

# Centering Black Pregnancy: A Response to *Medical Paternalism, Stillbirth, & Blindsided Mothers*

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*ABSTRACT:* In *Medical Paternalism, Stillbirth, & Blindsided Mothers*, Professor Jill Wieber Lens identifies an important void in pregnancy-related disclosures, which has rendered stillbirth risk largely invisible to pregnant patients. She then makes a compelling case that medical paternalism is animating this pattern of nondisclosure and that pregnant patients should have a right to evidence-based information about stillbirth risk and prevention. An important question remains, however, about whether Lens' proposed solution—a novel informed consent malpractice claim that would assign blame for the stillbirth through a tort liability regime—is likely to promote her goals of patient empowerment and better pregnancy care.

*This Response urges that any proposed reforms to pregnancy care be evaluated by how well they would serve those most vulnerable to both aspects of the problem Lens identifies—that is, those who are disproportionately likely to suffer a pregnancy loss, like stillbirth, and to experience information withholding and other autonomy-denying actions by health care providers. Racial and ethnic minorities, people struggling with poverty, and those with disabilities tend to fall into both categories; but to illustrate the need for this kind of centering in addressing pregnancy care reform, this Response focuses specifically on the experiences of Black women. Centering Black women's experiences of pregnancy—both within the health care relationship and as targets of reproductive regulation and control in society more broadly—reveals the dangers and limits of a tort liability approach that reinforces the association between pregnancy behavior and fetal harm for purposes of assigning legal blame. On a more hopeful note, however, this Response also shows that centering Black pregnancy is key to designing pregnancy care*

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*reform that is truly empowering for all patients, and thus more likely to improve health outcomes for pregnant patients and their children.*

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## I. INTRODUCTION

How do we ensure that pregnant patients<sup>1</sup> are empowered to make health-related decisions during pregnancy? This is the fundamental question that Professor Jill Wieber Lens considers in the context of stillbirth risk in

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1. Where possible, I use the term “pregnant patients” instead of “pregnant women” or “mothers,” and “pregnancy care” and “pregnancy outcomes” instead of “maternal health care” or “maternal outcomes,” in recognition of the fact that people giving birth may not necessarily identify as female and so as not to reinforce traditional, biologically-based definitions of gender that some use to reinforce gender-stereotypes and deny recognition and equal treatment to transgender individuals and those identifying as non-binary. In the context of reproductive health, and especially pregnancy care, it is important, however, to acknowledge and confront how such traditional gender categories have been and continue to be used to deny women’s autonomy. In addition, cis-gender women seem to be the primary focus in much research on pregnancy care. For this reason, there will be a number of instances where a reference to pregnant women or women’s health is the most precise and accurate language to use. For a more thorough discussion of the challenges of terminology in a framework that is both designed to illuminate traditional gender-based inequities as well as challenge the limits of such categorization, see LORETTA J. ROSS & RICKIE SOLINGER, *REPRODUCTIVE JUSTICE: AN INTRODUCTION* 6–8 (2017). For more information on the important research into the pregnancy experience of transgender men, see Margaret Besse, Nik M. Lampe & Emily S. Mann, *Experiences with Achieving Pregnancy and Giving Birth Among Transgender Men: A Narrative Literature Review*, 93 *YALE J. BIOLOGY & MED.* 517, 518 (2020) (describing the limited research revealing that “transgender men face substantial obstacles to achieving pregnancy and significant challenges during pregnancy and birth . . . which are informed by institutionalized cisnormativity embedded within medical norms and procedures”) (footnote omitted).

*Medical Paternalism, Stillbirth, & Blindsided Mothers*.<sup>2</sup> Professor Lens highlights the stigma around stillbirth that makes it largely invisible in provider communications to patients, explaining that physicians go so far as to treat it as taboo and confess discomfort at the prospect of having to even discuss it.<sup>3</sup> Physicians suggest that disclosure would cause women unnecessary anxiety, in light of the low risk of stillbirth and scientific uncertainty around preventability<sup>4</sup>—treating women as emotionally fragile and justifying the denial of information as a means to protect them from harm. Lens sees this as an example of the “protective paternalism” that characterized the early history of medical care in this country, and that informed consent doctrine was supposed to eradicate.

To promote better information sharing, Lens proposes what she admits is a novel informed consent malpractice claim that would assign blame for the stillbirth through a tort liability regime.<sup>5</sup> Citing research suggesting that certain behaviors may prevent or reduce the risk of stillbirth, namely smoking cessation, sleep positioning, and self-monitoring of fetal movement,<sup>6</sup> Lens argues that a physician who fails to disclose this information should be held accountable when a stillbirth occurs. She argues for tort liability, despite conceding that causation would be difficult to prove because of how much is still unknown regarding the causes of stillbirth.<sup>7</sup> For Lens, this scientific uncertainty should not doom the malpractice claim because the preponderance standard is weak enough to accommodate it. More importantly, she hopes that by emphasizing the *possible* causal link between stillbirth and certain pregnancy behavior, tort law will catalyze research and pregnancy care reforms that will ultimately improve birth outcomes by empowering women to make healthy choices.<sup>8</sup>

By calling attention to this problem, Lens makes several valuable contributions to the literature on informed consent and pregnancy care. She renders visible a risk that has been stigmatized through medical silence and concealed through medical paternalism. She demonstrates how this nondisclosure undermines patient self-determination in pregnancy care—an area in which women’s decision making has been too often and too easily devalued or infringed. And she highlights the important connection between information sharing and good health outcomes in pregnancy, noting that “empowered mothers play a crucial role in [stillbirth] prevention.”<sup>9</sup> Lens makes a compelling case that medical paternalism is playing a role in stillbirth

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2. Jill Wieber Lens, *Medical Paternalism, Stillbirth, & Blindsided Mothers*, 106 IOWA L. REV. 665 (2021).

3. *Id.* at 706.

4. *Id.* at 686–93.

5. *Id.* at 669.

6. *Id.* at 702.

7. *Id.* at 699–700; *see also id.* at 692 (“Admittedly, far too much medical uncertainty exists about the causes of and ability to prevent stillbirth.”).

8. *Id.* at 669, 700.

9. *Id.* at 699.

nondisclosure and that pregnant patients should have a right to evidence-based information about stillbirth risk and prevention.

Important questions remain, however, about whether Lens' proposed liability claim is likely to promote her goals of patient empowerment and better pregnancy care. Indeed, her proposal may have unintended effects that undermine autonomy and quality of care, especially for women who are disproportionately at risk of pregnancy-related harms. This Response urges that any proposed solution be evaluated by how well it would serve those most likely to suffer pregnancy loss like stillbirth, and experience information withholding and other communication problems with physicians generally—that is, the patients most vulnerable to both aspects of the problem Lens identifies. Women of color, poor women, and women with disabilities tend to fall into both categories, but to illustrate the need for this centering in addressing pregnancy care reform, this Response focuses on the experiences of Black women.

As Lens acknowledges, Black women are twice as likely to suffer from stillbirth as white women.<sup>10</sup> But largely missing from her critique of the problem, and discussion of her solution, are Black women's specific experiences that reveal how both medical paternalism and laws purporting to promote fetal health are deployed differently against them. Only by centering Black women's experiences of pregnancy—both within the health care relationship and as targets of reproductive regulation and control more broadly—can we see the dangers and limits of a tort liability approach that reinforces the association between pregnancy behavior and fetal harm for purposes of assigning legal blame.

Part II fleshes out the dangers of a liability-based approach to stillbirth nondisclosure that ties legal blame to a focus on behavior as a possible cause of stillbirth.<sup>11</sup> The causal link central to Lens' liability claim reinforces two dangerous assumptions about pregnancy behavior and blame: one is the overemphasis on women's behavior as a potential cause of poor birth outcomes; the other is the notion that this link justifies punitive interventions as an effective means of promoting fetal health. Together, these assumptions reinforce a mother-blame narrative that has been used by legal, social service, and medical actors to target certain women for criminal punishment, intrusive surveillance, and unwanted and harmful medical interventions, all while denying women the support necessary for true empowerment. These harmful actions targeting women have not promoted fetal health, and they undermine autonomy, health, and equity for women from marginalized communities, especially Black women. In fact, such actions reflect a broader and disturbing pattern of law being used as a tool of reproductive injustice that punishes and controls Black women's reproduction. Lens decries punitive actions against pregnant women and attempts to distinguish her

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10. *Id.* at 672; *see also* Shannon M. Pruitt et al., *Racial and Ethnic Disparities in Fetal Deaths — United States, 2015–2017*, 69 *MORBIDITY & MORTALITY WKLY. REP.* 1277, 1277 (2020).

11. *See infra* Part II.

approach by limiting it to tort claims against physicians.<sup>12</sup> Part II shows that this is unlikely to prevent the harmful effects of reinforcing a link between pregnancy behavior and fetal harm, given that our current legal system punishes, regulates, and surveils pregnancy behavior in the name of preventing fetal harm without strong or any supportive scientific evidence and despite an overwhelming consensus about the myriad other factors beyond patients' control that can contribute to poor fetal health.

Part III focuses on the limits of tort liability as a means of promoting patient empowerment and improved pregnancy care.<sup>13</sup> While the weakness of informed consent doctrine as a tool for promoting effective communication is well understood, this shortcoming is particularly profound in pregnancy care. Research reveals a remarkable breakdown in informed consent practice, in terms of physicians' failure to appreciate the kind of information patients want and patients' lack of understanding of risk, even beyond the stillbirth issue. The picture gets even bleaker with emerging research that centers the experiences of Black women of varying socioeconomic levels. Black women are more likely to report discrimination, disrespect, dismissal of concerns, medical abuse, and coercion by providers. In addition, interviews with patients and birth workers describe providers withholding information as a covert way of denying women decision-making control related to their pregnancy, and of disciplining or punishing them when they try to assert control over their birth planning and question health care providers. This withholding appears to be operating not only as a product of the medical dominance that still shapes pregnancy care, but also as a form of obstetric racism that has a mutually constitutive relationship to the racialized attitudes and stereotypes of Black mothers that exist in other sectors of society.

Part IV reconsiders Lens' stillbirth critique and proposed solution in light of Black women's vulnerability to punitive and coercive actions rooted in the mother-blame narrative described in Part II, and the specific ways that medical dominance and obstetric racism subordinate Black women within the pregnancy care relationship as described in Part III.<sup>14</sup> This Response is focused primarily on showing how centering Black pregnancy is essential to understanding stillbirth nondisclosure as a part of a broader pregnancy-care problem, and to recognizing the potential dangers and limits of a liability-based approach that reinforces the association of pregnancy behavior and fetal harm for purposes of assigning legal blame. But Part IV suggests that centering Black pregnancy is also key to designing pregnancy care reform that is truly empowering for patients and improves pregnancy outcomes, including reducing preventable stillbirths.<sup>15</sup> Although a comprehensive consideration of reform alternatives to tort liability is beyond the scope of this Response, Part IV highlights recent efforts to improve pregnancy communication and care that go beyond disclosure. These efforts offer a more holistic approach

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12. Lens, *supra* note 2, at 669.

13. See *infra* Part III.

14. See *infra* Part III.

15. See *infra* Part IV.

for supporting all women—including those from marginalized communities—in their quest for safe and empowering pregnancy care. Part V concludes by emphasizing that the success of these reform efforts depends on an even broader movement to eradicate punitive and coercive actions targeting pregnant women—a movement aimed at correcting the myopic focus on specific pregnancy behaviors as the cause of fetal harm and eradicating the blame mindset that animates our punitive approach to the regulation of health and reproduction.

## II. MOTHER-BLAME & LAW AS A TOOL OF REPRODUCTIVE INJUSTICE

This Part describes the dangers of Lens' liability-based approach to stillbirth nondisclosure, which ties legal blame to a focus on pregnancy behavior as the cause of fetal harm. Professor Lens' theory of informed consent liability depends on three assumptions: that pregnant women can take steps to prevent or reduce the risk of stillbirth, namely smoking cessation, sleep position, and self-monitoring of fetal movement; that physicians should disclose this information so that women are empowered to take these steps; and that physicians should be held to account for a stillbirth when a patient has been deprived of this information. An essential element of this claim, therefore, is the asserted causal connection between specific pregnancy behaviors and pregnancy loss. But as Lens concedes, causation is a difficult question in any stillbirth because of how much is still unknown regarding the causes of stillbirth.<sup>16</sup>

Lens raises legitimate concerns about how scientific uncertainty is used—in conjunction with attitudes about mothers as emotionally fragile—by physicians to avoid the issue of stillbirth prevention altogether.<sup>17</sup> Yet, advocating for tort liability based on such weak causal claims risks undermining the very goals Lens wants to achieve. Specifically, her claim reinforces two dangerous assumptions about pregnancy behavior and blame that have undermined patient autonomy, equity, and health for Black women—the overemphasis on women's behavior as a potential cause of poor birth outcomes and individual blame as the basis for legal intervention purporting to prevent or punish fetal harm.

In contrast to the way Lens describes scientific uncertainty being used to obscure a connection between stillbirth and pregnancy behavior, the causal association between pregnancy behavior and pregnancy loss, including stillbirth, is actually quite powerful and routinely deployed against certain women through the punishment, regulation, and surveillance of pregnancy behavior. And unlike Lens' focus on the medical stereotyping of mothers as emotionally fragile and in need of protection from the harm they would experience from even contemplating stillbirth loss, certain women—especially Black women—are stereotyped as potential threats to their fetuses and assumed culpable for pregnancy loss. Newspaper headlines are

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16. See Lens, *supra* note 2, at 699.

17. *Id.* at 690–99.

peppered with examples of women being criminally prosecuted for pregnancy behavior assumed to have caused or increased the risk of stillbirth or miscarriage, even where evidence contradicts this presumed causal link.<sup>18</sup> But these articles only provide a snapshot of what women endure. Concerns about how maternal behavior *may* affect fetal health have been used to target women for a wide range of deprivations.

#### A. THE MANY FORMS OF MOTHER-BLAME

The presumed link between pregnancy behavior, fetal harm, and blameworthiness has long animated the use of law to punish or control various aspects of certain women's reproduction. A lack of data means we do not know exactly how many women are affected by such legal deprivations in the United States. But a research project into the "[a]rrests of and [f]orced [i]nterventions on [p]regnant [w]omen" from 1973 to 2005 by Lynn Paltrow and Jeanne Flavin<sup>19</sup> provides a rich picture of the characteristics of patients targeted, the operation of "blame" and "health" in the deployment of legal punishment and control, and the extent to which traditional legal safeguards are either ignored, weakened, or evaded altogether. Paltrow and Flavin reviewed over four hundred cases in which "pregnancy was a necessary factor leading to attempted and actual deprivations of . . . liberty."<sup>20</sup> Liberty deprivation is defined as any restraint or attempt to restrain or curtail a pregnant woman's liberty whether through criminal or civil laws.<sup>21</sup> This included "arrests; incarceration [(including sentencing increases)]; detentions in hospitals, mental institutions, [or] treatment programs; and forced medical interventions."<sup>22</sup>

Pregnant women suffering from miscarriage, stillbirth, or infant death after delivery have been charged for crimes such as "homicide by child abuse," manslaughter, and murder.<sup>23</sup> As some courts have rejected prosecutors'

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18. See, e.g., *Judge May Release Woman on Bail Who Was Charged with Murder After Giving Birth to Stillborn Baby*, CBS NEWS (Mar. 9, 2021, 4:57 AM), <https://www.cbsnews.com/news/chelsea-becker-stillborn-murder-bail-possible> [<https://perma.cc/KU5H-JQ6N>]; Alex Wigglesworth, *With a Woman in Prison for a Stillbirth, California's Murder Law is Tested*, L.A. TIMES (Dec. 16, 2020, 6:00 AM) (woman serving an 11-year sentence based on prosecutors' allegation that her drug use caused stillbirth), <https://www.latimes.com/california/story/2020-12-16/adora-perez-appeal-stillborn-murder-charge> (last visited Aug. 26, 2021); 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/BDC3-7KB5>] (discussing the charge of depraved heart murder of a 16-year-old Mississippi teenager who ingested drugs during pregnancy and showing that it is one of many examples of criminal prosecutions against pregnant women for pregnancy loss).

19. Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL., POL'Y & L. 299 (2013).

20. *Id.* at 301.

21. *Id.* Based on other sources, the study authors concluded that this is likely a substantial undercount. *Id.* at 304–05.

22. *Id.* at 301.

23. *Id.* at 306, 314, 320–22.

attempts to use such laws to prosecute fetal harm, states have used feticide laws, enacted purportedly for the purpose of punishing violent acts against pregnant women by third parties that cause pregnancy loss, to punish pregnant women for miscarriage and stillbirth.<sup>24</sup> Even in the absence of harm, however, allegations that certain behavior constitutes child endangerment, child abuse, or child neglect have been the basis of criminal charges, as well as grounds for child protection and family separation actions.<sup>25</sup> Legal action has also been used to try to control women's behavior during pregnancy, for example through criminal prosecution and coerced diversion to an addiction treatment program, or by civil detention in a medical or other facility, typically for the purpose of forcing the woman to accept unwanted medical intervention, such as a cesarean section.<sup>26</sup>

Paltrow and Flavin found that the women arrested or subjected to other deprivations of liberty were socially vulnerable, either because of poverty, membership in a socially marginalized group, or other social stressors. They were overwhelmingly indigent,<sup>27</sup> and women of color, especially African American women, were overrepresented.<sup>28</sup> Such cases were widespread, occurring in almost every state,<sup>29</sup> but racial disparities were more pronounced in certain states and regions, especially in the South. Significantly, certain hospitals seemed to account for a disproportionate number of cases. For example, in South Carolina, a state with a disproportionate number of cases, the Medical University of South Carolina ("MUSC"), a public hospital, was responsible for 30 of the cases.<sup>30</sup> As detailed in other accounts, MUSC crafted a plan to work with state and local law enforcement and social service agencies to address drug use by pregnant women.<sup>31</sup> The program targeted women who met certain guidelines, such as those with little or incomplete prenatal care and dependent on public assistance. The women were tested for cocaine when they arrived at the hospital to deliver, and those who tested positive were given a "choice" between enrolling in a substance abuse program or being arrested for their drug use. Those who rejected the program, failed to adhere to the treatment plan, or subsequently failed a drug test were prosecuted.<sup>32</sup>

Paltrow and Flavin's study revealed the significant role of health care providers in targeting certain women for liberty deprivations based on

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24. *State Laws on Fetal Homicide and Penalty-Enhancement for Crimes Against Pregnant Women*, NAT'L CONF. OF STATE LEGISLATURES (May 1, 2018), <https://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx> [<https://perma.cc/YE8Z-SC6E>].

25. Paltrow & Flavin, *supra* note 19, at 322–26.

26. *Id.* at 300, 309.

27. *Id.* at 311.

28. *Id.*

29. The authors reviewed cases throughout "forty-four states, the District of Columbia, and some federal jurisdictions." *Id.* at 309.

30. *Id.*

31. See Priscilla A. Ocen, *Pregnant While Black: The Story of Ferguson v. City of Charleston*, in *REPRODUCTIVE RIGHTS AND JUSTICE STORIES* 161, 168–72 (Melissa Murray, Katherine Shaw & Reva B. Siegel eds., 2019).

32. *Id.* at 170.



pregnancy behavior. In the study, the authors were able to identify the source of the disclosure that initiated criminal justice involvement in 276 cases in the study, which in 112 cases was initiated by “health care, drug treatment, or social work professionals, including doctors, nurses, midwives, hospital social workers, hospital administrators, and drug treatment counselors.”<sup>33</sup> In 47 of those cases, confidential information was initially disclosed to child welfare or social service agencies, and they, in turn, informed the police. Racial disparities in reporting by health care providers were stark:

Nearly half (48 percent) of African American women were reported to the police by health care providers, compared to less than one-third (27 percent) of white women. White women, by contrast, were far more likely (45 percent) to have their cases come to the attention of the police through other mechanisms, such as reports by a probation or parole officer, an arrest unrelated to pregnancy, or a report from a boyfriend or family member.<sup>34</sup>

These cases demonstrate that the very system pregnant women are supposed to depend on for safe and supportive health care during pregnancy has been complicit, if not the driving force, in determining which women will be targeted for punitive, harmful and unwanted interventions based on their behavior. Moreover, to the extent negative attitudes and biases about Black women have been recognized as driving criminal and other legal actions that disproportionately target Black women and the poor, this data suggests that these attitudes are not external to the health system. Rather, as discussed further in Part III, these attitudes are mutually constitutive with attitudes and stereotypes of the health care and other professionals that shape the pregnancy care relationship itself.

Finally, Paltrow and Flavin’s study uncovered interesting trends with respect to the specific behavior that typically triggered liberty deprivations. One telling finding was that the authors could not clearly identify a particular behavior as *the* motivating factor for taking legal action against pregnant women. This was because the arrest warrants and other documents used to support legal action revealed numerous motivating factors.<sup>35</sup> Consider illegal drug use—this was a common basis for the legal actions reviewed in this study, in part because of the powerful cultural association between drug use and fetal harm, and in part because of the criminality of the behavior.<sup>36</sup> Nonetheless, in cases where illegal drug use was involved, other patient behaviors or characteristics were often cited in support of legal action.<sup>37</sup>

In fact, regardless of whether illicit drug use was involved, other behaviors—that would otherwise be considered lawful and even constitutionally protected—were often documented in support of legal

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33. Paltrow & Flavin, *supra* note 19, at 326–27 (footnotes omitted).

34. *Id.* at 327 (footnote omitted).

35. *Id.* at 316.

36. *Id.* at 313, 333.

37. *Id.* at 316.

action.<sup>38</sup> Alcohol use and smoking—one of the behaviors subject to the disclosure that Lens seeks to enforce through physician liability for stillbirth—were among the additional behaviors cited in numerous cases. In other cases, behaviors listed in support of legal action involved a patient’s refusal to follow treatment “orders,” lack of prenatal care, and giving birth outside of a hospital. Such behavior looks more like the kind of choice patients traditionally have the right to make about whether and when to seek or accept health care; alternatively, it may not reflect real choice at all, but rather may be the result of poverty-related barriers to care. In either case, using this as a compounding factor for punitive or coercive intervention raises ethical and legal concerns. In one case, a woman’s refusal to submit to sterilization was cited in support of prosecution—a decision not only implicating patient autonomy, but also the constitutional right to reproductive choice. Finally, in some cases the fact that the women suffered from a particular kind of medical condition, such as being positive for HIV, was cited in support of legal action—implicitly reinforcing the stigma that certain medical conditions are linked to risky behavior, and thus must be evidence of a patient’s poor decision making or untrustworthiness in self-care.

Indeed, one of the important findings from the study is how often legal action has been used by health care workers to force women to submit to unwanted medical interventions, such as cesarean section or blood transfusion, denying women autonomy to make health care decisions relevant to their pregnancy and health.<sup>39</sup> In the case of a white indigent woman, Laura Pemberton, doctors believed that a vaginal birth after having previously having had a cesarean section posed a risk to the fetus, and they successfully sought a court order to force Pemberton to undergo a cesarean instead.<sup>40</sup> In the process, a sheriff took her into custody while she was in active labor, strapped her legs together—creating a serious health risk—“and forced her to go to a hospital” for an emergency hearing.<sup>41</sup> Although the judge found that the state’s interest in protecting fetal life justified the forced cesarean, Pemberton later gave birth to three more children vaginally.<sup>42</sup> Indeed, there are a number of other instances where a physician’s insistence that a forced cesarean section was necessary to protect fetal health was later proved wrong.<sup>43</sup>

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38. *Id.* at 316 (“More than half the 348 cases ( $n = 177$ ) in which a woman was identified as having used an illegal drug also specifically referred to other factors, in addition to the pregnancy, as part of the rationale or circumstances justifying the arrest or detention. Regardless of whether there was a drug-related allegation, refusal to follow treatment orders was identified as part of the justification for the arrest, detention, or forced medical intervention in nearly one in five cases.”).

39. *Id.* at 317.

40. *Id.* at 306–07.

41. *Id.*

42. *Id.* at 307.

43. See generally John C. Fletcher, *Drawing Moral Lines in Fetal Therapy*, 29 CLINICAL OBSTETRICS & GYNECOLOGY 595 (1986) (summarizing review of six cases in which the woman “escaped” doctors’ attempts to perform a cesarean based on their beliefs it was necessary for fetal health and ultimately had a successful vaginal birth). See also Stephanie Teleki, *Birthing a Movement*

*B. IN THE NAME OF HEALTH*

Pemberton's treatment is just one example of many which reveal a significant disconnect between the government's purported health justifications for these deprivations and their actual effect. First, Paltrow and Flavin's study revealed that these liberty deprivations persisted despite weak or no evidence that the pregnant woman's behavior actually caused or would cause fetal harm. Indeed, legal rules governing the credibility of scientific evidence and proof of causation have been either misapplied, distorted, or ignored in these actions. In one well-known case, the state of South Carolina charged Regina McKnight, a twenty-one-year-old Black woman, with homicide by child abuse based on the theory that her use of cocaine caused her stillbirth.<sup>44</sup> Paltrow and Flavin noted that after only 15 minutes of deliberation, the jury found her guilty and she "was sentenced to twelve years in prison."<sup>45</sup> Her conviction was eventually overturned due to ineffective assistance counsel because the state relied on outdated research as to the effect of drugs on pregnancy, and her own counsel failed to present "recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition . . . or other conditions commonly associated with the urban poor."<sup>46</sup>

Law enforcement officials continue to bring homicide or child abuse charges against women who have used illicit drugs, based on discredited science about "crack babies" from the 1980s. In fact, Paltrow and Flavin "found numerous instances in which cases proceeded without any evidence, much less scientific evidence, establishing a causal link between the harm and the pregnant woman's alleged action or inaction."<sup>47</sup> Importantly, they found "courts failed to act as judicial gatekeepers to ensure, as they are required to do, that medical and scientific claims are in fact supported by expert testimony based on valid and reliable scientific evidence."<sup>48</sup>

Although the dominant narrative justifying legal action against pregnant women based on "risky behavior" is concern for fetal health, Paltrow and Flavin's investigation revealed a shocking disregard of the health of the fetus and woman by government officials and hospital staff while the woman was in custody. For example, in the case of a pregnant woman who voluntarily sought addiction help at a hospital, hospital staff reported her to state authorities, and she was forcibly taken to a different hospital much further away from her family and involuntarily committed to a psychiatric ward.<sup>49</sup> During this time, "she received no prenatal care and was prescribed numerous medications,"

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to Reduce Unnecessary C-Sections: An Update from California, HEALTHAFFS. (Oct. 31, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20171031.709216/full> [<https://perma.cc/NB3J-RLR6>].

44. Paltrow & Flavin, *supra* note 19, at 306.

45. *Id.*

46. McKnight v. State, 661 S.E.2d 354, 358 n.2 (S.C. 2008).

47. Paltrow & Flavin, *supra* note 19, at 318.

48. *Id.*

49. *Id.* at 307 (describing the case of Rachel Lowe).

though it was not clear if she was actually receiving appropriate addiction treatment.<sup>50</sup> She was eventually released when a doctor testified that her addiction did not pose a significant risk to the fetus, but she was in custody for several days and under state surveillance for the rest of her pregnancy.<sup>51</sup>

This example also illustrates how punitive and coercive government action even targets women who voluntarily seek medical help to stop or address the very behavior that is presumed risky to the fetus. Even women's voluntary disclosure of drug use or addiction from *before* the pregnancy—disclosed to facilitate proper prenatal care—has been used as grounds to restrain them and force unwarranted medical intervention.<sup>52</sup> The chilling effect that such actions can have on pregnant patients' willingness to seek care is one of the reasons for widespread and growing opposition by a diverse range of medical and public health organizations, including specialists in addiction medicine, pediatric medicine, obstetrics, and public health. These organizations point to the violation of ethical and legal principles that undermines trust and makes patients understandably fearful of seeking care.<sup>53</sup> But they also cite research suggesting that neither confinement nor forced intervention promotes fetal health; indeed, they argue that this is more likely to undermine both fetal and maternal health by subjecting pregnant women to harmful conditions and interventions that likely do not reflect the evidence-based treatment that would be appropriate for a particular patient.<sup>54</sup>

50. *Id.*

51. *Id.* at 307–08.

52. See, e.g., Erik Eckholm, *Case Explores Rights of Fetus Versus Mother*, N.Y. TIMES (Oct. 23, 2013), <https://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html> [<https://perma.cc/A26V-CMRC>] (The article describes the case of a woman who was 14 weeks pregnant and voluntarily disclosed at a prenatal checkup that she had been addicted to Percocet the year before. She was not still using drugs, which was confirmed by a urine test, and only disclosed the information because she thought her doctor should know. The doctor and a social worker insisted that she start an anti-addiction drug anyway. When the patient refused, county sheriffs came to her home and took her to court, where the doctor accused her of endangering her fetus and she was ordered to attend a mandatory 78-day stay at a drug treatment facility or risk prosecution.).

53. See Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUST., Feb. 2015, at 1, 3; Nancy D. Campbell, *When Should Screening and Surveillance Be Used During Pregnancy?*, 20 AMA J. ETHICS 288, 289 (2018); CTR. FOR REPRO. RTS., PUNISHING WOMEN FOR THEIR BEHAVIOR DURING PREGNANCY: AN APPROACH THAT UNDERMINES WOMEN'S HEALTH AND CHILDREN'S INTERESTS 4 (2000), [https://reproductiverights.org/wp-content/uploads/2020/12/pub\\_bp\\_punishingwomen.pdf](https://reproductiverights.org/wp-content/uploads/2020/12/pub_bp_punishingwomen.pdf) [<https://perma.cc/GVT7-7Y49>].

54. See *Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids*, AM. SOC'Y OF ADDICTION MED. (Jan. 18, 2017), <https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2017/01/19/substance-use-misuse-and-use-disorders-during-and-following-pregnancy-with-an-emphasis-on-opioids> [<https://perma.cc/HqjY-5L24>] (noting “the importance of working with a pregnant woman to facilitate her quitting or at least reducing substance use during pregnancy, and engaging in addiction-related treatment if necessary,” but “oppos[ing] criminalizing and other punitive approaches to substance use during pregnancy as they turn women away from prenatal care, thus compromising maternal and fetal well-being;” also asserting that “[p]unishing pregnant women impedes proper medical care and the promotion of public health”); Comm. on Health Care for Underserved Women, Am. Coll. of Obstetricians & Gynecologists, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, 117 OBSTETRICS & GYNECOLOGY 200, 200 (2011)

Relatedly, coercive actions have also been used to target women who may have been denied care in voluntary drug treatment programs or otherwise have likely not had access to the kind of care and support they need. For example, one of the hospitals found to generate a disproportionate number of cases in the Paltrow and Flavin study was a public hospital in South Carolina,<sup>55</sup> which was relied on disproportionately by poor and Black women for pregnancy care.<sup>56</sup> It entered into a partnership with law enforcement in which criminal actions were brought against women who tested positive for drugs, with the goal of forcing them into a diversionary drug treatment program.<sup>57</sup> But South Carolina has failed to take more supportive steps that would promote better pregnancy care and outcomes. For example, it has not expanded Medicaid, making it much harder for poor individuals to get the kind of care they need prior to, during, and post-pregnancy essential to promoting the patient's health and the health of the fetus or child.<sup>58</sup> Moreover, a study of drug treatment programs has shown that many pregnant women have trouble accessing them voluntarily, either because the programs will not take them or because of limited slots.<sup>59</sup>

### C. BLACK MOTHERHOOD

Numerous scholars have made the connection between the targeting of Black women for unjustifiable and harmful intervention and punishment, and a social and legal construction of Black motherhood rooted in gendered racism that presumes and reinforces negative attitudes of black mothers as unfit and harmful to their children.<sup>60</sup> Such attitudes have justified the ongoing subordination of Black women through reproductive control and surveillance, and provide greater context for understanding the many forms of reproductive injustice and denial of dignity that Black women experience. Punitive and coercive actions targeting Black women in the name of fetal protection are more consistent with a practice of punishing, controlling or

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("[I]ncarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse" and providers are "encouraged to work with state legislators to retract legislation that punishes women for substance abuse during pregnancy."); Stephen W. Patrick & Davida M. Schiff, *A Public Health Response to Opioid Use in Pregnancy*, 139 PEDIATRICS, Mar. 2017, at 1, 4 (noting that punitive measures "are not in the best interest of the health of the mother-infant dyad," and recommending "treatment programs that provide nonjudgmental, trauma-informed services").

55. See Paltrow & Flavin, *supra* note 19, at 309.

56. See Ocen, *supra* note 31, at 161.

57. See *id.* at 168–69.

58. See Rachel Garfield, Kendal Orgera & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2021), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid> [<https://perma.cc/7ZYP-BWM7>].

59. See, e.g., Stone, *supra* note 53, at 13–14.

60. See ROSS & SOLINGER, *supra* note 1, at 13–16, 168–74; JEANNE FLAVIN, OUR BODIES, OUR CRIMES: THE POLICING OF WOMEN'S REPRODUCTION IN AMERICA 11–25 (2008); DOROTHY E. ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 3–18 (Second Vintage Books Edition 2017).

even deterring Black pregnancy or reproduction itself, based on presumptions of unfitness, as opposed to reasonable or effective measures for preventing harm or promoting health.<sup>61</sup>

Indeed, the targeting of Black pregnant women for rights' deprivations both reinforces and is reinforced by a powerful cultural narrative of Black mothers as unfit, inherently dangerous to their children, and untrustworthy. This narrative has shaped U.S. law and policy for many systems, including welfare, family regulation, law enforcement, and, of course, public health and health care.<sup>62</sup> Consider the disturbing racial parallels between criminal or medical interventions in the name of preventing fetal harm and family regulation by state child protection agencies.<sup>63</sup> In "child protection" cases, Black families are less likely than white families to receive supportive services, and more likely to experience child removal—disparities that cannot be explained by factors relevant to assessment of risk and intervention.<sup>64</sup> The grounds for taking legal actions against families have expanded significantly over time using the category of "child neglect" or "unsuitable" home environments, which often involves poverty-related deprivations that may be beyond the control of the parent and be better addressed through poverty supports.<sup>65</sup> And the purported "protection" or "welfare" goals of these separations do not seem to be materializing for youth put into foster care—where Black children are disproportionately represented—based on reports of poor health outcomes.<sup>66</sup>

Negative attitudes about Black mothers have even shaped the creation and administration of programs that are specifically designed to help

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61. ROBERTS, *supra* note 60, at 154 ("The criminal regulation of pregnancy . . . belongs to the continuing legacy of the degradation of Black motherhood . . . . The prosecutions are better understood as a way of punishing Black women for having babies rather than as a way of protecting Black fetuses."); see also Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 GEO. WASH. L. REV. 1163, 1170–71 (2017); Michelle Goodwin, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* 8–11 (2020). The disproportionate targeting of Black pregnant women engaging in behavior or suffering from conditions believed to pose a risk of fetal harm parallels racial disparities in punitive versus supportive care approaches to mental health challenges and substance use disorders among Black versus white communities more broadly. See, e.g., Keturah James & Ayana Jordan, *The Opioid Crisis in Black Communities*, 46 J.L., MED. & ETHICS 404, 409–11 (2018) (contrasting the compassion expressed for people suffering from opioid addiction, a crisis viewed as predominantly affecting whites, with the criminalization and demonization of the Black communities disproportionately affected by a similar heroin epidemic in the 1960s and 1970s and the "crack-cocaine" epidemic of the 1980s and 90s).

62. See generally Dorothy E. Roberts, *Racism and Patriarchy in the Meaning of Motherhood*, 1 AM. U. J. GENDER & L. 1 (1993) (describing how racism and patriarchy have shaped the notions of motherhood in certain societal contexts).

63. For a compelling critique of racism within the child welfare system, see generally DOROTHY ROBERTS, *SHATTERED BONDS: THE COLOR OF CHILD WELFARE* (2002), and Alan J. Dettlaff & Reiko Boyd, *Racial Disproportionality and Disparities in the Child Welfare System: Why Do They Exist, and What Can Be Done to Address Them?*, 692 ANNALS AM. ACAD. POL. & SOC. SCI. 253 (2020).

64. See Dettlaff & Boyd, *supra* note 63, at 264–65.

65. *Id.* at 262–64.

66. See *id.* at 255.

pregnant women and mothers. Federal and state policy debates about whether to expand welfare and Medicaid coverage—both programs under which pregnant women have been prime beneficiaries—have always been shaped by perceptions about which groups would benefit and whether they were deserving, with racial identity as a salient factor in arguments about where to draw the line.<sup>67</sup> One of the most well-known examples of this occurred during the 1980s, when President Reagan successfully led efforts to rollback welfare, relying on the stereotype of the “Black Welfare Queen” as the archetype of a person with poor work ethic, having criminal tendencies, and using childbirth as a means to defraud taxpayers.<sup>68</sup> Even when poverty support programs are enacted or expanded, negative stereotypes of the undeserving poor motivate policymakers to create additional hurdles to program eligibility, such as through drug testing or burdensome documentation requirements proving work status.<sup>69</sup> Having to navigate such barriers is not only stigmatizing, it also creates an additional emotional and physical toll on those already suffering from poverty-related stressors.

Pregnant women, in particular, are subjected to ever-increasing surveillance by a whole host of state actors as a condition of dependence on public assistance, even those who are well-meaning. For example, social risk screening is increasingly touted as a way to connect poor pregnant women with poverty-related determinants of health and reduce racial health disparities.<sup>70</sup> Yet, because of intrusive questioning about a vast spectrum of behaviors touching on intimate home, relationship, and parenting matters, women targeted for such screenings are deprived of the privacy protections afforded to families not struggling with poverty.<sup>71</sup> They may also feel coerced into accepting “help,” fearing that refusal will be viewed as evidence of

67. See generally JILL QUADAGNO, *THE COLOR OF WELFARE: HOW RACISM UNDERMINED THE WAR ON POVERTY* (1994) (describing how racial issues have transformed the American welfare state).

68. See *id.* at v–vi.

69. See Sara Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS U. J. HEALTH L. & POL’Y 127, 140–42 (2011); Jennifer Wagner & Jessica Schubel, *States’ Experiences Confirm Harmful Effects of Medicaid Work Requirements*, CTR. ON BUDGET & POL’Y PRIORITIES (Nov. 18, 2020), <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements> [<https://perma.cc/W59HY66X>]; *Drug Testing for Welfare Recipients and Public Assistance*, NAT’L CONF. OF STATE LEGISLATURES (Mar. 24, 2017), <https://www.ncsl.org/research/human-services/drug-testing-and-public-assistance.aspx> [<https://perma.cc/9H2G-P2P5>].

70. See, e.g., THE MATERNAL & CHILD HEALTH RSCH. PROGRAM, *PREGNANCY PSYCHOSOCIAL RISK SCREENING VALIDATION STUDY 1*, [https://media.mchtraining.net/research/documents/fin\\_alreports/harrisonR4omco784oFinalReport.pdf](https://media.mchtraining.net/research/documents/fin_alreports/harrisonR4omco784oFinalReport.pdf) [<https://perma.cc/449Y-86WT>] (“To facilitate multidimensional psychosocial risk screening [in clinical settings], the Prenatal Risk Overview (PRO) was developed to assess 13 risk domains associated with poor birth outcomes or poor compliance with prenatal care: telephone access, transportation access, food security, housing stability, social support, partner violence, sexual/physical abuse by a non-partner, depression, cigarette smoking, alcohol use, drug use, legal problems, and child protection involvement.”) (footnote omitted).

71. See *id.* at 3; see also KHIARA M. BRIDGES, *THE POVERTY OF PRIVACY RIGHTS* 1–6, 110–14 (2017).

parental unfitness or behavior that poses a risk to the fetus or child and warranting intervention by child protection officials.<sup>72</sup> This highlights the importance of being attentive to how even well-meaning legal interventions can become tools of further deprivation and reproductive injustice that can undermine autonomy, health, and equity goals.

D. *DISTINGUISHING MALPRACTICE FROM MOTHER-BLAME*

Toward the end of her article, Lens acknowledges and decries the fact that the presumed link between certain pregnancy behavior and stillbirth has been used to criminally prosecute women for stillbirth, as well as the fact that poor women and racial minorities have been overwhelmingly prosecuted under “fetal protection laws.”<sup>73</sup> She argues that her causal claims should not be viewed as supporting such criminal actions against women for engaging in the behavior that would be the subject of physician disclosures, because the burden of proof under a malpractice preponderance standard is much lower than the reasonable doubt standard required for criminal cases.<sup>74</sup> As this part has shown, however, this distinction is unlikely to prevent the myriad forms of punishment and control of Black reproduction and pregnancy.

Blame operates in numerous ways—subjecting women to a variety of unwanted, invasive, punitive, and harmful actions—many of which are not subject to the type of evidentiary rigors and other formal safeguards of a criminal trial or any legal process at all. Even in the case of criminal actions, the normal rules governing causation and scientific evidence have not always provided a meaningful safeguard. As Lens acknowledges, juries may be prone to fundamental attribution error and implicit racial or other biases about defendants that leads them to disregard contrary explanations for stillbirth, or even the reality that there may be no explanation for the stillbirth.<sup>75</sup> Moreover, it will be difficult to insulate the causal association between pregnancy behavior and legal blame in light of the significant parallels in the policy rationales that drive tort liability for stillbirth nondisclosure and the criminalization and other more intrusive regulations of pregnancy behavior. In both cases, the law is viewed as a tool of accountability and deterrence of blameworthy conduct assumed to cause pregnancy loss.

Importantly, the mere *belief* in a link between pregnancy behavior and fetal harm has been impervious to legal rules governing the credibility of scientific evidence and burdens of proof relating to causation and harm. This belief has also been completely unmoored from health care ethics, public health recommendations, and evidence-based standards of care, when it is used as justification for treating certain women as legally culpable

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72. See BRIDGES, *supra* note 71, at 9–10; Stone, *supra* note 53, at 6–7.

73. Lens, *supra* note 2, at 711–13.

74. *Id.* at 711. It is important to acknowledge that not all pregnant patients intend to be parents, as in the case of surrogates. Thus, another implication of tort liability linked to pregnancy behavior is that it potentially increases surrogates’ exposure to tort claims brought by the intended parents.

75. *Id.* at 712–13.



perpetrators of harm, rather than victims of a devastating loss in need of care and protection. Even evidence of poverty-related barriers to care or that a pregnant woman suffers from particular health conditions are ignored as potential causes of poor health and a reason to provide women with greater support; instead, they serve as further justification for punishing or controlling behavior deemed deviant, risky, or noncompliant. Although there has been mounting legal and health policy pushback against the purported health justifications for such actions, progress has been uneven, and marginalized women, in particular, remain vulnerable to forced medical interventions, temporary confinement, or taking a plea to a criminal charge that would not have stood up on appeal. Nuanced distinctions in burdens of proof cannot cabin the more powerful racial and mother-blame stereotypes that drive the punishment and attempted control of Black pregnancy.

The bottom line is that Lens' attempt to distinguish her malpractice claim from criminal prosecutions of women for pregnancy behavior will likely not guard against the dangers enumerated in this Part. In attempting to create nondisclosure liability tied to claims that smoking, sleep position, or the failure to monitor movement can be identified as a cause of stillbirth, Lens risks fueling the ever-expanding regulation of pregnancy behavior by legal and medical actors. This expansion not only subjects women to punishment for a growing range of lawful behaviors, and even accidents, in the name of fetal health but also renders them vulnerable to more subtle forms of surveillance and control that eschew formal legal rules and protections.

### III. OBSTETRIC RACISM & THE LIMITS OF TORT LAW

One may wonder if by focusing on the dangers of blame reinforced by Lens' approach, as in Part II, I risk letting the perfect be the enemy of the good. Is there a countervailing value to allowing such a claim based on its potential for incenting better information sharing during pregnancy? Part III addresses this question by first pointing to the limits of tort liability as a means of promoting effective provider-patient communication during pregnancy generally. It then centers Black pregnancy to show why tort law is particularly ill-equipped to address the overlapping forms of subordination that undermine Black women's autonomy, health, and equity within the pregnancy care relationship.

#### A. *INEFFECTIVE COMMUNICATION*

Informed consent doctrine has not ensured informed decision making by patients, let alone patient empowerment. Informed consent liability primarily punishes failures to provide the minimal disclosure deemed necessary to a patient's ability to exercise self-determination. While information disclosures are necessary, however, they are far from sufficient for promoting patient empowerment. One reason is that informed decision making cannot exist without effective provider-patient communication and patient understanding, which, in turn, is shaped not only by *what* information is communicated but also by *how it is communicated*. The manner of

communication affects how patients perceive the information disclosed, as well their willingness to share further information that would be relevant to ensuring a better understanding by the provider and patient of the patient's condition, risks, and which treatment options best align with the patient's values and needs.<sup>76</sup> Informed consent doctrine has paid little, if any, attention to these elements of informed decision making.<sup>77</sup>

This disconnect between informed consent jurisprudence on the one hand, and the more capacious concept of informed decision making, on the other, has long been acknowledged by legal scholars, health advocates, and medical researchers. And consistent with Lens' critique, the connection has increasingly been made between informed decision making and good health outcomes. Low health literacy, patients' reports of poor provider communication, and evidence of poor health outcomes due to patients' lack of understanding of care instructions have been cited as examples of health communication failures and barriers to good health that have not been effectively addressed by informed consent liability.<sup>78</sup> In some areas, decision aids have been designed to promote better patient understanding of particular conditions and available treatment options, often through a collaborative effort involving patients, medical experts, and professionals with expertise in how best to promote health literacy and shared decision making.<sup>79</sup> But fear of liability is not what tends to catalyze this kind of collaborative and patient-centered reform. Rather, such reforms have arisen because of the *failure* of informed consent liability to promote effective communication, coupled with a growing awareness of or concern about the human and financial costs of those failures in certain areas of health care.<sup>80</sup>

#### B. MEDICAL DOMINANCE OF PREGNANCY

Pregnancy care is an area that has received much greater attention in the past decade because of concerns about poor outcomes and their link to poor treatment, including problems in provider-patient communication. Scrutiny of pregnancy care was initially sparked by what were seen as shamefully high maternal mortality rates in the United States compared to most other high-

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76. See Holly Goldberg, *Informed Decision Making in Maternity Care*, 18 J. PERINATAL EDUC. 32, 36-37 (2009).

77. 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, 292-96 (2011).

78. *Id.* at 285.

79. *Id.* at 278-83. Even the successful stillbirth reforms from other countries that Lens mentions in her piece reflect approaches developed through a more collaborative and patient-centered process.

80. *Id.* at 256-57.

income countries,<sup>81</sup> as well as comparatively high infant mortality rates.<sup>82</sup> A number of factors contributing to poor outcomes have been identified at the community or system level (such as barriers to safe and stable housing or reliable transportation), health facility level (e.g., limited experience, or capacity to deal with obstetric emergencies and/or care for high-risk infants), and the provider-patient level.<sup>83</sup> In provider-patient interactions, the Centers for Disease Control and Prevention (“CDC”) cites “missed or delayed diagnosis and lack of continuity of care,” as provider factors.<sup>84</sup> “[L]ack of knowledge of warning signs and nonadherence to medical regimens” have been listed as contributing “patient factors,” although research that centers patients’ experiences helps contextualize such factors as the product of larger structural forces that shape the provider-patient relationship, including provider communication problems and other autonomy-denying actions.<sup>85</sup>

In particular, pregnancy care communication defects are substantial and have been characterized as reflecting a fundamental breakdown of informed consent. Surveys document patients’ poor understanding of the risks and reasons for certain procedures, providers’ lack of understanding about the information pregnant patients want, and providers’ underestimation of patients’ desire to participate in healthcare decision making.<sup>86</sup> Indeed, many physicians are not trained how to involve patients in health care decisions or how to integrate the principles of informed decision making into practice.<sup>87</sup> Even more disturbing are patients’ reports of feeling coerced into “choosing” certain procedures, especially medical interventions such as a cesarean section which some studies have found to be associated with poor birth outcomes.<sup>88</sup>

This pattern reflects, in part, the stark power imbalance in any provider-patient relationship—a relationship shaped by a culture in which patients’ needs are often reduced to the particular illness, disease, or injury that is the object of medical gaze, and patients’ participation in treatment has been

81. See Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald & Laurie Zephyrin, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, COMMONWEALTH FUND (Nov. 18, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/no-v/maternal-mortality-maternity-care-us-compared-10-countries> [https://perma.cc/2BMG-N8VM] (explaining that in 2018, the ratio of deaths in the United States was more than double that of most other high-income countries). According to data from the CDC’s national Pregnancy Mortality Surveillance System (“PMSS”) for 2011–2015, several hundred women die from pregnancy-related complications every year and most of these deaths are preventable. See Emily E. Petersen et al., *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention*, 13 *STATES, 2013–2017*, 68 *MORBIDITY & MORTALITY WKLY. REP.* 423, 423–24 (2019).

82. Ashish P. Thakrar, Alexandra D. Forrest, Mitchell G. Maltenfort & Christopher B. Forrest, *Child Mortality in the US and 19 OECD Comparator Nations: A 50-Year Time-Trend Analysis*, 37 *HEALTH AFFS.* 140, 140–41 (2018).

83. Petersen et al., *supra* note 81, at 425.

84. *Id.*

85. *Id.*

86. See Goldberg, *supra* note 76, at 36–37.

87. *Id.*

88. *Id.*

primarily viewed through a lens of “compliance.” Patients’ own values, preferences, and assessment of their needs is often ignored or devalued, especially if in conflict with a physician’s recommendation. But this power dynamic is even more pronounced and consequential in pregnancy care, where physicians perceive duties to two patients—the pregnant woman and fetus. Physicians tend to insist on deference to their medical judgment about what pregnant women should do or not do to reduce fetal risk—even in the absence of strong supporting evidence—and physicians are more likely to perceive women’s “noncompliance” as a threat to fetal health that must be managed. As evidence of the power such medical judgment holds, conflicts over pregnancy-related decision making that are actually between physicians and their pregnant patients have been successfully reframed as conflicts between mother and fetus, making the adoption of the “maternal-fetal conflict” label ubiquitous across the legal, medical, and bioethical disciplines discussing the issue.<sup>89</sup> Moreover, physician expertise is typically given deference in the face of scientific uncertainty in tort law and in the case of more coercive actions targeting pregnant women described in Part II. Women’s reproductive choices do not get similar respect or protection in the face of scientific uncertainty.

### C. OBSTETRIC RACISM

The limits of tort liability as a tool for patient empowerment become even more stark when we center the experiences of Black women and consider how obstetric racism compounds the harms caused by medical paternalism during pregnancy. Black women’s experience of paternalism in pregnancy is very different from the presumed fragility and “protective paternalism” that Lens describes in her critique of the stillbirth problem. This disconnect helps show why a liability regime focused on disclosure will be of limited effect in reducing stillbirths and other poor outcomes for women whose treatment is shaped by more pervasive problems in communication and other autonomy-denying actions.

Although lack of information is a problem in pregnancy care generally, Black women are more likely to report experiencing information withholding or “packaging” of information to influence patient decision making and to view it as linked to discrimination and a lack of physician confidence in the patient’s judgment.<sup>90</sup> Information withholding is experienced as an exercise of power—a way for physicians to covertly deny women decision-making control related to their pregnancy. Indeed, Black women are more likely to report feeling coerced, bullied or harassed into certain procedures.<sup>91</sup> They also disproportionately report experiencing discrimination in other ways connected to defects in provider-patient communication, including the

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89. Michelle Oberman, *Mothers and Doctors’ Orders: Unmasking the Doctor’s Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 451–54 (2000).

90. See Molly R. Altman et al., *Information and Power: Women of Color’s Experiences Interacting with Health Care Providers in Pregnancy and Birth*, 238 SOC. SCI. & MED., Oct. 2019, at 1, 3–4.

91. *Id.*

dismissal of their concerns, disrespect, and the use of harsh language and rough handling that can rise to the level of medical abuse.<sup>92</sup> While education tends to be a mediating factor in studies of provider-patient communication, one study produced the surprising finding that “[h]igher education was associated with *more* reported communication problems” but only among one group—Black women.<sup>93</sup>

In a study titled *Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing*, Dána-Ain Davis centers the experiences of Black women and care workers by gathering information through interviews and oral histories and then presenting several narratives to illustrate common themes.<sup>94</sup> Importantly, this study focused on Black women of higher educational and professional status, to rule out the many socioeconomic factors that are often entangled with structural racism and can also shape pregnancy care.<sup>95</sup> The narratives provide a rich picture of Black women’s experience of discrimination in pregnancy, in ways that shape their ability to manage their own health and the health of their fetus or child.<sup>96</sup>

Davis shares the case of a woman who had engaged a midwife and had a birthing plan specifying a preference against medical intervention, but was told upon arrival that hospital personnel would not respect her plan without any explanation as to why.<sup>97</sup> Even after her baby was admitted to the Neonatal Intensive Care Unit (“NICU”), she had trouble getting information about her baby’s condition or why he had to be kept away from her for so long. Another woman described how concerns about her pregnancy were dismissed repeatedly by her treating physician, and then by staff at a hospital emergency room hours before she gave birth prematurely to very low-birth weight babies.<sup>98</sup> She described how her concerns about risk due to her use of In Vitro Fertilization (“IVF”) and prior fibroid surgery were disregarded by her treating physician, based on the fact that she did not have diabetes or high blood pressure—which Davis points out are markers of disease often associated with Black people.<sup>99</sup> When her newborns were admitted to the NICU, she was struck by the fact one of the NICU staff commented on the strength of Black babies, and assured her they would be fine.<sup>100</sup> When after a

92. *Id.*

93. Laura Attanasio & Katy B. Kozhimannil, *Patient-Reported Communication Quality and Perceived Discrimination in Maternity Care*, 53 *MED. CARE* 863, 863 (2015) (emphasis added).

94. Dána-Ain Davis, *Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing*, 38 *MED. ANTHROPOLOGY* 560 (2019).

95. *Id.* at 563.

96. In a subsequent study focusing on women who used assisted reproductive technology, Davis augmented her theory of obstetric racism, finding four additional forms of obstetric racism that women confronted in the ART context. Dána-Ain Davis, *Reproducing While Black: The Crisis of Black Maternal Health, Obstetric Racism and Assisted Reproductive Technology*, 11 *REPROD. BIOMED. & SOC’Y ONLINE* 56 (2020).

97. Davis, *supra* note 94, at 565–66.

98. *Id.* at 564–65.

99. *Id.* at 564.

100. *Id.*

month, one of the twins died from a hospital-based infection, the patient wondered to what extent this racialized, perceived strength of Black babies may have led to neglect, and whether, if they were white, they would have been perceived as more fragile and thus in need of greater care.<sup>101</sup> Davis highlighted the salience of this concern in light of a 2017 Stanford University study that found Black infants in the NICU received qualitatively inferior care compared to other infants.<sup>102</sup>

Davis also presented the experience of a woman who had been subjected to a painful procedure right after birth without anesthesia and without being told what was happening or why.<sup>103</sup> Davis and other scholars have attributed the harsh treatment of Black women, at least in part, to myths about the obstetrical and gynecological hardiness of Black women<sup>104</sup> or that Black people have thicker skin than white people and thus have a greater pain tolerance<sup>105</sup>—both of which have led to a desensitization to Black pain. And although such myths arose during the period of slavery, in part to justify the horrific experimentation and other abusive acts to enslaved people, evidence shows such myths persist among medical students and providers today and result in poorer quality care.<sup>106</sup>

Finally, interviews by birth workers supported patients experiences as forms of obstetric racism. Birth workers observed that Black women were often targeted for unwanted medical interventions, for reasons that were unclear, which they viewed both as a form of medical dominance and obstetric racism.<sup>107</sup> Birth workers also described what seemed to be a deliberate withholding of information as form of discipline or punishment, used against Black women, in particular, who tried to assert control over their birth planning and question health care providers.<sup>108</sup>

Consider the implications of obstetric racism for how provider disclosures—prompted by the threat of tort liability—may impact pregnancy care. Lens counts on such disclosures to promote physician-patient dialog and informed decision making. But the examples above show how obstetric racism impedes the type of ongoing communication or other support needed to

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101. *Id.* at 565.

102. *Id.*

103. *Id.* at 567.

104. *Id.* at 561.

105. Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCI. U.S. AM. 4296, 4296–97 (2016); see also DOROTHY ROBERTS, *FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY* 92–94 (2011) (describing evidence of contemporary beliefs that Black people have a higher pain tolerance than whites); HARRIET A. WASHINGTON, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT* 41–42, 55–58 (2006) (describing the origins of myths that Black people are impervious to pain).

106. Davis, *supra* note 94, at 561–62.

107. *Id.* at 568–69.

108. *Id.* at 568.

empower women as co-managers or co-experts in making healthy choices during pregnancy. Indeed, the problem is not only that physicians do not view and treat Black pregnant women as respected partners in pregnancy care; it is that these experiences also make Black women less likely to trust physicians and share relevant information in return. Women who have been stigmatized as unfit or untrustworthy mothers due to racism, or because of their struggle with conditions or behaviors deemed risky and deserving of punishment, may be less likely to seek help and disclose sensitive information about such behavior.<sup>109</sup> This is confirmed by recent studies documenting mistrust among low-income pregnant patients and new parents who fear disclosing their struggle with unmet social needs, like food or housing insecurity, even for the purpose of getting help. Their fear is that health care providers will report the information to legal authorities, like child protection officials, who will use the information against them.<sup>110</sup>

Moreover, just as Lens draws the connection between information failures and poor fetal and maternal health outcomes in the case of stillbirth, it is important to recognize how the intersection of medical paternalism and obstetric racism during pregnancy can have profound effects on the health of Black women and their children. The racial disparities in stillbirth are characteristic of disparities in other pregnancy outcomes. Black women disproportionately suffer poor birth outcomes, including miscarriages and preterm deliveries, and Black infant mortality is more than twice that of white infants.<sup>111</sup> Black women are at risk too. They die at more than three to four times the rate of white women from pregnancy-related causes,<sup>112</sup> are twice as likely to suffer from pregnancy-related morbidity, and experience unexpected outcomes that may have short or long-term health consequences.<sup>113</sup>

There is growing evidence of disparities in treatment that are likely connected to pregnancy outcomes. For example, Black women are less likely to be offered, or connected with, postpartum care generally,<sup>114</sup> which

109. *Id.*

110. DAVID SCHLEIFER, ANTONIO DIEP & KIRK GRISHAM, IT'S ABOUT TRUST: LOW-INCOME PARENTS' PERSPECTIVES ON HOW PEDIATRICIANS CAN SCREEN FOR SOCIAL DETERMINANTS OF HEALTH 13 (2019) ("Parents' concerns about discussing sensitive social needs with pediatricians included worries about being judged and discriminated against [and] fear of intervention by a child welfare agency . . .").

111. *Infant Mortality and African Americans*, U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF MINORITY HEALTH, <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23> [<https://perma.cc/gS5F-A2WM>].

112. Petersen et al., *supra* note 81, at 423; *see also Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 5, 2019, 1:00 PM), <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html> [<https://perma.cc/8MZS-AGPH>].

113. *See, e.g.*, William A. Grobman et al., *Racial and Ethnic Disparities in Maternal Morbidity and Obstetric Care*, 125 *OBSTETRICS & GYNECOLOGY* 1460, 1460 (2015); Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 *CLINICAL OBSTETRICS & GYNECOLOGY* 387, 388–90 (2018).

114. *See* Nina Feldman & Aneri Pattani, *Black Mothers Get Less Treatment for Postpartum Depression Than Other Moms*, KAISER HEALTH NEWS (Dec. 6, 2019), <https://khn.org/news/black>

contributes to delays in identifying problems that result in mortality, morbidity, or untreated mental health conditions. At the same, Black women are more likely to be subject to certain kinds of medical interventions that are viewed as riskier or unwanted, such as cesarean sections.<sup>115</sup> Although a common conclusion of such studies is the need to investigate racism as a potential cause of health disparities,<sup>116</sup> emerging research into the role of obstetric racism and power in pregnancy care described above—especially studies centering the voices and experiences of patients of color—demonstrates the myriad ways that racism shapes treatment and health.

#### D. RACE & GENDER INEQUITY IN TORT LAW

There is one final reason tort liability should be understood as an ineffective tool for addressing the medical paternalism that undermines Black women's pregnancy care and outcomes—tort law's own checkered history and contemporary record of exacerbating racial and gender inequity under the law. As Lens and others have noted, tort law has devalued pregnancy-related and gendered harms.<sup>117</sup> In the case of racism-related harms, including the kind of gendered racism manifested in forced and coerced sterilization and other reproductive abuses, tort law has been virtually irrelevant.<sup>118</sup> While there have been some improvements to tort law involving issues of race and gender, it continues to reproduce certain race and gender inequities.

For example, tort liability depends on the people harmed to bring claims to help establish new norms or practices; but many states have capped non-economic damages—the primary damage associated with pregnancy loss—making it harder for these plaintiffs to find attorneys willing to sue. As a

mothers-get-less-treatment-for-postpartum-depression-than-other-moms [https://perma.cc/379K-8LL8] (explaining that treatment lapses may be the result of Black women failing to report symptoms due to their fear that the information will be shared with child welfare services and used against them; noting that lapses may also be the result of ineffective screening tools that do not effectively identify symptoms in terms that may be more relevant or accessible for those in certain communities); Katy Backes Kozhimannil, Connie Mah Trinacty, Alisa B. Busch, Haiden A. Huskamp & Alyce S. Adams, *Racial and Ethnic Disparities in Postpartum Depression Care Among Low-Income Women*, 62 PSYCHIATRIC SERVS. 619, 623 (2011) (“[Differences in initiation and continuation of postpartum depression care] represent stark racial-ethnic disparities potentially related to outreach, detection, service provision, quality, and processes of postpartum mental health care. . . . [T]hese results emphasize that postpartum depression remains an underrecognized and undertreated condition for all low-income women, especially for those from racial and ethnic minority groups.”).

115. See, e.g., Grobman et al., *supra* note 113, at 1462 (noting that disparities in obstetric interventions that may be related to poor outcomes have been shown to occur in other racial or minority groups as well).

116. See *id.* at 1466; Allison S. Bryant, Ayaba Worjolloh, Aaron B. Caughey & A. Eugene Washington, *Racial/Ethnic Disparities in Obstetric Outcomes and Care: Prevalence and Determinants*, 202 AM. J. OBSTETRICS & GYNECOLOGY 335, 338 (2010).

117. See Jill Wieber Lens, *Tort Law's Devaluation of Stillbirth*, 19 NEV. L.J. 955, 958–61 (2019); see also MARTHA CHAMALLAS & JENNIFER B. WRIGGINS, *THE MEASURE OF INJURY: RACE, GENDER, AND TORT LAW* 3–4 (2010) (describing the evolution of “gender-linked limitations on recovery” in negligence that continue “to disfavor the type of claim that women plaintiffs are likely to bring, placing them at a considerable structural disadvantage”).

118. CHAMALLAS & WRIGGINS, *supra* note 117, at 29.



result of these caps and other barriers to civil justice, racial minorities and women are disproportionately shut out of the system.<sup>119</sup> Moreover, for women who are the most vulnerable to the harms Lens describes, bringing an informed consent malpractice claim would likely expose their own behavior to more intensive scrutiny than it already receives. Physicians are likely to defend themselves, in part, by redirecting the blame back onto the patient's own behavior or other characteristics.<sup>120</sup> And this is likely to be successful. Like the legal actions targeting Black pregnant women in Part II, "[i]n certain types of cases, the gender and race of the victims are so salient that they deflect attention from the negligent actions of the defendant, making it seem more likely that the plaintiff is solely responsible for the adverse outcome."<sup>121</sup> Tort law, as currently theorized and implemented in practice, is simply ill-equipped to effectively combat the overlapping forms of subordination that undermine autonomy, health, and equity during pregnancy.

#### IV. CENTERING BLACK WOMEN IN PREGNANCY CARE REFORM

Centering Black pregnancy reveals problems with the implicit and explicit assumptions that seem to drive Lens' critique of the stillbirth problem and her belief that tort liability can catalyze the reforms for empowering patients to make healthy choices. While Lens does a nice job of teasing out the particularities of stillbirth that contribute to nondisclosure, a closer look at the experiences of Black women suggest that their experience with stillbirth may be indicative of, and shaped by, more pervasive communication problems and other autonomy-denying actions by providers that cannot be adequately remedied by (and indeed may be exacerbated by) recognizing a new medical malpractice claim. Instead, the deprivation of Black women's liberty by the medical and legal establishment must be addressed through more structural reforms that ensure true patient empowerment rather than reinforcing mother-blaming. Lens's proposal evinces her faith in law as a tool for securing autonomy and improving health outcomes. Yet the women most vulnerable to mother-blaming, do not experience the law as a tool of protection or safety during pregnancy; rather law has been a tool of reproductive injustice, and "health"—as a justification—has been its enabler.

Consider the implications of Black women's experiences for addressing stillbirth under Lens' proposed solution. Tort liability may make physicians more likely to mention the risk of stillbirth and connections to smoking, sleep position, and self-monitoring of fetal movement. But what then? In the case of smoking, will addiction treatment be accessible? If so, will a patient feel comfortable revealing this problem to the physician to get help? What about the on-going communication necessary for self-monitoring to be effective—how will the physician handle the patients' concerns and role as a co-

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119. *Id.* at 2–3.

120. *Id.* at 4 (critiquing the doctrine of causation to show "how prevailing gender and race stereotypes, race- and gender-based schemas, and other common cognitive 'shortcuts' infect causal judgments and bias decision making"); see Clark, *supra* note 77, at 301–06.

121. CHAMALLAS & WRIGGINS, *supra* note 117, at 4.

manager of care? How might the physician's fear of tort liability exacerbate the operation of mother-blame, medical dominance, and obstetric racism that already undermines autonomy, health, and equity in pregnancy?

This Response is focused primarily on showing how centering Black pregnancy is essential to understanding stillbirth nondisclosure as a part of a broader pregnancy care problem, and to recognizing the potential dangers and limits of a liability-based approach that reinforces the association of pregnancy behavior and fetal harm for purposes of assigning legal blame. But it is also important to recognize that centering Black pregnancy can be key to designing pregnancy care reform that is truly empowering for patients and improves pregnancy outcomes, including reducing preventable stillbirths. Although a comprehensive consideration of reform alternatives to tort liability is beyond the scope of this Response, this piece concludes by highlighting recent efforts to improve pregnancy communication and care that go beyond disclosure and offer a more holistic approach to supporting all women, including those from marginalized communities, in their quest for safe and empowering pregnancy care. Several aspects of these reforms are notable.

The first is that these efforts tend to center pregnant women's experiences and needs—treating them not simply as patients upon whom treatment is delivered, but as co-experts and co-leaders in reforming pregnancy care. For example, the National Partnership for Women and Families has been conducting a series of landmark surveys about pregnancy, called Listening to Mothers, which has made visible significant “gaps between women's actual experiences and experiences they should have in light of their preferences, best maternity care practice and their legal rights.”<sup>122</sup> It provides valuable information about what women expect to know that can shape further research, practice guidelines, support better training for physicians on shared decision making, and inform broader patient education and health literacy efforts.<sup>123</sup>

A growing number of these efforts couple patient-centering with an explicit interrogation of racism within the health care system that disempowers women and undermines quality of care.<sup>124</sup> One example is the

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122. *Listening to Mothers Reports and Surveys*, NAT'L P'SHIP FOR WOMEN & FAMS., <https://www.nationalpartnership.org/our-work/health/maternity/listening-to-mothers.html> [<https://perma.cc/KS9P-7GV7>].

123. See, e.g., Elizabeth H. Day, *Applying the Listening to Mothers II Results in Lamaze Classes*, 16 J. PERINATAL EDUC. 52, 52–53 (2007); Maternity Ctr. Ass'n, *Recommendations from Listening to Mothers: the First National U.S. Survey of Women's Childbearing Experiences*, 31 BIRTH 61, 62–64 (2004).

124. Equity is increasingly incorporated in pregnancy related reforms at every level of policy or practice: from community-led efforts to reduce Black infant mortality (Robert M. Pestronk & Marcia L. Franks, *A Partnership to Reduce African American Infant Mortality in Genesee County, Michigan*, 118 PUB. HEALTH REPS. 324, 325 (2003)), to multi-disciplinary efforts to improve pregnancy care (Elizabeth A. Howell et al., *Reduction of Peripartum Racial and Ethnic Disparities: A Conceptual Framework and Maternal Safety Consensus Bundle*, 47 J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 275, 275–76 (2018)), to data collection for maternal mortality reviews

SACRED Birth Study,<sup>125</sup> designed for the development and validation of a quality improvement tool using an anti-racist and equity-based lens. This tool is called the Patient Reported Experience Measure of Obstetric Racism (“PREM-OB scale”) and was developed exclusively “for, by, and with Black mothers and birthing people,” women community leaders, and women scholars.<sup>126</sup> The hope is that this tool will enable hospitals, researchers, and policymakers “to examine associations between overall birth experience, patient experiences of obstetric racism, and clinical data to improve policy and practice.”<sup>127</sup>

Many of these efforts also acknowledge the need to address other structural inequities and barriers to care in order to truly empower patients to make healthy choices by ensuring they have not only the information, but also the supportive environment and material resources necessary to act on this information. This approach is reflected in the work of the Black Mamas Matter Alliance (“BMMA”), a Black women-led cross-sectoral alliance focused on Black maternal health, rights, and justice.<sup>128</sup> BMMA specifically grounds its approach in a reproductive justice framework—a belief that every person should have the legal, economic, social, and political resources to make reproductive decisions in safe, healthy, and noncoercive conditions.<sup>129</sup> It advocates for a holistic approach to care based on several principles that promote autonomy, equity, and health outcomes for pregnant patients and children. This approach, of course, emphasizes the importance of ensuring informed consent; but it also requires care that: “[i]s affordable and accessible;” “[i]s confidential, safe, and trauma-informed;” “[i]s Black Mama-, family-, and parent-centered and patient-led;” “[h]onors and fosters resilience;” “[i]s responsive to the needs of all genders and family relationships;” and “[p]rovides wraparound services and connections to social services.”<sup>130</sup> Notably, BMMA points to specific examples of care models that are implementing these principles, such as the JJ Way (developed by a midwife), MommyUp, Mamatoto Village, and the Black Midwives Care(r) Model.<sup>131</sup>

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(Michael R. Kramer et al., *Changing the Conversation: Applying a Health Equity Framework to Maternal Mortality Reviews*, 221 AM. J. OBSTETRICS & GYNECOLOGY 609, 615 (2019)).

125. SACRED stands for “Safety, Autonomy, Communication, Racism, Empathy, and Dignity.” See *SACRED Birth during COVID19*, U.C. San Diego, <https://sacredbirth.ucsf.edu> [<https://perma.cc/3MK7-J8VA>] (emphasis in original).

126. *Id.*

127. Vanessa Grubbs, *Researchers Seek Reproductive Justice for Black Women*, CAL. HEALTH CARE FOUND. (Sept. 25, 2020), <https://www.chcf.org/blog/researchers-seek-reproductive-justice-black-women/#related-links-and-downloads> [<https://perma.cc/2XCF-N6ZJ>].

128. See *About*, BLACK MAMAS MATTER ALLIANCE, <https://blackmamasmatter.org/about> [<https://perma.cc/22B7-ZHSL>].

129. BLACK MAMAS MATTER ALLIANCE, *SETTING THE STANDARD FOR HOLISTIC CARE OF AND FOR BLACK WOMEN* 11 (2018), [https://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA\\_BlackPaper\\_April-2018.pdf](https://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf) [<https://perma.cc/9BRX-VG3J>].

130. *Id.* at 6.

131. *Id.* at 15–17.

Admittedly, developing the kinds of holistic, patient-centered, and supportive reforms identified in this Part is an inherently slow and deliberative process that can run into political roadblocks, inertia, and medical culture resistant to change. And as Lens notes in her piece, physicians in the United States have resisted calls to incorporate stillbirth prevention as part of pregnancy care. Nonetheless, I believe that three recent trends make this a particularly ripe time for meaningful pregnancy care reform that will empower even marginalized women most vulnerable to harm.

First, the last couple of decades have seen growing scrutiny of the human and financial toll of certain physician practices and medical intervention in pregnancy.<sup>132</sup> More importantly, reforms that ensure greater respect for patients' birth choices and empower them as co-managers of their pregnancy are increasingly viewed by powerful actors, such as health care payors and managers of hospital systems, as important tools for quality and cost reform.<sup>133</sup> Second, the last decade has seen an increasing focus on the importance of structural determinants of health, again, as a factor in shaping health outcomes and cost. This has triggered an explosion of Medicaid policy innovations seeking to leverage health funding for social supports, including training and nursing home visits for pregnant women and new mothers, precisely because of their importance in promoting health and healthy choices among those struggling with poverty.<sup>134</sup> This is part of a growing movement among health justice advocates for legal and policy reforms touching every domain of health, including climate and the environment, housing, infrastructure, employment, education, welfare supports, and policing and child protection actions.<sup>135</sup>

Finally, while the progress from these movements has been uneven, especially for Black women who continue to face multiple forms of subordination that undermine their autonomy and health, last year saw a transformational awakening to the role of structural racism in health and

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132. Teleki, *supra* note 43. California has been one of the leaders of pregnancy care reforms addressing maternal mortality and morbidity through the California Maternal Quality Care Collaborative ("CMQCC"), a multi-stakeholder organization founded in 2006 at Stanford University School of Medicine with the State of California. Reducing unnecessary cesarean sections has been an important focus of reform. See *Supporting Vaginal Birth*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, <https://www.cmqcc.org/content/supporting-vaginal-birth> [https://perma.cc/YMX2-T7P5].

133. See Erika R. Cheng, Aaron E. Carroll, Ronald E. Iverson & Eugene R. Declercq, *Communications Between Pregnant Women and Maternity Care Clinicians*, 3 JAMA NETWORK OPEN, no. 5, 2020, at 1, 3; Rebekah E. Gee & Maureen P. Corry, *Patient Engagement and Shared Decision Making in Maternity Care*, 120 OBSTETRICS & GYNECOLOGY 995, 995-96 (2012).

134. *Medicaid's Role in Addressing Social Determinants of Health*, ROBERT WOOD JOHNSON FOUND. (Feb. 1, 2019), <https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html> [https://perma.cc/Y6HE-S477].

135. See, e.g., Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, 277-78 (2015); Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833, 837-39 (2016); *Blueprint for Changemakers: Achieving Health Equity Through Law & Policy*, CHANGELAB SOLS., <https://www.changelabsolutions.org/product/blueprint-changemakers> [https://perma.cc/ZE3Q-3XJJ].

beyond that has finally pushed equity and racism to the forefront of virtually every discussion of reform. And as these issues become more visible through formal research and informal sharing of patient experiences through social media, the public's consciousness about and discontent with the harmful effects of structural inequity has expanded and intensified. Even the powerful medical industry, which has long resisted acknowledging the operation of racism in health care, is finding that position untenable today.<sup>136</sup>

## V. CONCLUSION

This piece opens by asking: How do we ensure that women are empowered to make health-related decisions during pregnancy? Part IV highlights current efforts to empower women and improve outcomes through approaches that are patient-centered, supportive, and explicitly antiracist. But the reality is that the success of pregnancy care reforms depends on an even broader movement to eradicate reproductive injustice, especially the punitive and coercive actions targeting pregnant women in the name of fetal health. Central to this movement is a shift away from the myopic focus on specific pregnancy behaviors as the cause of fetal harm and a rejection of the blame mindset that relies on punishment and control to regulate health and reproduction. Liability proposals that reinforce the association of pregnancy behavior, fetal harm, and blame threaten to reproduce this injustice—undermining reforms that are more equitable, supportive, and empowering, and thus likely more effective at improving pregnancy care and outcomes.

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136. See, e.g., *Birth Equity*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, <https://www.cmqc.org/content/birth-equity> [<https://perma.cc/9GDJ-47KG>]; Apoorva Mandavilli, *Editor of JAMA Leaves After Outcry Over Colleague's Remarks on Racism*, N.Y. TIMES (Jun. 2, 2021), <https://www.nytimes.com/2021/06/01/health/jama-bauchner-racism.html> [<https://perma.cc/2F8W-RDW2>].