

# Considering the Risks of Medical Paternalism and Tort Liability for Reproductive Harms: A Conversation with Jill Wieber Lens

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In *Medical Paternalism, Stillbirth, & Blindsided Mothers*,<sup>1</sup> Professor Jill Wieber Lens offers her readers and the scholarly community a thought-provoking and novel framework for thinking about the potential tort consequences of doctors' failure to inform pregnant people about the risk of stillbirth. Like many other scholars in the newest generation of feminist theorists, Professor Lens is helping to build a rich academic literature on reproductive rights that both branches out from the traditional focus on contraceptives and abortion while also centering the multifaceted, sometimes tragic lived experiences of women in the reproductive process. This is crucial and important work, and the article is a valuable addition, centering an issue that even those writing in reproductive rights and justice often overlook.

Professor Lens has a dual focus in the article—both to critique the medical paternalism that animates doctors' reluctance to provide pregnant women with information regarding stillbirth and to offer bereaved women a mechanism for redress through the tort system when a failure to provide this information results in a stillbirth.<sup>2</sup> By her own admission, however, her main goal is to incentivize doctors to provide full and complete information about stillbirth—including ways to avoid it—primarily as a mechanism to decrease the risk and number of stillbirths.<sup>3</sup> This is without doubt a worthwhile goal.

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

2. *Id.*

3. *Id.* at 714 (identifying “[t]he primary benefit of educating women about the risk of stillbirth” as “the possible decrease in stillbirths”).

In this short Response, however, I hope to add to Professor Lens' important work in two ways. First, I want to widen the lens to focus on the goal of eradicating medical paternalism towards women generally, and pregnant women specifically, not as a means to an end—the reduction of stillbirth—but as an important goal in its *own* right, unconnected to the potential positive public health outcomes that it may create. In particular, I will argue that eradicating medical paternalism is a necessary component of eradicating inequity based on sex. Second, I focus on a potential danger that may result from Professor Lens' approach that, while she notes its presence, I feel is insufficiently explored within the original article. That danger is that the framework she proposes could result in additional criminal or civil liability redounding to pregnant women themselves following a stillbirth. In making these two arguments, I hope only to *add* to the important discussion that Professor Lens has begun in this piece, and indeed to highlight the importance of the conversation that she has started.

### I. THE HARMS OF MEDICAL PATERNALISM

Stillbirth is one of the most tragic things that can befall a woman, a family, and a community. The eager anticipation of a new baby is replaced with absolute devastation and—often—with confusion about why or how such a thing could happen.<sup>4</sup> The lack of information that pregnant women have about stillbirth, and the taboo surrounding its discussion more broadly, only compound and further alienate those who have experienced it.<sup>5</sup> Reducing stillbirth is a critical goal in its own right, particularly since it is marginalized women and communities who share an unfair and disproportionate burden of this tragedy.<sup>6</sup> In light of this, it is not surprising that Professor Lens would focus on how medical paternalism is connected to higher risks of stillbirth and how reducing or eliminating such paternalism might result in a decrease to the stillbirth rate. But as Professor Lens herself notes, while the cause of some stillbirths can be known and while some stillbirths can likely be avoided, it is undoubtedly true that for many stillbirths, neither is the case.<sup>7</sup> In these instances, does the “harm” associated with medical paternalism persist? It seems clear that it does. Medical paternalism and the harm it occasions rests, as it were, on its own bottom. While I don't believe Professor Lens would

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4. *Id.* at 669–72 (describing the lack of knowledge about the incidence and reasons for stillbirth).

5. *Id.* at 717 (“Mothers are traumatized by stillbirth. Their children have died. They are then further traumatized once they later learn that their child's death is a cultural taboo. Despite its frequency, stillbirth remains hidden culturally.”).

6. See generally Jill Wieber Lens, *Miscarriage, Stillbirth, & Reproductive Justice*, 98 WASH. U. L. REV. 1059 (2021) (discussing how women of color are more likely to experience miscarriage and stillbirth and how a reproductive justice approach should include these issues).

7. Lens, *supra* note 1, at 699 (“[C]ausation is a difficult question in any stillbirth because of how much is still unknown regarding the causes of stillbirth.”).

disagree with me on this point,<sup>8</sup> I think it worthwhile to make the point more explicitly than it is made in her original article.

Inspired by Professor Lens' own brave use of her personal tragedy to inform her scholarship,<sup>9</sup> I offer my own more mundane personal story to illustrate the less tangible, but no less important, harms associated with the medical paternalism that is often the hallmark of pregnant women's interaction with the medical system. In the first trimester of my second pregnancy, a small basal cell carcinoma was discovered above my left eyebrow. Eager to have it removed so as to avoid any potential spread, and with the encouragement of my dermatologist who was aware of my early pregnancy, I scheduled its removal with a local skin surgeon. On the morning of my surgery, the middle-aged male surgeon who was slated to perform the surgery told me that I could safely postpone the surgery until after the baby arrived if I wanted to do so. Surprised, I told him that it was my understanding that the surgery would pose absolutely no risk to the pregnancy but that if I had been misinformed, that of course I would postpone. He assured me that, yes, the surgery posed absolutely no risk to the pregnancy, but went on to say that if "something happened" and I lost the pregnancy, he worried because "women often blame themselves for these things." I paused for a moment and, in my clearest voice, restated my original question—"Does this surgery pose *any* threat to my pregnancy?" "No," he said. "Then I'd like to go forward."

Obviously, the paternalism that I experienced in that moment did not translate to any immediate harm. And due to the very slow rate of growth for most cancers of this kind, it probably would not have resulted in harm even if I *had* elected to wait until after my baby was born to undergo the surgery. But it doesn't negate the *wrongness* of the experience I had that day. It doesn't negate the fact that this man felt completely comfortable suggesting that I—an educated woman in my mid-thirties! A law professor no less!—was irrational enough that I would no doubt "blame myself" were something to happen that caused me to lose the pregnancy, even if I knew that such an outcome was *entirely unrelated* to my choice to go forward with the surgery. The fact that he had such a thought is offensive. The fact that he felt completely comfortable voicing that thought *to me* is outrageous. And moreover, it constitutes a type of sex discrimination.<sup>10</sup> Because of my pregnancy—and my sex—he assumed not only that my healthcare decisions would be made

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8. At some points in Professor Lens' Article, she too seems to advocate for the "right to know" unconnected from any potential ability to prevent stillbirth. *See id.* at 669 ("[A] woman has a right to know of the risk of stillbirth before it happens to her child . . ."). But ultimately, her focus remains on the right to know, and its attendant tort claim for failure to provide informed consent, as a mechanism for prevention. *See id.* ("Tort liability in the United States incentivizing doctors to disclose and educate women about the risk of stillbirth could similarly reduce the number of stillborn babies and bereaved mothers.").

9. Jill Wieber Lens, *Tort Law's Devaluation of Stillbirth*, 19 NEV. L.J. 955, 956–57 (2019).

10. *See* Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 1029–50 (arguing abortion restrictions violate equal protection as they are often predicated on sex-based stereotypes about women's roles and ability).

differently than they would if I were a man but also that such a difference would be marked by some type of inherent, unavoidable irrationality.<sup>11</sup>

Of course, the law is likely not a sufficiently nuanced tool to address the type of harm I experienced, which I was mostly able to ameliorate by ranting to some friends and thinking of all sorts of things that I *should* have said to the surgeon in the moment.<sup>12</sup> The causal links between medical paternalism, lack of informed consent, and potential for stillbirth bring along their own potential issues for civil litigants. However, Professor Lens skillfully addresses these issues in her article by discussing how the applicable standard in tort suits—preponderance of the evidence—allows for potential redress when doctors fail to provide pregnant women with basic information about the risks of stillbirth and how patients can best avoid it.<sup>13</sup> There is no lawyer who would suggest *my* experience would give rise to a cognizable legal claim—not only is there no causal link, but there is also no immediate harm.

Even so, I think it is vitally important to recognize that even absent an *immediate* harm, such paternalism results in systemic harm to women, to women's physical and mental health, and to women's larger quest for social and political equality. That if the facts of my experience had been ever-so-slightly different, real harm *could* have resulted.<sup>14</sup> What if he had simply refused to perform the surgery? What if I had misunderstood his confusing message, opted to wait, and the cancer had spread? Considering his apparent disdain for the mental capabilities of pregnant women, doesn't it seem likely that this surgeon—well-respected and at the top of his field—was likely engaging in some assumptions about the women on his staff?<sup>15</sup> And, perhaps most importantly and hardest to measure, what is the cumulative effect on women when such messages about their supposed (dis)abilities are reinforced, in ways both overt and subtle, over the entire course of their

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11. An assumption shared by many medical providers. See generally Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223 (2009) (discussing the assumption that women are irrational in the healthcare context).

12. And which, of course, I did not think of until hours—days—later.

13. Lens, *supra* note 1, at 709 (“[T]he mother need only demonstrate that had her doctor properly warned her of the risk of stillbirth, then, more likely than not, her child would not have been stillborn.”).

14. And indeed, as several high-profile cases have shown, harm—even fatal harm—is unfortunately a very real risk. See Nina Martin & Renee Montagne, *The Last Person You'd Expect to Die in Childbirth*, PROPUBLICA (May 12, 2017), <https://www.propublica.org/article/die-in-childbirth-maternal-death-rate-health-care-system> [<https://perma.cc/V67Z-KYUG>]. This risk is even more heightened for women of color, who face both systemic sexism and systemic racism. See Jallicia Jolly, *A Black Doctor Died After Childbirth. 4 Years Later, Her Mother and Daughter are Still Living with the Grief*, THE LILY (May 18, 2021), [https://www.thelily.com/an-esteemed-black-doctor-died-after-childbirth-4-years-later-her-mother-and-daughter-are-still-living-with-the-grief/?tid=recommended\\_by\\_lily](https://www.thelily.com/an-esteemed-black-doctor-died-after-childbirth-4-years-later-her-mother-and-daughter-are-still-living-with-the-grief/?tid=recommended_by_lily) [<https://perma.cc/gYN6-4CSR>].

15. An assumption that was likely well-founded. On a return visit, one of his nurses confided to me that she was pregnant and didn't feel comfortable telling the doctor about her pregnancy for fear he would change her work duties.

lives?<sup>16</sup> As long as medical providers continue to expect women to be unable to act in rational, autonomous ways as a result of pregnancy, then the physical fact of pregnancy will always remain an impediment to ensuring women are treated as full, equal people in healthcare contexts and beyond.<sup>17</sup> And if women are consistently treated in a way that presupposes their inability to assess and respond to risk, what that might do to their own belief in their abilities and inherent equality?<sup>18</sup>

Thus, while I don't fault Professor Lens for connecting medical paternalism to the potentially devastating outcome of stillbirth, which she does to great effect, I do think that we must insist that the conversation about the prevalence of medical paternalism towards women generally, and pregnant women specifically, not solely focus on the potential negative public health outcomes of such an approach. And even more so that we must not focus it on the potential negative public health outcomes for *babies*, which itself is too often centered when we are speaking of women's wellbeing and experiences in healthcare.<sup>19</sup> We must recognize the need to counteract stereotypical and discriminatory modes of thinking and acting in the world as unacceptable, illogical, and ultimately harmful even when the causal link between such behavior and negative outcomes is considerably more tenuous than the link Professor Lens is exploring.

## II. THE INHERENT RISKS OF CREATING MECHANISMS FOR ADDRESSING REPRODUCTIVE HARM

My second critique of Professor Lens' article is in the same vein as the first, in that I think the article could expand the conversation in an additional way, specifically by discussing potential negative, unintended consequences

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16. Cf. Elizabeth A. Pascoe & Laura Smart Richman, *Perceived Discrimination and Health: A Meta-Analytic Review*, 135 *PSYCH. BULL.* 531 (2009) (performing meta-analysis that supports the finding that discrimination has a significant negative effect on both mental and physical health); Susan H. Berg, *Everyday Sexism and Posttraumatic Stress Disorder in Women: A Correlational Study*, 12 *VIOLENCE AGAINST WOMEN* 970 (2006) (examining "the correlations between everyday (nonviolent) sexism and the development of trauma symptoms in women").

17. An unfortunate reality that Professor Lens obviously recognizes herself. See Lens, *supra* note 1, at 692 ("This idea that a pregnant woman is fragile, irrational, or emotional and thus unable to make a decision or in need of protection is not new. This type of characterization is present in both childbirth and abortion cases.").

18. See generally DERALD WING SUE, *MICROAGGRESSIONS IN EVERYDAY LIFE: RACE, GENDER, AND SEXUAL ORIENTATION* (2010) (discussing the effect of constant sexist and discriminatory messages on self-image).

19. Manian, *supra* note 11, at 289 ("The woman-protective anti-abortion claim not only reinforces the familiar notion that women are irrational decision-makers, but also the notion that women serve their ultimate role in society when they are mothers and that, as mothers, their only choice is to be self-sacrificing."). Of course, losing a baby to stillbirth itself can have long-term health consequences for women, too, as Lens herself points out. Lens, *supra* note 1, at 674-75. Focusing on these negative public health outcomes for women, however, still avoids the unfortunate tendency to center the health of babies as the most—or only—important metric for harm or success.

that may flow from the framework she proposes.<sup>20</sup> Unfortunately, this is an evergreen issue in the reproductive justice world, as too often, legal frameworks that were actually or at least theoretically developed with an intention to provide legal redress for the *benefit* of pregnant women instead morph into additional mechanisms to *blame* or *punish* pregnant women.<sup>21</sup> While explicitly not Professor Lens' intention for her framework to result in civil or criminal liability for pregnant women themselves—and indeed an outcome she explicitly rejects within the text of the article<sup>22</sup>—the risk is potent enough that her minimal engagement with the risk of such liability attaching to pregnant women seems insufficient. In the following paragraphs, I hope to detail the risk inherent in the adoption of her proposed framework more fully. I do not explore these risks with the expectation that any of the identified risks would necessarily result in the need to reject Professor Lens' proposed framework, but instead with the hopes that these risks are fully understood and weighed when deciding on the desirability of expanding liability in this potentially fraught area.

As a necessary starting point, it is critical to repeat that nowhere within her article, or any of Professor Lens' other articles on related topics,<sup>23</sup> does she champion or even condone an explicitly punitive approach towards pregnant women. Unfortunately, however, her intent is not controlling. Indeed, there are plenty of examples within the law where an idea resulted in an outcome completely contrary to the intention of those that proposed the original idea.<sup>24</sup> Even more to the point, there are numerous examples of how new legal claims introduced as a way to protect, honor, or compensate mothers for harms have been perverted as additional way to punish, criminalize, and stigmatize mothers themselves.<sup>25</sup> Without a more definite way

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20. Professor Lens advocates for the availability of an informed consent medical malpractice tort claim for women who experience stillbirth when their doctors failed to disclose the risks of stillbirth before it occurred. Lens, *supra* note 1, at 669.

21. See, e.g., *supra* notes 22–31 and accompanying text. Of course, much of the “woman-protective” legislation is not, in any real sense, designed with the ultimate goal of helping women. See Siegel, *supra* note 10, at 991–94 (describing the “woman-protective” argument put forth by anti-abortion activists that laws that burden abortion are necessary in order to protect women from having abortions that they will come to regret).

22. Lens, *supra* note 1, at 712–13 (describing criminal prosecutions of women for their own stillbirths as “problematic” and “troubling” and noting that most of the women prosecuted are poor and/or racial minorities).

23. See e.g., Lens, *supra* note 6; Lens, *supra* note 9.

24. Perhaps most lodged in the popular imagination is the contention that “sex” was inserted into Title VII of the Civil Rights Act of 1964 as a method to scuttle the bill. CHARLES WHALEN & BARBARA WHALEN, *THE LONGEST DEBATE: A LEGISLATIVE HISTORY OF THE 1964 CIVIL RIGHTS ACT* 234 (1985).

25. For instance, laws that protect both women and children from domestic violence have been coupled with “failure to protect” convictions for mothers who do not sufficiently protect their children from abuse, even if they, too are the victims of that abuse. See Jane H. Aiken, *Motherhood as Misogyny*, *WOMEN & L. (JOINT PUBLICATION)* 19, 29 (2020) (noting that although failure-to-protect statutes are written in gender-neutral terms, it is almost exclusively mothers who are prosecuted under them).

to protect against such a metamorphosis in the stillbirth context, the mere expression of an intention to avoid such an outcome is insufficient.

With those caveats in mind, Professor Lens' article undersells the potential risk of introducing a tort perspective into this arena. One example provides a relevant illustration of the potential dangers involved. A long-accepted legal principle is that a parent had a right to recover for harm inflicted upon a minor child.<sup>26</sup> In fact, recovery for the loss of a child has deep roots in the common law.<sup>27</sup> As Professor Lens has explored in previous work, in the middle of the twentieth century, legal barriers to mothers' tort claims for harm to—or loss of—pregnancies fell away, allowing women to access legal redress against third parties for harm to a fetus as well.<sup>28</sup> These laws were construed as allowing women legal protection for the maternal-fetal bond and recompense when that relationship was harmed.<sup>29</sup> Thus, it was the infringement of the mother's right to her unborn child that was originally protected under these laws. As the law developed, children who experienced harm in utero were likewise allowed to recover for harm done to their mothers during pregnancy.<sup>30</sup>

But in the decades following the development of these new tort theories, a dramatic shift occurred. Now that allowing redress for a harm to a fetus was both culturally accepted and legally cognizable, prosecutors and state legislators, among others, began to look to pregnant women *themselves* as culprits when harm befell a fetus.<sup>31</sup> Coupled with the rapid development of

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26. See *Persons—Parents' Right to Recover for Injury to Minor Child*, 12 HARV. L. REV. 283 (1898) (discussing cases from the late nineteenth century allowing a parent to recover for harm to a child).

27. See 6 THOMAS D. SAWAYA, *Parents' Right to Recover for the Death of Their Children*, in FLORIDA PERSONAL INJURY LAW & PRACTICE § 20:5 (2020) (discussing the history of the right to recover for the loss of a child).

28. See Jill Wieber Lens, *Children, Wrongful Death, and Punitive Damages*, 100 B.U.L. REV. 437, 447–49 (2020) (describing the history of allowing civil tort suits for harm inflicted on fetuses); Michael L. Rustad & Thomas H. Koenig, *Taming the Tort Monster: The American Civil Justice System as a Battleground of Social Theory*, 68 BROOK. L. REV. 1, 39–40 (2002) (discussing development of cases allowing recovery for harm to fetuses and neonates).

29. See, e.g., *Cavazos v. Franklin*, 867 P.2d 674, 677–78 (1994) (discussing difference between wrongful death claims brought on behalf of a viable, unborn fetus and claims brought by the parents of a viable unborn fetus for their own, unique harms).

30. See, e.g., *Smith v. Brennan*, 157 A.2d 497, 501 (1960) (allowing an infant recovery against a tortfeasor for prenatal injuries suffered as a result of injuries to the mother in an automobile accident).

31. See Meghan Boone & Benjamin J. McMichael, *State-Created Fetal Harm*, 109 GEO. L.J. 475, 476–80 (2021) (describing the history of criminal prosecutions of pregnant women, including the recent rapid expansion of such criminalization). This shift is connected to the anti-abortion movement and the idea of promoting fetal personhood more generally. See Lynn M. Paltrow, *Pregnant Drug Users, Fetal Persons, and the Threat to Roe v. Wade*, 62 ALB. L. REV. 999, 1000 (1999) (“An ongoing and concomitant part of the anti-choice strategy, however, has been to establish fetal rights under the law.”).

medical technology that allowed greater insight into fetal development,<sup>32</sup> pregnant women are now increasingly criminalized for their own failure to protect a fetus from harm.<sup>33</sup> This disturbing trend is only gaining steam.<sup>34</sup> Indeed, recently there have been multiple instances of mothers who are *victims* of criminal or negligent behavior that are nonetheless prosecuted for the harm that befalls their children or pregnancy as a result.<sup>35</sup>

As Professor Lens notes, the increase in so-called fetal endangerment or fetal harm laws has resulted in an absolute explosion of criminal prosecutions of women for their behavior while pregnant.<sup>36</sup> Indeed, one aspect of this trend is the criminalization of stillbirth.<sup>37</sup> In fact, the article discusses two of the most high-profile instances in which women were criminally prosecuted as a result of a stillbirth.<sup>38</sup> Professor Lens' proposed framework is not intended to add fuel to this trend, but instead is aimed at the action of doctors—and not women. There is even an implicit hope contained in the article that her proposed framework might help to combat such prosecutions by bringing attention to the real medical reasons for stillbirth, as well as the ways in which the causes can still be unknown. While Professor Lens expresses her hope that the different burdens of proof in tort and criminal law would protect women from potential prosecution,<sup>39</sup> her own research in this area makes it clear that such legal niceties do not prevent overzealous prosecutors from blaming women for tragic reproductive outcomes.<sup>40</sup>

32. Salim Al-Gailani & Angela Davis, *Introduction to "Transforming Pregnancy Since 1900"*, 47 *STUD. HIST. & PHIL. BIOLOGICAL & BIOMEDICAL SCIS.* 229, 230 (2014) (describing the development of "high technology" obstetrics and common critiques).

33. See generally Linda C. Fentiman, *The New "Fetal Protection": The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children*, 84 *DENV. U. L. REV.* 537 (2006) (describing the increasing criminalization of pregnant women and the resulting negative public health outcomes).

34. See Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 *GEO. WASH. L. REV.* 1163, 1174-75 (2017) (noting that of more than half of all prosecutions of pregnant women for crimes relating to alleged or potential fetal harm have occurred since 2007). In fact, the first laws directly aimed at criminalizing behavior in pregnancy have only occurred in the last decade. See, e.g., *TENN. CODE ANN.* § 39-13-107(c)(2) (2015) (effective until July 1, 2016).

35. See Julia Jacobo & Barbara Schmitt, *Louisiana Mother Charged with Killing 1-Year-Old Daughter in Car Crash She Didn't Cause*, *ABC NEWS* (Mar. 1, 2018, 3:47 PM), <https://abcnews.go.com/US/louisiana-mother-charged-homicide-crash-killed-year-daughter/story?id=53437927> [<http://perma.cc/VL78-J2EU>] (Louisiana mother prosecuted for death of child when a speeding off-duty cop struck her car and child was in car seat secured incorrectly); Elinor Aspegren, *Alabama Woman Charged in Fetus' Death After She Was Shot and Lost Her Pregnancy*, *USA TODAY* (June 27, 2019, 5:28 PM), <https://www.usatoday.com/story/news/nation/2019/06/27/alabama-woman-charged-fetus-death-after-shot-marshae-jones/1582667001> [<https://perma.cc/5KYD-K3V2>] (Pregnant Alabama woman charged with manslaughter after she was shot in the stomach).

36. See Lens, *supra* note 1, at 711-12.

37. See *id.*

38. See *id.*

39. *Id.* at 712-13 (discussing different standards of proof in tort and criminal cases).

40. *Id.* at 713.



Professor Lens herself unintentionally reinforces the idea that women are ultimately responsible for the health of their pregnancies, by arguing that *women* are best situated to monitor their pregnancies: “A mother’s empowerment and participation in her health care is a crucial part of stillbirth prevention; mothers know their children best and only mothers can notice a change and seek medical attention.”<sup>41</sup> And later, quoting other scholars who advocate that “the mother[ has a] special awareness of her unborn baby that no one else knows or can truly understand” and that they therefore have a “crucial role . . . in protecting their unborn baby.”<sup>42</sup> Even if you agree with her assessment of the unique insight and knowledge a pregnant woman sometimes has about her own pregnancy—which I do—it is not hard to imagine how such sentiments could seamlessly transform into an expectation that if something goes wrong with a pregnancy, the most obvious person to blame for that undesirable outcome is the “only” or “best” situated person who had a chance to avoid it. Indeed, her own assertions about delay in seeking medical attention following a decrease in fetal movement as a cause of stillbirth,<sup>43</sup> coupled with her assertion that, “[o]nly the mother is able to monitor her unborn child all day, every day[ and o]nly she can notice if the movements are less regular or weaker than the day before,”<sup>44</sup> seem to build an equally strong case that it is pregnant women who are ultimately responsible. This is not an outcome that Professor Lens is advocating for, of course, but the implications are potentially very dangerous for pregnant women.

All of this is not to argue against the need for the interventions that Professor Lens advocates for, *per se*, but to urge caution. Introducing additional mechanisms by which the law makes harm to a fetus or pregnancy legally cognizable comes with inherent risks that pregnant women will be further policed and punished for undesirable pregnancy outcomes. Thus, approaching such projects extremely carefully and intentionally is paramount. In her understandable zeal to make the law more responsive to the real harm created by failures of informed consent in the stillbirth context, however, Professor Lens, I worry, does not take seriously enough the risks inherent in this project.

To be clear, the critique that I have just lobbed at Professor Lens is one that has been (rightfully) levelled at my own scholarship. No one scholar—no matter how astute—can successfully address every potential unintended consequence of their ideas. But we must continue to ask *how* reproductive justice advocates and scholars can balance the need for frameworks that allow for injured or bereaved women to access the justice they deserve while *also* preventing those same frameworks from being weaponized by those intent on

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41. *Id.* at 699–700.

42. *Id.* at 702 (quoting Joann O’Leary, Jane Warland & Lynnda Parker, *Prenatal Parenthood*, 20 J. PERINATAL EDUC. 218, 218 (2011)).

43. *Id.* at 707.

44. *Id.* at 703.

demonizing and limiting the choices of pregnant women. Thinking carefully about trade-offs is especially crucial given that the anti-choice community attempts to use arguments like those presented in Professor Lens' article to further limit access to abortion and to increase the accelerating trend towards punishing and criminalizing pregnant women. In other words, how can we widen the conversation within the reproductive justice community to allow for the full array of lived experience without allowing such conversations to be twisted and used to further harm, criminalize, and marginalize other women? The complete answer to these questions, of course, is beyond my knowledge or ability to conjure. But what I am convinced of is the need for engaging with that conversation in a clear-eyed and strategic way. Wishing that our work will not be weaponized in ways that we cannot control is insufficient. Scholars in this area must commit ourselves fully to wrestling with the inherent risks of our work if we are to live up to our goal of reproductive justice for *all* women.