCY & CHILDBIRTH, 1, 4 (2012).

62. *Id.*

of blame.⁶³ In another study, parents “reported encounters with health professionals who did not share information, who restricted access to additional information or who had poor skills in helping people with grief.”⁶⁴ This same study focused on parents’ decisions whether to have an autopsy and stressed that “an environment of trust is needed to facilitate the process of decision making and consent,” and that “[l]oss of trust in health professionals can be a significant impediment to informed decision making.”⁶⁵ These studies were not specific to Black parents, and there’s every reason to expect even more distrust for those parents, especially since studies do document that negative experiences with health care providers add to the trauma of stillbirth for Black parents.⁶⁶

No one solution will fix this distrust. A rational first step, however, does seem to be getting doctors to acknowledge that stillbirth does still happen—that the risk of it for Black women is actually double, close to 1 in 87 pregnancies—a message communicating that the doctors want everything possible done to ensure a positive pregnancy outcome. Informed consent law can help motivate this disclosure.

Professor Clark is correct that a difference exists between mere disclosure of information consistent with informed consent law versus parents actually being empowered to make informed decisions.⁶⁷ Similarly, Professor Campbell recently argued that informed consent’s emphasis on “individual agency” means it cannot “protect against medical harm to disempowered social groups,” including Black women.⁶⁸ Both Clark’s and Campbell’s concerns, are geared more towards whether informed consent can solve forced medicalization—a doctor’s pressuring a Black woman into a medical procedure, like a c-section.⁶⁹ This is a very different application of informed consent than what I advocated in *Medical Paternalism*—a doctor informing women of the risk of stillbirth and the importance of sleeping on their side, monitoring fetal movement, and not smoking.⁷⁰ These are all actions pregnant people take on their own outside of the doctor’s office.

Regardless, Clark and Campbell are right to be concerned about informed consent’s emphasis on individual agency. Still, we must start somewhere. At this point, whether based in racist stereotypes of Black women or the stereotype of the emotional pregnant woman, doctors do not even say the word “stillbirth” until after the birthing parent has given birth to a dead baby. Allowing continued nondisclosure only sustains the power imbalance and breeds further distrust. Plus, other reforms can and should accompany

63. *Id.* at 5.

64. Dell Horey, Vicki Flenady, Liz Conway, Emma McLeod & Teck Yee Khong, *Decision Influences and Aftermath: Parents, Stillbirth and Autopsy*, 17 HEALTH EXPECTATIONS 534, 539 (2012).

65. *Id.* at 541.

66. Lens, *Reproductive Justice*, *supra* note 26, at 1095–96.

67. *See* Clark, *supra* note 2, at 101–02.

68. Campbell, *supra* note 59, at 72.

69. *Id.* at 67–68.

70. Lens, *Medical Paternalism*, *supra* note 4, at 697.

doctors' disclosure of the risk of stillbirth. One possibility is increased doula care. Numerous studies have suggested that the use of doulas help empower marginalized women within pregnancies and childbirth and improve birth outcomes.⁷¹

Obstetrical racism also affects care of Black pregnant patients in other ways relevant to stillbirth that are worth mentioning. In a congressional hearing on the racial disparity within the nation's maternal mortality rate, Representative Cori Bush, who is Black, testified about her experiences in her two pregnancies.⁷² When she was five months pregnant with her first child, she remembers sitting in her doctor's office and seeing a sign that said: "If you feel like something is wrong, something is wrong. Tell your doctor."⁷³ Bush told her doctor that she felt "severe abdominal pain, but her doctor" told her she was "fine" and to "go home."⁷⁴ "A week later, . . . Bush went into labor[] [and] [h]er son . . . was born" at only 23-weeks gestation.⁷⁵ He spent time in the NICU and today is in his twenties.⁷⁶ Bush's doctor later apologized to her for dismissing her and promised to do better.⁷⁷

Informed consent law can require doctors to disclose the risk of stillbirth to pregnant patients and to inform them of the importance of monitoring fetal movement, but it cannot force doctors to take concerns about fetal movements seriously when patients seek medical assistance. Doctors' dismissal of concerns in prenatal care is too common, especially for Black pregnant patients.⁷⁸ The pregnant person, actually, however, is *the* expert on their baby—the only consistent caretaker the baby has, given the lack of continuity in care in current obstetric practice.⁷⁹ We must find ways to overcome the stereotype of the Black pregnant patient as anything less.

Representative Bush's difficulties with prenatal care continued with her second pregnancy, and her experience gives us clues into another racist stereotype undermining medical care to prevent stillbirths of Black babies.

71. See e.g., Kristina Wint, Thistle I. Elias, Gabriella Mendez, Dara D. Mendez & Tiffany L. Gary-Webb, *Experiences of Community Doulas Working with Low-Income, African American Mothers*, 3 HEALTH EQUITY 109, 109–10 (2019); Kenneth J. Gruber, Susan H. Cupito & Christina F. Dobson, *Impact of Doulas on Healthy Birth Outcomes*, 22 J. PERINATAL EDUC. 49, 54–55 (2013).

72. Michele Munz, *U.S. Rep. Cori Bush Reveals How She Nearly Lost Her Two Babies*, ST. LOUIS POST-DISPATCH (May 6, 2021), https://www.stltoday.com/lifestyles/health-med-fit/health/u-s-rep-cori-bush-reveals-how-she-nearly-lost-her-two-babies/article_2925e2b3-6720-595c-ad22-edfa-2103e69c.html [<https://perma.cc/5VP8-5PU8>].

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. See Lens, *Reproductive Justice*, *supra* note 26, at 1091 n.270; Clark, *supra* note 2, at 104–05.

79. Lens, *Medical Paternalism*, *supra* note 4, at 703. UK emphasizes continuity of care (of midwives) as way to help reduce stillbirths. Megan Ford, *NHS Plan Will See Roll Out of Care Bundles to Reduce Stillbirths*, NURSING TIMES (Jan. 8, 2019), <https://www.nursingtimes.net/news/policies-and-guidance/nhs-plan-will-see-roll-out-of-care-bundles-to-reduce-stillbirths-08-01-2019> [<https://perma.cc/D47E-XWGG>].

Again she went into preterm labor, but this time at 16 weeks.⁸⁰ Bush insisted that the doctor she saw do something, but he told her that she would lose the baby and that she should go home and let her child “abort” as she could “get pregnant again because that’s what you people do.”⁸¹ Bush’s regular doctor, the same one who promised to do better, was called and “placed a cervical cerclage on the opening to [Bush’s] uterus” and Bush went on to have a successful pregnancy.⁸²

The harm of stillbirth is consistently underestimated. One of the most powerful underestimating forces is the idea of child replaceability—that to the extent stillbirth causes any harm, it can easily be fixed by having another baby.⁸³ “The replacement-child strategy of coping with grief is seen in stillbirth bereavement probably more frequently than in any other case.”⁸⁴ The idea of child replaceability is even stronger when combined with racist stereotypes of Black women as “breeders,” a stereotype that dates back to slavery, or the more recent stereotype of Black women as “welfare queens” who have many children to take advantage of government assistance.⁸⁵

Discovering your unborn child is dead and that you still need to deliver him is bad enough. Medical care for Black parents must improve, especially given that studies of other populations demonstrate that positive experiences with health care providers help lessen the intensity of grief and with coping.⁸⁶

IV. THE ROLE OF TORT LAW

I do believe tort law is empowering, especially for parents after loss of a child, as it provides parents with a means of private redress for their moral injury.⁸⁷ But my ideal future is not one with thousands of lawsuits filed over stillbirths; rather, I hope the possibility of lawsuits would create needed structural change—to change medical practices that currently do not incorporate stillbirth prevention measures.

Changing medical practices is not easy in this country. We do not have a government-run health system that can adopt stillbirth prevention initiatives

80. Munz, *supra* note 72.

81. *Id.*

82. *Id.*

83. Jill Wieber Lens, *Tort Law’s Devaluation of Stillbirth*, 19 NEV. L.J. 955, 993–95 (2019).

84. Kirkley-Best & Kellner, *supra* note 35, at 423.

85. Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1443 (1991); *see also* Lisa Rosenthal & Marci Lobel, *Stereotypes of Black American Women Related to Sexuality and Motherhood*, 40 PSYCH. WOMEN Q. 414, 414–16 (2016); Campbell, *supra* note 59, at 51–52. Clark also mentions the welfare queen stereotype of Black women and how this stereotype of the Black bad mothers has shaped policies and legal reforms. *See* Clark, *supra* note 2, at 99.

86. Jackelyn Y. Boyden, Karen Kavanaugh, L. Michele Issel, Kamal Eldeirawi & Kathleen L. Meert, *Experiences of African American Parents Following Perinatal or Pediatric Death: A Literature Review*, 38 DEATH STUD. 374, 378 (2014).

87. Lens, *supra* note 27, at 482–83. As Clark points out and I have noted, the current existence of caps on the recovery of noneconomic damages is hampering tort law’s private redress role for parents. *Id.* at 472–73; *see also* Clark, *supra* note 2, at 108–09.

and force change within the practices of doctors throughout the country. For decades, stillbirth advocacy groups have tried to work with medical professionals to change practices with little to no successes. It took until 2020 for the American College of Obstetricians and Gynecologists to allow induction of labor at term (37 weeks) in pregnancy after stillbirth.⁸⁸ The changed standard explains that induction is allowable if the patient is “educated regarding, and accept[s], the associated neonatal risks,” or, in other words, has given informed consent.⁸⁹ But the changed standard also hints of condescension, explaining that the patient may desire induction because of “maternal anxiety” or “severe patient anxiety”⁹⁰—as if severe anxiety would be abnormal for a patient who already has given birth to one stillborn child and desires to avoid their next child also being stillborn.

Medical Paternalism thus looks to informed consent law to attempt to change what seems like otherwise unchangeable nondisclosure medical practices. Informed consent is not a perfect fit as Professor Sawicki was not convinced by my argument that informed consent law would apply even though the risk of stillbirth is not specifically tied to any medical procedure.⁹¹ Sawicki still proposes a medical duty to disclose information regarding stillbirth, but via the general medical malpractice.⁹² The problem with this argument (which she acknowledges) is that “whether a [general disclosure] duty . . . exists depends on whether it is within the standard of practice of reasonably competent physicians.”⁹³ Doctors’ current custom is to *not* discuss stillbirth, and juries do not have the power to deviate from this custom. Sawicki correctly points out that some courts have disregarded a customary medical practice if unreasonable, and the failure to disclose stillbirth easily could be an unreasonable medical practice.⁹⁴ I appreciate Sawicki’s approach, but I lack her faith in courts allowing juries to overrule customary doctor practices, especially when it comes to stillbirth. Doctors’ nondisclosure of stillbirth is longstanding, the assumed unpreventability of stillbirth is widespread, and the perception of doctors as experts is even stronger in obstetrics. These factors make me less confident that a general medical malpractice claim based on nondisclosure of stillbirth would motivate changes to medical practices. This is why I relied on informed consent theory instead; even with the applicability problems, the materiality test clearly dictates mandatory disclosure.

88. Am. Coll. of Obstetricians & Gynecologists & Soc’y for Maternal-Fetal Med., *Management of Stillbirth*, 135 *OBSTETRICS & GYNECOLOGY* e110, e125–26 (2020); see also Lens, *Reproductive Justice*, *supra* note 26, at 1092 n.272 (discussing that United Kingdom medical guidelines on stillbirth are far more advanced than United States guidelines, which is not surprising given the UK’s initiatives to reduce stillbirths).

89. Am. Coll. of Obstetricians & Gynecologists & Soc’y for Maternal-Fetal Med., *supra* note 88, at e125–26.

90. *Id.* at e125.

91. See Sawicki, *supra* note 3, at 80.

92. *Id.* at 81.

93. *Id.*

94. *Id.* at 82–83.

Professor Sawicki disagreed on the most applicable tort claim, but she still agreed that tort law is a vehicle to motivate integration of stillbirth prevention into obstetrics care.⁹⁵ Professor Clark disagrees, criticizing reliance on tort law and instead advocating for more collaborative efforts to change medical practices.⁹⁶ She specifically points to other examples of broader partnerships advocating for and improving prenatal care in the United States and believes these are the best way forward for stillbirth prevention efforts instead of a top-down tort law reform.⁹⁷

The problem with relying on broader partnerships for stillbirth prevention is that, at least in the United States, stillbirth is rarely included, much less prioritized. In England, for example, holistic initiatives also include stillbirth—reducing maternal mortality, neonatal deaths (infant deaths within the first 28 days of life), *and* stillbirths⁹⁸—placing stillbirths on the same level of importance as maternal and neonatal deaths. Even though the fetus is everywhere in America because of the ever-present abortion debate, we do not place stillbirth anywhere close to the same level of importance as maternal and infant mortality.

For instance, Professor Clark applauds the success of the California Maternal Quality Care Collaborative (“CMQCC”).⁹⁹ The CMQCC describes itself as an “organization committed to ending preventable morbidity, mortality, and racial disparities in California maternity care.”¹⁰⁰ It also describes its purpose as “to improve health outcomes for mothers and infants.”¹⁰¹

The words stillborn and stillbirth yield no results when searched on the CMQCC’s website; apparently “mothers” assumes only live childbirths. The CMQCC also established quality care measures for hospitals.¹⁰² Although a stillbirth indicates possible inferior perinatal care, the number of stillbirths is not a quality measure for a hospital, meaning the number of stillbirths that occur at the hospital is apparently not deemed relevant to the quality of care

95. *See id.* at 81.

96. *See* Clark, *supra* note 2, at 109–13.

97. *Id.*

98. In 2015, England’s Department of Health announced an initiative “to reduce the rate of stillbirths, neonatal and maternal deaths . . . [from 2010 statistics] by 50% by 2030.” NAT’L MATERNITY REV., BETTER BIRTHS: IMPROVING OUTCOMES OF MATERNITY SERVICES IN ENGLAND 50 (2016), <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf> [<https://perma.cc/8JX6-MYZF>]. Shortly after, the Department moved up its goal to 2025. NAT’L HEALTH SERV., BETTER BIRTHS FOUR YEARS ON: A REVIEW OF PROGRESS 9 (2020), <https://www.england.nhs.uk/wp-content/uploads/2020/03/better-births-four-years-on-progress-report.pdf> [<https://perma.cc/KF7V-8LLE>].

99. Clark, *supra* note 2, at 112 n.132.

100. *Who We Are*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, <https://www.cmqcc.org/who-we-are> [<https://perma.cc/6Y35-RBJP>].

101. *Id.*

102. *See* CAL. MATERNAL QUALITY CARE COLLABORATIVE, MATERNAL DATA CENTER (MDC) MEASURE LIST (2021), https://www.cmqcc.org/sites/default/files/Measure%20List_CA_Sept%202021.pdf [<https://perma.cc/CGJ6-R578>].

provided.¹⁰³ My intent is not to criticize the CMQCC for not emphasizing stillbirth prevention. It's understandable. Stillbirth is far too common but it is still rare, its harm is underestimated, and its assumed inevitability makes it seem less fixable than maternal and infant mortality. My point is only to be clear that stillbirth prevention is rarely a part of these greater efforts to protect mothers and infants.

It's also inappropriate to assume that the same measures that may help prevent maternal and infant mortality will also help reduce stillbirth rates. One example is the standard of care prohibiting "elective" induction before 39 weeks of pregnancy; the number of such inductions is a CMQCC quality measure for hospitals that would weigh against hospital accreditation.¹⁰⁴ The March of Dimes heavily lobbied for the adoption of the 39-week rule to reduce complications resulting from births before then.¹⁰⁵ Studies have suggested the possibility, however, that institution of the rule has increased term stillbirths (after 37 weeks).¹⁰⁶ A rule to help prevent one outcome can easily increase the possibility of another outcome, and broadly-focused partnerships do not always appreciate these nuances (especially when stillbirth is such a low priority).

Stillbirth groups have tried for years to raise awareness and incorporate stillbirth prevention efforts into prenatal care, the type of more collaborate change Clark thinks is preferable to tort law. This includes groups like Count the Kicks, the Star Legacy Foundation, and PUSH for Empowered Pregnancy. Their attempts at collaborative changes will continue regardless of any changes within tort law. Their work demonstrates that integration of stillbirth prevention into informed consent doctrine is not purely a top-down reform with no collaboration.

Regardless, it's unclear why using tort law would be less effective or appropriate. Clark mentions that changes in other countries were more collaborative.¹⁰⁷ But tort law has also played a part. Notably, one motivating factor for England's initiative to reduce stillbirths by half was medical malpractice. An investigation at Furness General Hospital revealed avoidable

103. See *id.* This is also despite a 2019 study of California births showing that the physical risks to women during childbirth are greatly increased in stillbirth versus live childbirths. I discuss this study in Lens, *Medical Paternalism*, *supra* note 4, at 674–75.

104. CAL. MATERNAL QUALITY CARE COLLABORATIVE, *supra* note 102. Another quality care standard is the number of c-section deliveries, disincentivizing c-sections even if desired when one is presented with the trauma of vaginal birth of a dead baby, a desire that is a birth justice issue. Lens, *Reproductive Justice*, *supra* note 26, at 1091–93.

105. Jane E. Brody, *A Campaign to Carry Pregnancies to Term*, N.Y. TIMES (Aug. 8, 2011), <https://www.nytimes.com/2011/08/09/health/09brody.html> [<https://perma.cc/M4QT-Q6TE>].

106. See e.g., James M. Nicholson et al., *U.S. Term Stillbirth Rates and the 39-Week Rule: A Cause for Concern?*, 214 AM. J. OBSTETRICS & GYNECOLOGY 621.e1, 621.e3–e5 (2016); James M. Nicholson, *The 39-Week Rule and Term Stillbirth: Beneficence, Autonomy, and the Ethics of the Current Restrictions on Early-Term Labor Induction in the U.S.*, 15 BMC PREGNANCY & CHILDBIRTH, 1, 1–2 (2015); Rachel A. Pilliod, Mekhala Dissanayake, Yvonne W. Cheng & Aaron B. Caughey, *Association of Widespread Adoption of the 39-Week Rule with Overall Mortality Due to Stillbirth and Infant Death*, 173 JAMA PEDIATRICS 1180, 1181 (2019).

107. Clark, *supra* note 2, at 102 n.79.

maternal deaths, stillbirths, and neonatal deaths.¹⁰⁸ Government-run health care also means negligence claims against the government directly incentivizing government action.¹⁰⁹ In response, the National Health Service in England announced the Saving Babies' Lives Care Bundle in 2015 as part of its plan to halve the number of stillbirths, neonatal, and maternal deaths by 2025.¹¹⁰ The combination of tort law incentives and other parental activism is not very different than what *Medical Paternalism* proposes along with other parental activism already underway in this country.

Tort law may effectively create incentives to force change to medical practices. It is, however, not a complete solution to preventing preventable stillbirths. As mentioned above, if pregnant patients notice changes in fetal movement, will doctors take their concerns seriously? What other reforms can help empower pregnant patients, especially marginalized ones? If pregnant patients now fully understand the importance of not smoking, will they have access to addiction treatment? Something must be in place such that pregnant patients get help for smoking cessation instead of fearing criminal consequences if they were to disclose their addiction.¹¹¹ Moreover, reducing exposure to secondhand smoke should be equally as important.

Tort law alone certainly can't prevent all preventable stillbirths. Broader, structural reforms that equally prioritize stillbirth prevention are also necessary, as Professor Clark argues¹¹² and I also argued would result from incorporation of pregnancy loss into the reproductive justice movement.¹¹³ But tort law could play a very important role in those broader reforms by motivating doctors to disclose the risk of stillbirth to their patients and to educate them on simple preventative measures. There is no reason why pregnant patients should only learn that the risk of stillbirth still very much exists after their child has died in the womb, when the birthing parent must then still give birth to their baby the same as if it were alive. We have to start somewhere.

108. BILL KIRKUP, THE REPORT OF THE MORECAMBE BAY INVESTIGATION 5, 15 (2015), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_vo.1.pdf [<https://perma.cc/8BLZ-T5VG>].

109. James Titcombe & Bill Kirkup, *Saving Babies' Lives*, HEALTH SERVS.J. (Feb. 11, 2019), <https://www.hsj.co.uk/comment/saving-babies-lives/7024392.article> [<https://perma.cc/CL6R-YZCX>] ("The NHS currently faces claims of £2.1bn on maternity-related clinical negligence cases (2017-18 figures), compared with the £1.9 bn per year that is spent on delivering babies.").

110. Ford, *supra* note 79.

111. The UK has specifically increased measures to help with smoking addiction in its later rollout of initiatives to reduce stillbirths. As part of the country-wide rollout of the Saving Babies' Lives Care Bundle in 2019, women will have access to specialist stop smoking support and given the opportunity for carbon monoxide testing within prenatal care to see if they've been consuming smoke. Megan Ford, *Stop Smoking Support to be Ramped Up in Maternity Services*, NURSING TIMES (Apr. 2, 2019), <https://www.nursingtimes.net/news/policies-and-guidance/stop-smoking-support-to-be-ramped-up-in-maternity-services-02-04-2019> [<https://perma.cc/L8U9-DQNZ>].

112. See Clark, *supra* note 2, at 110–11.

113. Lens, *Reproductive Justice*, *supra* note 26, at 1082–88.

V. CONCLUSION

There is no experience quite like stillbirth. This is the baby that you've been preparing for and excited to finally hold in your arms. Then, just weeks or even days before the baby's due date, he dies. He dies in the one place that's supposed to be the safest for him, your womb. While still grappling with the knowledge that your unborn baby has died, you learn that you will still give birth to him the same as if he was alive. And the only experience of holding your baby in your arms will be holding his dead body.

In Torts, every law student learns about the groundbreaking case of *Dillon v. Legg*, in which the California Supreme Court announced a parent's ability to recover damages for emotional distress caused by observing their child's severe injury death.¹¹⁴ With stillbirth, the parent is not only at the scene of their child's death, the birthing parent's body *is* the scene of the death.¹¹⁵ And the birthing parent is then a literal "human coffin" until they give birth to their child.¹¹⁶

Fortunately, stillbirth is rare in the United States. But the risk still very much exists. And it is a material risk about which every pregnant person should know. Doctors should inform pregnant patients of both the risk and the easy measures that can be done to help prevent stillbirth. Despite extensive lobbying efforts and international successes, doctors in the United States do not seem interested in making this change on their own.

As it has in the past, tort law can motivate changes to medical practices. Simply informing pregnant patients of the risk and the preventative measures will not prevent even all of the preventable stillbirths. But again, we have to start somewhere.

114. See generally *Dillon v. Legg*, 441 P.2d 912 (Cal. 1968) (holding that a parent has a claim for negligent infliction of emotional distress if the parent witnesses the tortfeasor severely injure or kill the parent's child).

115. See Hannah Robert, *The Bereavement Gap: Grief, Human Dignity and Legal Personhood in the Debate Over Zoe's Law*, 22 J.L. & MED. 319, 327-29 (2014).

116. LINDA L. LAYNE, *MOTHERHOOD LOST: A FEMINIST ACCOUNT OF PREGNANCY LOSS IN AMERICA* 86 (2003).