

Criminalization of Stillbirth

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ABSTRACT: Increasingly, pregnancy loss, especially stillbirth, is ending with arrest. Anticriminalization efforts are often focused on repealing the “fetal personhood” laws that encouraged or enabled the arrests. This Article argues, however, that repealing the laws is, at best, an incomplete solution, doing little to address the inclinations underlying criminalization.

Anticriminalization efforts must instead be more holistic. First, a focus is needed on rewriting the dominant cultural scripts that lead to suspicion and blame after stillbirth—scripts that stillbirth is exceedingly rare (it’s not, it’s surprisingly common), and that good mothers grieve appropriately (again no, the script ignores the influence of trauma). Second, anticriminalization efforts must include a push to standardize medical care for stillbirth, leaving less room for bias-influenced variable care. Both awareness of the realities of pregnancy loss and standardized medical care can help alleviate health care providers’ inclination to call the police.

Finally, repealing fetal personhood laws is not only an incomplete solution, but also harmful. Repealing these laws devalues the lived experience of those whose unborn children are killed by tortious or criminal actors, a perspective that is often lost within the push to protect abortion rights. Instead of repeal, the legal inapplicability to pregnant people must be affirmed, and private causes of action can be created to empower those whose pregnancy loss ends in criminalization.

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INTRODUCTION

Pregnancy loss is very common. About one in four pregnancies will end in miscarriage, meaning pregnancy loss before twenty weeks.¹ About one in 175 births is a stillbirth, meaning pregnancy loss after twenty weeks of pregnancy.² Those statistics translate to over a million miscarriages and another twenty thousand plus stillbirths a year in the United States.³ That's about 2,800 miscarriages and sixty stillbirths every day.

1. See *infra* notes 99–102 and accompanying text.

2. *About Stillbirth*, CDC (Aug. 26, 2025), <https://www.cdc.gov/stillbirth/about> [<https://perma.cc/299R-DMBF>] (“A stillbirth is the loss of a pregnancy after 20 weeks and before birth.”); *Data and Statistics on Stillbirth*, CDC (Aug. 26, 2025), <https://www.cdc.gov/stillbirth/data-research> [<https://perma.cc/QXW6-7P96>] (“Stillbirth affects about 1 in 175 births . . .”). *But see* Am. Coll. of Obstetricians & Gynecologists & Soc’y for Maternal-Fetal Med., *Management of Stillbirth*, 135 *OBSTETRICS & GYNECOLOGY* e110, e122 (2020) [hereinafter ACOG, *Management of Stillbirth*] (stating the risk of stillbirth is one in 160).

3. Jill Wieber Lens, *Miscarriage, Stillbirth, & Reproductive Justice*, 98 *WASH. U. L. REV.* 1059, 1070 (2021) [hereinafter Lens, *Miscarriage*].

Again, pregnancy loss is *very* common. It is becoming increasingly common, however, for pregnancy loss, especially stillbirth, to end with arrest.⁴ Long before *Dobbs* rejected the constitutional right to abortion,⁵ women, especially marginalized women (who already face heightened risks of stillbirth), were being arrested and prosecuted for allegedly causing their unborn child's death.⁶ More such arrests and prosecutions are expected after *Dobbs* and its resulting increased focus on fetal life and decreased availability of legal abortion.⁷ These arrests usually start with a health care provider calling the police.⁸

Anticriminalization efforts are often focused on the laws that (supposedly) encouraged or even enabled these arrests.⁹ These are so-called "fetal personhood" laws, like laws amending criminal and tort laws to also apply to fetal death.¹⁰ Created when *Roe* was still good law and abortion (before viability) was a constitutional right,¹¹ these laws contain exceptions for lawful abortion and provisions making them inapplicable to the pregnant person.¹² But the laws still open the door to a legal idea of the fetus as a person and beg the question why they shouldn't be applied to the pregnant person. Ergo, the answer is to repeal the laws.¹³

This Article, however, takes a broader and more holistic approach. It does so by examining the criminalization of stillbirth within the greater context of stillbirth and pregnancy loss more generally. It asks why so many, including health care providers, are inclined to view this literal everyday occurrence as a crime, and why so many are quick to suspect and blame pregnant women for stillbirth.¹⁴ This broader perspective suggests the "why" of pregnancy loss criminalization is much broader than the laws, and that the "why" will persist even if laws were to change.

Those reasons include the dominant cultural scripts about pregnancy loss, none of which are accurate.¹⁵ Culturally, pregnancy loss is believed to be rare, and later pregnancy loss is essentially nonexistent, making it inherently

4. See *infra* Section I.A.

5. See generally *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022).

6. See *infra* Section I.A.

7. See *infra* Section I.A.

8. See *infra* note 51 and accompanying text.

9. See *infra* note 295 and accompanying text.

10. See *infra* pp. 145–46.

11. See generally *Roe v. Wade*, 410 U.S. 113 (1973).

12. See *infra* notes 384–85 and accompanying text.

13. See, e.g., PURVAJA S. KAVATTUR ET AL., THE RISE OF PREGNANCY CRIMINALIZATION: A PREGNANCY JUSTICE REPORT 49 (2023), <https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/9-2023-Criminalization-report.pdf> [<https://perma.cc/7EFW-URA3>].

14. This Article lacks the space to address the "why" specific to drug use, the "why" so many are quick to conclude drug use causes stillbirth, in marked contrast to usual assumptions of stillbirth as unpreventable. For a discussion of how the "War on Drugs" likely relates to this surprising overconfidence on causation, see JILL WIEBER LENS, STILLBIRTH & THE LAW 187–90 (2025).

15. See *infra* Section II.A.

suspicious. Grief is required, as is conduct consistent with grief; the slightest misstep is inherently suspicious. That grief is also expected because, again culturally, pregnancy loss occurs in desired pregnancies only, creating suspicion if the pregnancy was ever undesired. Cultural scripts also erase the physicality and bodily process of pregnancy loss, immediately villainizing the woman if the pregnancy loss occurred in less than pristine circumstances (like on the toilet). But again, none of this is accurate.

Raised awareness of these realities—the commonality of pregnancy loss, its potential trauma, its physicality—must be a part of anticriminalization efforts. This awareness can help curb the suspicion and blame that often follows stillbirth. Raised awareness is especially important for health care workers, even labor and delivery (“L&D”) health care providers. Stillbirth is common, but not common enough that an individual L&D nurse or obstetrician is likely to see it often.¹⁶ Normalization of stillbirth and its trauma can help alleviate health care providers’ inclinations to call the police.

Another reason why health care providers might be inclined to call the police is because they lack explicit guidelines of how affirmatively to care for someone giving birth to their stillborn baby.¹⁷ Unlike other countries, the United States lacks clear guidelines on bereavement medical care for stillbirth.¹⁸ The lack of guidelines invites variation, including variation based on biases, the same biases that are likely often fueling those inclinations to call the police.

This Article thus also introduces another more holistic anticriminalization measure—standardizing medical care for stillbirth.¹⁹ Studies show that the care one receives when giving birth to their child is crucially important for their mental health and grief process.²⁰ Standardization is needed for care, such as empowering patient decisions on methods of childbirth, encouraging parents to spend time with their baby, and the creation of mementos to help with memory-making. Clear guidelines remind health care providers of how to care for people in what can be an extremely traumatic time, and clear guidelines dictate that health care providers need to focus on making the best possible experience for the patient—rather than starting a criminal investigation.

Importantly, both raised awareness of the realities of pregnancy loss and standardized care would benefit not only those suspected of causation, but instead all experiencing pregnancy loss. This Article’s more holistic approach thus presents an opportunity for a coalition between anticriminalization and pregnancy loss communities, a coalition consistent with broader reproductive justice efforts.

16. See *infra* notes 107–08 and accompanying text.

17. See *infra* Section II.B.

18. See LENS, *supra* note 14, at 132–34. See generally ACOG, *Management of Stillbirth*, *supra* note 2.

19. See *infra* Section II.B.

20. See *infra* notes 271–74 and accompanying text.

This Article also calls for a pause in anticriminalization efforts to repeal “fetal personhood” laws.²¹ Repealing these laws is at best an incomplete solution; at worst, it is a harmful solution. Behind tort and criminal fetal death laws are bereaved families seeking recognition of their unborn children. Repealing these laws neglects and devalues those who have lost their unborn children to tortious or criminal acts. The perspective of bereaved families is often lost within the anticriminalization efforts, and within efforts to protect abortion rights; if recognized at all, harm to them is seen as unavoidable collateral damage.

Bereaved families need not be collateral damage, however. Anticriminalization advocates can instead work to affirm the existing legal inapplicability to the pregnant person by raising awareness as to why inapplicability is needed—to ensure pregnant persons are inclined to access prenatal care.²² Another possible anticriminalization measure is the creation of a private cause of action for the pregnant person, the same as the California Legislature created after the prosecutions of Chelsea Becker and Adora Perez for their children’s stillbirths.²³ Brittany Watts, an Ohio woman arrested after her stillbirth, similarly recently sued her health care providers and those involved in her arrest and prosecution.²⁴

Part I of this Article briefly details the problems of criminalization of pregnancy, describing the statistics and criminalization’s perverse effect of increasing pregnancy losses and infant deaths. Part II then suggests needed holistic solutions to criminalization, including raising awareness of the realities of pregnancy loss and standardizing medical care for stillbirth. Part III calls for a pause in anticriminalization efforts to repeal fetal personhood statutes, arguing that such repeal would be harmful. The final Part concludes.

I. THE PROBLEMS OF CRIMINALIZATION

The “criminalization of pregnancy” refers to the phenomenon of criminal consequences for a person’s conduct during pregnancy.²⁵ Numerous scholars

21. See *infra* Part III.

22. See *infra* Section III.C.

23. See *infra* Section III.C.

24. See generally Complaint, *Watts v. Bon Secours Mercy Health*, No. 4:25-cv-00049 (N.D. Ohio Jan. 10, 2025). Watts’s complaint included claims for violation of federal constitutional rights, a violation of EMTALA, malicious prosecution, intentional and negligent infliction of emotional distress, medical malpractice, unauthorized disclosure of confidential medical information, and conspiracy. *Id.* at 16–25.

25. Cf. *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (July 2024), <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period> [<https://perma.cc/S44B-T7MK>] (“Criminalization of pregnancy is the punishing or penalizing of individuals for actions that are interpreted as harmful to their own pregnancies, including enforcement of laws that punish actions during pregnancy that would not otherwise be criminal or punishable.”).

have already written extensively about the criminalization of pregnancy.²⁶ This Part does not recount that extensive, important literature, instead briefly reviewing the alarming statistics and one harm of criminalization very germane to this Article—causing more stillbirths.

A. THE STATISTICS

The nonprofit group Pregnancy Justice has done its best to document the criminalization of pregnancy in the United States. The first comprehensive study attempting to document cases between 1973, the year the Supreme Court decided *Roe*, and 2006.²⁷ That study, published in 2013, found 413 such cases in the United States.²⁸ In September 2023, Pregnancy Justice released another report detailing 1,396 arrests from January 2006 to June 2022, the year the Supreme Court overruled *Roe* in *Dobbs*.²⁹ Most recently, in September 2024, Pregnancy Justice released another report finding at least 210 pregnancy-related prosecutions between June 24, 2022 and June 23, 2023, essentially the year after the *Dobbs* decision.³⁰ This number was “the largest single-year number since researchers began tracking these cases.”³¹ Tracking these cases is extremely difficult and there’s little doubt that the numbers found in these studies are an undercount.³²

Importantly, Pregnancy Justice’s data covers all arrests for conduct related to pregnancy—far from all of which involved pregnancy loss.³³ In the 2006 to

26. See generally GRACE E. HOWARD, *THE PREGNANCY POLICE: CONCEIVING CRIME, ARRESTING PERSONHOOD* (2024); Valena E. Beety & Jennifer D. Oliva, *Policing Pregnancy “Crimes,”* 98 N.Y.U. L. REV. ONLINE 29 (2023); Sarah E. Burns & Sarah S. Wheeler, *A Review and Look Ahead at Criminalizing Pregnancy in the Name of the State Interest in Fetal Life*, 76 SMU L. REV. 369 (2023); WENDY A. BACH, *PROSECUTING POVERTY, CRIMINALIZING CARE* (2022); Meghan Boone & Benjamin J. McMichael, *State-Created Fetal Harm*, 109 GEO. L.J. 475 (2021); MICHELE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* (2020); Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 GEO. WASH. L. REV. 1163 (2017); Cortney E. Lollar, *Criminalizing Pregnancy*, 92 IND. L.J. 947 (2017); Melissa Ballengee Alexander, *Denying the Dyad: How Criminalizing Pregnant Drug Use Harms the Baby, Taxpayers and Vulnerable Women*, 82 TENN. L. REV. 745 (2015); Geneva Brown, *Bei Bei Shuai: Pregnancy, Murder, and Mayhem in Indiana*, 17 J. GENDER, RACE & JUST. 221 (2014). See also *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period*, *supra* note 25 (stating policy opposing the criminalization of actions taken by individuals during the pregnancy and postpartum periods).

27. 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, 301 (2013).

28. *Id.* at 309.

29. KAVATTUR ET AL., *supra* note 13, at 4.

30. WENDY A. BACH & MADALYN K. WASILCZUK, *PREGNANCY AS A CRIME: A PRELIMINARY REPORT ON THE FIRST YEAR AFTER DOBBS 2* (2024), <https://www.pregnancyjusticeus.org/wp-content/uploads/2024/09/Pregnancy-as-a-Crime.pdf> [<https://perma.cc/H89N-4GR3>].

31. *Id.*

32. *Id.*; Paltrow & Flavin, *supra* note 27, at 304; KAVATTUR ET AL., *supra* note 13, at 54–55 (explaining methods of identifying cases, including “repeated and systematic Google searches”).

33. KAVATTUR ET AL., *supra* note 13, at 24, 26.

2022 data, in sixty-six percent of the arrests, the pregnancies ended with live childbirth and no mentioned negative health outcomes.³⁴ In 14.9 percent of the arrests, pregnancies ended with live birth and some noted health problems at birth.³⁵ In 9.9 percent of the arrests, the arrests occurred during pregnancy, there was no noted pregnancy outcome. And no pregnancy outcome was determinable in another 15.5 percent of the arrests.³⁶ In the other arrests, the pregnancies ended other than in live childbirth: 7.2 percent in stillbirth, 1.4 percent in miscarriage, and 0.6 percent in abortion.³⁷

The same was true for the June 2022 to June 2023 prosecution data. Pregnancy Justice was able to find information on the baby in 166 of the 210 cases.³⁸ One hundred forty-four of those 166 involved live birth and subsequent continued life.³⁹ Twenty-two of the 166 involved fetal or infant death.⁴⁰ Pregnancy Justice opted not to try to separate fetal or infant death because in some cases birth occurred outside a medical facility and the state claimed live birth, whereas the birthing person claimed pregnancy loss.⁴¹ Correspondingly, only nine of the 220 criminal charges were of criminal homicide and another one was for abuse of a corpse.⁴²

Pregnancy loss thus is only a small part of the pregnancy criminalization picture. But it is possibly an increasing part due to increased interest specifically in pregnancy loss after *Dobbs*. According to Pregnancy Justice's data, the proportion of arrests involving pregnancy losses increased in the year after *Dobbs*.⁴³ More broadly, widespread availability of mifepristone and the increasing illegality of abortion makes pregnancy loss even more suspect.⁴⁴ Plus, pregnancy losses are bound to increase after *Dobbs*; more pregnancies mean more babies, but also more pregnancy losses.⁴⁵ And every pregnancy loss is now a potential crime scene.

34. *Id.* at 24.

35. *Id.*

36. *Id.*

37. *Id.*

38. BACH & WASILCZUK, *supra* note 30, at 12.

39. *Id.*

40. *Id.*

41. *Id.* at 26 n.35. The question of stillbirth versus live birth is somehow often still resolved based on the floating lung test despite its many, many problems. See Aziza Ahmed, *Floating Lungs: Forensic Science in Self-Induced Abortion Prosecutions*, 100 B.U. L. REV. 1111, 1125–27 (2020) (describing the test and critiques); Duaa Eldeib, *A Lab Test that Experts Liken to a Witch Trial Is Helping Send Women to Prison for Murder*, PROPUBLICA (Oct. 7, 2023, 5:00 AM), <https://www.propublica.org/article/is-lung-float-test-reliable-stillbirth-medical-examiners-murder> [<https://perma.cc/5YEU-4G7U>].

42. BACH & WASILCZUK, *supra* note 30, at 2. One hundred ninety-eight of the 220 charges were for child abuse, neglect, or endangerment. *Id.*

43. *Id.*

44. Greer Donley & Jill Wieber Lens, *Abortion, Pregnancy Loss, & Subjective Fetal Personhood*, 75 VAND. L. REV. 1649, 1706–11 (2022).

45. *Id.* at 1716.

Whether the baby is born healthy and well or the baby dies in the womb, the arrests are overwhelmingly based on drug use. This was true in the 2023 report, where “9 in 10 cases involved allegations of the co-occurrence of pregnancy and substance use.”⁴⁶ The same was true in the 2024 report, which explained that “nearly all the cases alleged the pregnant person used a substance during pregnancy.”⁴⁷ In both reports, the most common substance allegedly used by the pregnant person was methamphetamines.⁴⁸

What else the arrests have in common is that they have been, overwhelmingly, of marginalized women, specifically women of lower socioeconomic status. In 2022 and 2023, over seventy-five percent of the defendants were low income, determined by the fact that they were appointed counsel.⁴⁹ The same was true in the 2024 report.⁵⁰

A last very important commonality of these arrests is how many begin— with a health care provider calling the cops. Maybe it’s within routine prenatal care. Or maybe it’s while a woman is giving birth to her stillborn baby. Regardless, it’s a health care provider calling the cops to tell them that the pregnant person is (allegedly) using drugs. The 2023 Pregnancy Justice Report found that “[o]ne in three . . . pregnancy-related arrests were first instigated by a medical professional either directly or indirectly reporting to law enforcement.”⁵¹ The 2024 report similarly explains that “[p]regnancy criminalization continues to co-opt health care providers as law enforcement.”⁵² Michele Goodwin has previously characterized health care providers as “snitch[es],” “calling state attention to the women they serve and disclosing confidential patient information.”⁵³ She argues that health care providers are “serv[ing] as more than just the eyes and ears of the state,” and instead as “primary detectives and enforcers of state fetal protection statutes.”⁵⁴

B. THE HORRIFIC AND “PERVERSE” CONSEQUENCES OF CRIMINALIZATION

Extensive scholarship has documented the many, many harms of pregnancy criminalization.⁵⁵ One of those harms is worth repeating more extensively here given the Article’s focus on stillbirth. That harm is that criminalization of conduct during pregnancy will increase the number of stillbirths and infant deaths.

46. KAVATTUR ET AL., *supra* note 13, at 4.

47. BACH & WASILCZUK, *supra* note 30, at 15.

48. KAVATTUR ET AL., *supra* note 13, at 41 fig.14; BACH & WASILCZUK, *supra* note 30, at 16 fig.G.

49. KAVATTUR ET AL., *supra* note 13, at 23.

50. BACH & WASILCZUK, *supra* note 30, at 12.

51. KAVATTUR ET AL., *supra* note 13, at 46.

52. BACH & WASILCZUK, *supra* note 30, at 18.

53. GOODWIN, *supra* note 26, at 97.

54. *Id.*

55. See sources cited *supra* note 26.

This is because pregnant people will stop getting prenatal care.⁵⁶ Public health and medical advocates warned and continue to warn about this consequence of criminalization.⁵⁷ If pregnant people are concerned that a routine prenatal care visit will turn into an arrest, they won't get prenatal care. This is true even if the pregnant person desires help for their addiction, as many do.⁵⁸ But they won't seek that help if doing so is likely to end with criminal consequences. Grace Howard's study of criminalization similarly found that the possibility of criminal consequences caused women to avoid prenatal care and choose to give birth outside of the hospital.⁵⁹

More "negative" pregnancy outcomes are likely if people do not obtain routine prenatal care. This is known. Numerous studies specifically show a link between a lack of or a decrease in prenatal care and stillbirth.⁶⁰

Advocates have warned about these consequences. And then an empirical study proved the warnings true. Specifically, Meghan Boone and Benjamin J. McMichael published a study of the effects of Tennessee's 2014 to 2016 laws specifically criminalizing drug use during pregnancy.⁶¹ They found that the laws deterred pregnant people from obtaining prenatal care and thus increased fetal and infant deaths.⁶² Specifically, applying a sophisticated difference-in-difference regression analysis, "[t]he fetal endangerment law increased fetal deaths by 0.225 for every 1,000 births."⁶³ Applied to the number of births in Tennessee those years, the increased risk "mean[t] that Tennessee sponsored

56. HOWARD, *supra* note 26, at 133–36.

57. Boone & McMichael, *supra* note 26, at 512.

58. BACH, *supra* note 26, at 170–71; HOWARD, *supra* note 26, at 146 (discussing research showing "that pregnancy can motivate pregnant people with substance use disorder to seek treatment and that the vast majority of women who use drugs make an effort to reduce their consumption during pregnancy out of concern for the fetus").

59. HOWARD, *supra* note 26, at 134.

60. See, e.g., Diana Y. Huang et al., *Determinants of Unexplained Antepartum Fetal Deaths*, 95 *OBSTETRICS & GYNECOLOGY* 215, 220 (2000) (finding a significant correlation between unexplained fetal deaths and "fewer than four antenatal visits among fetuses delivered at 37 weeks or later"); Kaisa Raatikainen, Nonna Heiskanen & Seppo Heinonen, *Under-Attending Free Antenatal Care Is Associated with Adverse Pregnancy Outcomes*, 7 *BMC PUB. HEALTH* 4 (Sept. 27, 2007), <https://bmcpubhealth.biomedcentral.com/articles/10.1186/1471-2458-7-268> [<https://perma.cc/HN8F-2XFP>] (finding a correlation between a lack of prenatal care and poor pregnancy outcomes, including that the risk of stillbirth was "statistically higher than in the general obstetric population who attended routine antenatal care"); Tomasina Stacey et al., *Antenatal Care, Identification of Suboptimal Fetal Growth and Risk of Late Stillbirth: Findings from the Auckland Stillbirth Study*, 52 *AUSTRALIAN & N.Z. J. OBSTETRICS & GYNAECOLOGY* 242, 242 (2012) (finding that "[d]uring the 20th century, there was a significant reduction in the rate of stillbirths in high-income countries, in considerable part because of improvements in antenatal care"); see also Elizabeth M. McClure, Sarah Saleem, Omrana Pasha & Robert L. Goldenberg, *Stillbirth in Developing Countries: A Review of Causes, Risk Factors and Prevention Strategies*, 22 *J. MATERNAL-FETAL & NEONATAL MED.* 183, 186 (2009) (linking high stillbirth rates in developing countries to the lack of appropriate obstetric care).

61. See generally Boone & McMichael, *supra* note 26.

62. *Id.* at 504–05, 507, 509–11.

63. *Id.* at 505.

the deaths of approximately twenty fetuses in 2015.⁶⁴ The result was similar for infant deaths.⁶⁵ “[T]he . . . law increased the death rate of infants per 1,000 births by approximately 0.711,” meaning that “Tennessee sponsored the deaths of more than sixty infants in the first twenty-eight days of life with its fetal endangerment law.”⁶⁶ Boone and McMichael described these results of these laws as “perverse” given the purported intended effect to protect fetal life.⁶⁷

Countries actually invested in lowering their (already lower than the United States’s) stillbirth rates are focused on changing medical practices, not arresting pregnant people.⁶⁸ Threatening to arrest pregnant people is likely only to increase the number of stillbirths.

II. HOLISTIC ANTICRIMINALIZATION EFFORTS

It is not at all surprising that women are being arrested for allegedly causing their pregnancy losses. The lack of surprise isn’t due to antiabortion efforts or changed laws or increased emphasis on the fetus. The lack of surprise is due to the reality that suspicion and blame have long followed pregnancy loss.⁶⁹ And now, with criminalization, we have blame in tangible form.⁷⁰

Regardless of whether laws are written in a way to encourage or enable that arrest, the suspicion and blame will persist. Anticriminalization efforts must thus be about much more than laws. Anticriminalization efforts must also be very much about pregnancy loss itself.

This Article thus focuses on broader, more holistic solutions. The first solution is about rewriting the suspicion-causing cultural scripts of pregnancy loss.⁷¹ Stillbirth is not rare; behavior after is often trauma-influenced; stillbirth happens in undesired pregnancies; and pregnancy loss on the toilet happens all the time. More awareness of these realities should immediately lead to lessened suspicion; it’s much harder to conclude causation of stillbirth once one realizes more than sixty babies are stillborn in the United States every day.⁷² Public awareness can help alleviate societal blame, and awareness for health care providers can help minimize any inclination to call the police.

The second solution is pushing for standardization of medical care provided to people giving birth to their stillborn child.⁷³ The current lack of

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.* at 512.

68. LENS, *supra* note 14, at 202.

69. *See infra* Section II.A.

70. Jill Wieber Lens, *Counting Stillbirths*, 56 U.C. DAVIS L. REV. 525, 531 (2022) [hereinafter Lens, *Counting*].

71. *See infra* Section II.A.

72. *See infra* note 103 and accompanying text.

73. *See infra* Section II.B.

standardization invites variation in care, including variation influenced by biases and focused on suspicion. Standardizing care is a current strategy to attempt to minimize the influence of health care provider bias. Standardization also helps minimize the chances of health care providers committing obstetric violence to punish someone they suspect of causation, including forcing vaginal delivery or denying someone time with their baby. Standardizing care should encourage health care providers to focus on care for the person experiencing pregnancy loss—as opposed to focusing on calling the police.

These holistic solutions also provide an opportunity for a coalition between anticriminalization and pregnancy loss advocacy. These are communities who do not often have too much in common, especially when anti-criminalization efforts focus on repeal of “fetal personhood” statutes, something families bereaved by pregnancy loss would oppose. The solutions offered in this Article, however, offer an avenue for coalition as the solutions will benefit all experiencing stillbirth, helping to alleviate stigma and to ensure proper medical care. It is a coalition consistent with the holistic reproductive justice movement.

A. RAISING AWARENESS AND REWRITING THE RULEBOOK FOR STILLBIRTH

In response to a grand jury declining to indict Amari Marsh for murder after her pregnancy loss, the Legal Director of Pregnancy Justice said “[t]here’s no rulebook for pregnancy loss.”⁷⁴ But of course there is. And criminalization has thus far appeared more likely to occur when someone violates those rules.

It’s a rulebook that implies stillbirth is extremely uncommon, meaning every stillbirth is inherently suspicious.⁷⁵ There’s the dictate that stillbirth must also be full of visible grief and consistent conduct, denying the shock and mental trauma that can accompany it.⁷⁶ It’s also a rulebook that dictates suspicion of causation when one loses a pregnancy in an undesired pregnancy.⁷⁷ And there’s the rule that increases suspicion if stillbirth occurs under less than pristine circumstances, perhaps on the toilet.⁷⁸

74. Press Release, Women’s Rts. & Empowerment Network & Pregnancy Just., South Carolina Pregnancy Criminalization Case Dropped in a Victory for Maternal Health (Sept. 11, 2024), <https://www.pregnancyjusticeus.org/press/south-carolina-pregnancy-criminalization-case-dropped-in-a-victory-for-maternal-health> [<https://perma.cc/E48W-BQJ7>]. Based on media descriptions of what happened to Marsh, it was not a pregnancy loss. Most media stories report her as having a miscarriage, but Marsh’s baby showed signs of life when born—meaning it’s not a pregnancy loss, but instead a premature (live) birth. See, e.g., Lauren Sausser, *She Was Accused of Murder After Losing Her Pregnancy. SC Woman Now Tells Her Story*, KFF HEALTH NEWS (Sept. 23, 2024), <https://kffhealthnews.org/news/article/pregnancy-loss-criminalization-homicide-south-carolina-college-student> [<https://perma.cc/GY9G-PHAS>].

75. See *infra* Section II.A.1.

76. See *infra* Section II.A.2.

77. See *infra* Section II.A.3.

78. See *infra* Section II.A.4.

Rewriting these cultural rules is crucially important for anticriminalization efforts, as these cultural rules will persist regardless of the text of laws. Both health care providers and broader society must be retaught that pregnancy loss, including stillbirth, is common; can be mentally and physically traumatic; occurs in undesired pregnancies, and will increasingly do so with less legal access to abortion; and is sometimes physically uncontrollable, perhaps occurring even on the toilet.

This education and raised awareness can help normalize stillbirth. That normalization will help make stillbirth less suspicious. And it will make health care providers less quick to call the police when they see a baby die before birth.

1. The Regularity of Stillbirth

The first rule of stillbirth is that it is *extremely* rare, especially in a high-income country like the United States in the twenty-first century. A baby dying in the womb after twenty weeks of pregnancy simply seems impossible nowadays. (Except for those alleged “late” abortions antiabortion advocates are often very concerned about.⁷⁹)

More generally, pregnancy loss has been erased from discussions of pregnancy, again especially if that pregnancy loss is stillbirth. Numerous legal and cultural forces have contributed to the erasure of pregnancy loss. Starting with legal forces, the abortion debate, which has dominated mainstream thought on pregnancy for quite some time,⁸⁰ has long painted a picture that does not include pregnancy loss. More specifically, that picture shows that every pregnancy that does not end in abortion ends with live childbirth, presenting a linear idea of prenatal development and a binary within pregnancy. For the antiabortion side, banning abortion means babies will be born alive. For the abortion rights side, banning abortion means forced parenthood of those babies. This erasure was even stronger in *Dobbs*. Justice Alito quoted the Mississippi Gestational Act as fact: that the “unborn human being’s heart begins beating” at five to six weeks, that that human starts moving in week eight and has all “basic physiological functions” at week nine, that vital organs and hair and finger and toenails start to form at week ten, that the human is moving freely in womb at week eleven, and has “taken on ‘the human form’ in all relevant respects” by week twelve.⁸¹ This Act literally describes linear development at the same time, the first trimester, where the

79. See Greer Donley & Jill Wieber Lens, *What Is This ‘Post-Birth Abortion’ Donald Trump Keeps Talking About?*, ATLANTIC (Oct. 17, 2024), <https://www.theatlantic.com/ideas/archive/2024/10/trump-post-birth-abortion-attacks/680272> [<https://perma.cc/E76T-DU8L>].

80. LARA FREIDENFELDS, *THE MYTH OF THE PERFECT PREGNANCY: A HISTORY OF MISCARRIAGE IN AMERICA* 144–45 (2020); LENS, *supra* note 14, at 158–59; Donley & Lens, *supra* note 44, at 1658; LINDA L. LAYNE, *MOTHERHOOD LOST: A FEMINIST ACCOUNT OF PREGNANCY LOSS IN AMERICA* 59–74 (2002).

81. *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2244 (2022) (quoting MISS. CODE ANN. § 41-41-191 (2018)).

chances of miscarriage are the highest, around twenty-five percent. Similarly, in oral argument, Justice Barrett pointed to the existence of safe haven laws, laws allowing the dropping off of a newborn at a fire station with no legal consequences, as a reason legal abortion was no longer necessary,⁸² again assuming that a not-terminated pregnancy would end with a live baby to drop off at that fire station.

Antiabortion state legislatures have taken the erasure even a step further post-*Dobbs*. Most of these states have banned abortion as of conception, as of the moment the sperm fertilizes the egg.⁸³ But medically, pregnancy does not start at fertilization. It does not start until the fertilized egg implants into the uterine wall, the same time at which the body starts producing hcG and the pregnancy can be detected via blood or urine test. (To be very clear, pregnancy tests cannot detect conception/fertilization because the body does not start producing hcG until implantation.) Far from all fertilized eggs implant in the uterine wall. Scientists knew this but can better estimate how many do not implant from experience with in vitro fertilization, which is far less successful than most think.⁸⁴ It's estimated that about thirty-five percent of fertilized eggs do not implant in the uterine wall.⁸⁵ Yet antiabortion state legislatures paint a picture of linear development from fertilization.

Abortion rights narratives have also contributed to the erasure of pregnancy loss by accentuating “choice,” an accentuation that also increases the possibility of blame when pregnancy loss does occur. “Choice implies that reproductive decisions are within one’s control.”⁸⁶ As the reproductive justice movement has accentuated, choice is a farce. Choice assumes access and far from all had access to abortion care pre-*Dobbs*.

But choice is also a farce within reproductive life generally. One cannot choose their way out of infertility. And if pregnant, one cannot choose for their pregnancy to continue until live childbirth. Regardless of how many “good” choices a pregnant person makes—exercising, eating well, managing gestational diabetes, monitoring their baby’s movement, etc.—babies sometimes die in the womb, even mere weeks before their due date. Nothing about pregnancy loss feels like choice.⁸⁷ Yet choice has dominated thoughts about abortion and thus pregnancy for decades, implying that people with

82. Oral Argument at 54:02, *Dobbs*, 142 S. Ct. 2228 (No. 19-1392), https://www.supremecourt.gov/oral_arguments/audio/2021/19-1392 [<https://perma.cc/Eg8U-Q42M>].

83. See, e.g., TEX. HEALTH & SAFETY CODE ANN. §§ 170A.001–170A.005 (West Supp. 2024); ARK. CODE ANN. §§ 5-61-303 to 5-61-304 (West Supp. 2024).

84. Dov Fox & Jill Wieber Lens, *Valuing Reproductive Loss*, 112 GEO. L.J. 61, 87 (2023).

85. FREIDENFELDS, *supra* note 80, at 186.

86. Lens, *Counting*, *supra* note 70, at 577.

87. Lens, *Miscarriage*, *supra* note 3, at 1081.

capacity for pregnancy do have control of their reproductive health—and thus had some control over their pregnancy loss.⁸⁸

The erasure within abortion rights narrative was recently on display in a Georgia trial court decision finding Georgia's six-week abortion ban unconstitutional. To quote: "[T]he uncontroverted evidence from the trial of this case is that a pre-viability fetus survives only through the woman choosing—or being forced by law—to carry it at least to the 22nd or 23rd week of her pregnancy."⁸⁹ The baby survives *only* through the woman's choosing. But that's not true. She can choose to not have an abortion, but she can't choose to make the pregnancy continue to viability or beyond. The judge further described the prior rule in Georgia, banning abortion after viability as viability is the time at which the baby could survive independently of the woman. But before viability "*only* the pregnant woman can fulfill that role of life support for those many weeks and months."⁹⁰ The criminalization implication is easy. If the baby does die before viability, it must have been something the woman did in failing that life-support role.

Following this logic, the pregnant person was in control of whether the baby would make it to live childbirth and must be to blame when the baby doesn't. Emphasis on the individual's choice also erases the possibility of structural forces increasing the risks of pregnancy loss, and stillbirth more specifically. These could be structural forces like exposure to toxins and chemicals, climate change, or limited access to prenatal care due to maternal care deserts. Those structural forces also include the social determinants of health and structural discriminations that increase the risk of stillbirth for Black women and women with lesser economic means.⁹¹

A powerful non-legal force in the erasure of pregnancy loss, especially for stillbirth, is the medicalization of pregnancy and childbirth. To go back historically for a moment, pregnancy loss was a topic of interest within male doctors' push to assert their dominance within obstetrics and gynecology. As historian Shannon Withycombe describes, at the end of the nineteenth and the beginning of the twentieth centuries, doctors worked to convince society "that any instance of pregnancy loss was dangerous, abnormal, and required

88. Admitting a lack of control is difficult, especially in a society that believes in merit-based achievement. Linda Layne describes that after pregnancy loss, people struggle weighing self-blame versus the alternative of a lack of control. In her words, accepting lack of control "is hardly more palatable than self-blame." Linda L. Layne, "*True Gifts from God*": *Motherhood, Sacrifice, and Enrichment in the Case of Pregnancy Loss*, in TRANSFORMATIVE MOTHERHOOD: ON GIVING AND GETTING IN A CONSUMER CULTURE 174 (Linda L. Layne ed., 1999). But the lack of control is the reality, and it's a hard lesson for an individual and for society.

89. Final Order at 12, *SisterSong Women of Color Reprod. Just. Collective v. State*, No. 2022CV367796 (Super. Ct. Fulton Cnty., Ga. Sept. 30, 2024) (Odyssey Identity Provider, Fulton County Magistrate, State, and Superior Court Records Search) (on file with the *Iowa Law Review*).

90. *Id.* at 13.

91. See *infra* notes 100–05 and accompanying text.

the skilled hands and instruments of male elites.”⁹² The medicalization of pregnancy throughout the twentieth century has only fortified that picture of pregnancy loss as an aberration, if it occurs at all. Babies born severely premature are now surviving, and doctors are able to test embryos before implantation for fatal abnormalities.⁹³ These amazing advancements make it seem impossible that a seemingly healthy baby could die in the womb just weeks before the pregnancy due date.⁹⁴ “Stillbirth is thus widely believed to be something of the past—something that happened in a time when medical care was less advanced and happens currently only in lower-income countries without quality prenatal care.”⁹⁵ Then when “it does still occur, surely it was not due to medicine’s failure.”⁹⁶ And thus it must have been the woman’s fault.

But medicine has not evolved nearly as far as many think. Even in 2026 scientists cannot explain why labor (in pregnancy) starts.⁹⁷ And pregnancy loss still very much occurs, even after twenty weeks of pregnancy and even after thirty-seven weeks of pregnancy.

Despite its erasure within abortion rights, pregnancy loss is still happening. Miscarriage is most common, occurring in up to twenty-five percent of pregnancies, and that’s just known pregnancies, not the miscarriages that people (reasonably) mistake for late periods.⁹⁸ This is the generalized risk. Not all face the same risk. The risk of miscarriage is higher for marginalized women. Studies have found that “[e]ducational level and income were inversely associated with the risk of spontaneous abortion.”⁹⁹ Studies have also

92. SHANNON WITHYCOMBE, *LOST: MISCARRIAGE IN NINETEENTH-CENTURY AMERICA* 99, 111 (2019).

93. Fox & Lens, *supra* note 84, at 86–88.

94. Ironically, pushes against medicalization can also inure blame. The women’s health movement relies on ideas of control, and of who controls pregnancy and childbirth, no different than pro-choice ideas imply control. Anthropologist Linda Layne powerfully argues that the natural childbirth movement’s “ethic of individual responsibility” and even the idea “that women must wrest back control of their bodies from physicians, especially during pregnancy and birth, reinforces the notion that positive birth outcomes are something women can control.” Linda L. Layne, *Unhappy Endings: A Feminist Reappraisal of the Women’s Health Movement from the Vantage of Pregnancy Loss*, 56 *SOC. SCI. & MED.* 1881, 1888 (2003). Control over positive birth outcomes also means control to prevent negative birth outcomes—and blame when negative outcomes do happen.

95. Lens, *Counting*, *supra* note 70, at 577; see Fox & Lens, *supra* note 84, at 86–87.

96. Lens, *Counting*, *supra* note 70, at 577.

97. See *Labor*, JOHNS HOPKINS MED., <https://www.hopkinsmedicine.org/health/wellness-and-prevention/labor> [<https://perma.cc/N8KS-9Q6X>] (“[T]he exact trigger for the onset of labor is unknown.”).

98. Kate White, *Why Do Miscarriages Happen?*, MAYO CLINIC PRESS (Nov. 10, 2023), <https://mcpres.mayoclinic.org/pregnancy/why-do-miscarriages-happen> [<https://perma.cc/44N2-NKXE>].

99. Filippa Nyboe Norsker et al., *Socioeconomic Position and the Risk of Spontaneous Abortion: A Study Within the Danish National Birth Cohort*, *BMJ OPEN* 4 (June 25, 2012), <https://pmc.ncbi.nlm.nih.gov/articles/PMC3383986/pdf/bmjopen-2012-001077.pdf> [<https://perma.cc/A7YC-ZVPH>]; Danni Zheng, Chunyan Li, Taiwen Wu & Kun Tang, *Factors Associated with Spontaneous Abortion: A Cross-Sectional Study of Chinese Populations*, *REPROD. HEALTH* 2 (Mar. 4, 2017), <https://p>

shown Black women have an increased rate of miscarriage, possibly over forty percent.¹⁰⁰ An earlier study similarly found that Black women face double the risk of late miscarriage (between ten and twenty weeks) compared to white women.¹⁰¹

Stillbirth is less common, but still not rare. The American College of Obstetricians and Gynecologists (“ACOG”) describes stillbirth as one of the *most* common negative pregnancy outcomes.¹⁰² About sixty babies are born stillborn each day in this country.¹⁰³ Risk disparities exist. Studies have found that women of lower socioeconomic status face double the risk of stillbirth.¹⁰⁴ And studies have similarly found that Black women in the United States face double the risk of stillbirth compared to white women.¹⁰⁵

Raising awareness of this reality of pregnancy loss—erasing the erasure—is a crucially important step within anticriminalization efforts. The seeming impossibility of stillbirth in modern society immediately implies some sort of wrongdoing when a baby is stillborn. The impossibility means that a woman must be lying if she claims her baby was stillborn at a home birth. But the seeming impossibility is false. To the contrary, about sixty babies are born stillborn every day in the United States. Sixty babies a day. If something is that common, one would not immediately jump to suspicions of crime.

Similarly, awareness of the disparities in rate logically means that a marginalized woman’s stillbirth should be less suspicious than the stillbirth of a woman with higher socioeconomic status or a white woman. A marginalized woman faced a higher risk of both miscarriage and stillbirth. It makes sense that she experienced pregnancy loss. Moreover, emphasizing that marginalized women face increased risks also helps negate the logic of individual causation. How could something so common be caused by the individuals?

Increased awareness is needed generally, but especially for health care providers. Theoretically, health care workers should be more familiar with the

mc.ncbi.nlm.nih.gov/articles/PMC5336639/pdf/12978_2017_Article_297.pdf [https://perma.cc/S35D-X6JK].

100. Tulip Mazumdar, *Miscarriage Rates over 40% Higher in Black Women, Study Suggests*, BBC (Apr. 28, 2021), <https://www.bbc.com/news/health-56889861> [https://perma.cc/7UMR-VYAP].

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

102. ACOG, *Management of Stillbirth*, *supra* note 2, at e110.

103. *Id.*

104. Jennifer Zeitlin et al., *Socioeconomic Inequalities in Stillbirth Rates in Europe: Measuring the Gap Using Routine Data from the Euro-Peristat Project*, BMC PREGNANCY & CHILDBIRTH 5 (Jan. 19, 2016), <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0804-4> [https://perma.cc/BKY3-LU3S]; Olof Stephansson, Paul W. Dickman, Anna LV Johansson & Sven Cnattingius, *The Influence of Socioeconomic Status on Stillbirth Risk in Sweden*, 30 INT’L J. EPIDEMIOLOGY 1296, 1299 (2001).

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

commonality of stillbirth. But studies show they're not. In studies, OB/GYNs still describe it as "an unexpected clinical outcome" and an "unexpected event in their practice."¹⁰⁶ Even physicians, who theoretically should learn about stillbirth to some extent in their medical training, expressed "surprise[]" when presented with U.S. rates of stillbirth and shared the view that stillbirth primarily affects women in developing countries."¹⁰⁷

Stillbirth is shocking for all, including health care providers. Remember that stillbirth means "death, one of life's greatest sorrows, has occurred at precisely the moment in which the opposite, joy at birth, was expected."¹⁰⁸ "The sudden horror of the death is felt by all who attend it,"¹⁰⁹ including obviously the health care providers, and other researchers describe that stillbirth "disrupts the worldview" of health care providers.¹¹⁰

This shock, horror, and worldview disruption all likely contribute to health care providers' inclinations to call the police. But stillbirth is neither unexpected nor should it be shocking nor worldview disrupting. Sadly, it is a daily occurrence in modern day United States and not in any way inherently suspicious. If health care providers were more aware of its commonality, they would also be less likely to immediately think to call the police.

Increased awareness is needed for health care providers, and then they need to share that information with their pregnant patients. Anthropologist Linda Layne has written extensively about miscarriage after she herself experienced six miscarriages. In her words: "Why is it that when I had that first miscarriage I didn't even know that such a thing was possible?"¹¹¹ Layne advocates for "educating women and their partners about the nature and likelihood of pregnancy loss" within initial prenatal visits and continuing through pregnancy.¹¹² Historian Lara Freidenfelds, author of *The Myth of the Perfect Pregnancy*, similarly argues for these honest conversations to ensure pregnant people have realistic expectations.¹¹³

106. Maureen C. Kelley & Susan B. Trinidad, *Silent Loss and the Clinical Encounter: Parents' and Physicians' Experiences of Stillbirth—A Qualitative Analysis*, *BMC PREGNANCY & CHILDBIRTH* 3–4 (Nov. 27, 2012), <https://pubmed.ncbi.nlm.nih.gov/23181615> [<https://perma.cc/P4L4-KDSH>].

107. *Id.* at 3.

108. Elizabeth Kirkley-Best & Kenneth R. Kellner, *The Forgotten Grief: A Review of the Psychology of Stillbirth*, 52 *AM. J. ORTHOPSYCHIATRY* 420, 421 (1982).

109. *Id.*

110. Erin M. Denney-Koelsch & Denise Côté-Arsenault, *Introduction to Perinatal Palliative Care*, in *PERINATAL PALLIATIVE CARE: A CLINICAL GUIDE* 3, 3 (Erin M. Denney-Koelsch & Denise Côté-Arsenault eds., 2020).

111. Linda Layne, *A Women's Health Model for Pregnancy Loss: A Call for a New Standard of Care*, 32 *FEMINIST STUD.* 573, 578 (2006).

112. *Id.* at 583.

113. FREIDENFELDS, *supra* note 80, at 195.

As I've previously argued, doctors should also specifically be discussing the risk of stillbirth with pregnant patients.¹¹⁴ Increased education about miscarriage but not about stillbirth¹¹⁵ would normalize miscarriage only—and make later pregnancy loss *even more* suspect. Awareness of early pregnancy loss only implies that late pregnancy losses do not also happen and are inherently suspicious.

Layne and Freidenfelds also argue that honest discussions of pregnancy loss should be happening in pregnancy and childbirth classes, and in pregnancy manuals. These manuals often do mention at least miscarriage, but in a chapter at the end of the book. Layne describes the need to stop “[t]he pattern of ghettoizing information on pregnancy loss to a chapter of its own.”¹¹⁶ Stillbirth should also be mentioned. As Alan Goldenbach powerfully wrote after his son’s stillbirth at term, if these books are truly meant to prepare pregnant people “for every possible twist or turn,” “[s]tillbirth, the culprit that destroys more than one in every [175 births]” should be in them.¹¹⁷

Again, increased awareness of the commonality of pregnancy loss is crucial for anticriminalization efforts. Increased awareness reassures the pregnant person, the health care providers, and society that, no, there is nothing inherently suspicious about such a death; babies do routinely die just before birth (even) in the United States (even) in 2026. And raised awareness must include awareness of commonality for *who*. Specifically, that marginalized persons face an increased risk of stillbirth, a risk increased through no fault of their own.

2. Pregnancy Loss as Trauma

Another current cultural script for pregnancy loss is that one must react correctly emotionally—or at least not react insufficiently emotionally. The rule appears to be that one must experience pregnancy loss the same way they would the death of their child and then display those appropriate emotions.

This rule overlaps significantly with antiabortion narratives. According to the antiabortion movement, the “loss” in pregnancy loss is the death of a child. “Pro-life political and cultural campaigns have created effective images and symbols to inspire Americans’ emotional investment in early

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

115. Notably, Freidenfelds advocates for increased education and awareness of miscarriage, but not stillbirth. In her words: “Trying to learn about and anticipate all of the various possibilities leads to much worry relative to the potential benefit. . . . We can be realistic and still decide not to borrow trouble. . . .” FREIDENFELDS, *supra* note 80, at 195. But again, normalizing miscarriage but not stillbirth only makes stillbirths even more suspicious. Moreover, I reject ideas of withholding information from pregnant women based on paternalistic worries about causing worry. See Lens, *supra* note 114, at 692–99.

116. Layne, *supra* note 111, at 584.

117. Alan Goldenbach, *Blindsided*, in *THEY WERE STILL BORN: PERSONAL STORIES ABOUT STILLBIRTH* 7, 8 (Janel C. Atlas ed., 2014); *supra* note 2 and accompanying text.

pregnancy”¹¹⁸ This is why antiabortion pictures of pregnancy are always of an older fetus, “encouraging us to imagine this older fetus when we think about any pregnancy, at any stage.”¹¹⁹ “Women who look for support have lost pregnancies in a culture that has encouraged them to invest deeply in pregnancy very early on.”¹²⁰

If we are taught that life begins at conception, then any pregnancy loss is a death of a child. The antiabortion movement confirms “that sorrow is appropriate because a baby has died.”¹²¹

The rulebook may say to grieve pregnancy loss like the death of your child, but ironically, when people do so, or at least do so openly, they are often stigmatized. In studies, the “sentiment parents most wanted to convey to others[] was that their stillborn child is real and will always be remembered as part of their family.”¹²² And they find their expressions of their identities as parents rejected.¹²³ They encounter “awkwardness and discomfort” when they “try to discuss their experience, or when they try to normalize it by mentioning their stillborn child alongside their live children as part of their family.”¹²⁴ In studies, stillbirth parents explain they wish society would understand that they’re “not mentally unstable because [they] like to honor/celebrate/remember our stillborn child,” and that there’s nothing abnormal about a funeral for a stillborn child.¹²⁵ Apparently, grieving your deceased, unborn child is also the wrong thing to do, although the consequence is stigma, not arrest.

And thus, the rule is to grieve pregnancy loss like you would the death of your child (but also not too much). If one acts this correct way, there’s less inclination to suspect causation and less belief that punishment is appropriate.

Pregnancy loss and anticriminalization advocates relied on this idea in the case of Bei Bei Shuai. She was arrested after the death of her newborn daughter after ingesting rat poison at eight months pregnant.¹²⁶ After her arrest for murder of a fetus (notably, suicide is not a crime in Indiana), the trial judge denied Shuai bail.¹²⁷ The mentioned coalition of advocates filed an amicus brief urging the judge to reconsider the denial of bail based on Shuai’s grief:

Like other parents of very sick babies in neonatal intensive care, Ms. Shuai spent as much time as she possibly could with her daughter,

118. FREIDENFELDS, *supra* note 80, at 147.

119. *Id.* at 148.

120. *Id.* at 149.

121. *Id.*

122. Kelley & Trinidad, *supra* note 106, at 10.

123. *Id.*

124. *Id.* at 9.

125. *Id.* at 10.

126. *Shuai v. State*, 966 N.E.2d 619, 622 (Ind. Ct. App. 2012).

127. *Id.* at 623.

whom she named Angel. Ms. Shuai showed great relief when initially assured that her daughter's condition would improve; when Angel's condition deteriorated, Ms. Shuai wept and said she wished she could die instead of Angel. At one point she was so overwhelmed with grief that she fainted; when she came to, she continued to cry. Then, as other parents typically do in these situations, she held her daughter in her arms as she died. After Angel's death, Ms. Shuai sought religious counseling and dressed her daughter in traditional burial clothes. These are the reactions of a grieving parent, not those of a person so dangerous to society she should be incarcerated without bail pending trial.¹²⁸

Essentially, the amici argued that Shuai should be granted bail because of her grief. They argued:

A woman who has been targeted for prosecution after a perinatal loss shares these same feelings of despair. Although the voices of women in these circumstances are often obscured by societal reprobation, anecdotal reports confirm what is obvious: a woman, regardless of circumstances, also and just as poignantly grieves her loss.¹²⁹

This is a good argument. But its flipside also means that a lack of grief—conduct inconsistent with the good, grieving mother—means a reason to suspect and punish. And conduct supposedly inconsistent with that good, grieving mother has been present in many arrests. That includes things like the use of the toilet (discussed later), not going to the hospital quickly enough, bringing the baby to the hospital, not bringing the baby to the hospital, going on with one's day, failing to express enough of the correct emotions, or expressing the wrong emotions.

As Liz Kukura recounts, in the prosecution of Anne Bynum for abuse of a corpse and concealing a birth, the prosecutor emphasized that Bynum “had temporarily placed the stillborn fetus in her car before going to the hospital.”¹³⁰ This was apparently improper. At the same time, as Kukura points out, “[s]urely if she had disposed of the remains herself or left them at home while going to the emergency room, both hospital staff and law enforcement would have viewed this conduct as an indication of something nefarious.”¹³¹

128. Brief of Amicus Curiae of Legal Voice and Perinatal Loss Support Organizations and Experts at 15–16, *Shuai*, 966 N.E.2d 619 (No. 49A02-1106-CR-00486), 2011 WL 3892889, at *15–16 (citations omitted).

129. *Id.* at 15.

130. Elizabeth Kukura, *Punishing Maternal Ambivalence*, 90 FORDHAM L. REV. 2909, 2912 (2022).

131. *Id.* at 2919–20.

That is, of course, exactly what Brittany Watts did (left in the toilet).¹³² In her case, *not* bringing the baby to the hospital contributed to police investigation.

The prosecutor in Bynum's case also focused on the passage of time between childbirth and getting to the emergency room. Specifically, Bynum's prosecutor emphasized that Bynum "slept before going to the emergency room."¹³³ Not quickly getting to the hospital displays a lack of a proper "good mother" reaction—wanting to get to the hospital as soon as possible in hopes that the baby could be resuscitated.

Brittany Watts also reacted the wrong way. Not only did she leave her baby in the toilet, she "went on (with) her day" after.¹³⁴ She was apparently not at all affected by her child's death and instead went on with her day. A good, grieving mother wouldn't do that.

These women were suspected of causation because they reacted the wrong way. Even current ACOG guidelines, however, belie this idea of a "right" way. ACOG guidelines on stillbirth already inform doctors not to make judgments based on behavior. The stillbirth guideline explains that "grief is individual" and directs clinicians to "[r]ecogni[ze] . . . the grief journey and that all bereaved parents will handle and react differently to grief. The intensity and duration of grief will be different. Health professionals should be made aware that different grief responses are normal and that there is no perfect way to grieve."¹³⁵ This language in the ACOG guidelines is admirable, but the mere three sentences are insufficient to convey the inappropriateness of health care providers making judgments based on people's reactions.

The problem, however, is bigger than the number of sentences. It's also bigger than the idea that people grieve differently. The problem is that this language about people grieving differently fails to identify to health care providers the trauma involved. At the same time that stillbirth is a common and a natural bodily occurrence, it is still traumatic. And trauma can affect reactions.

There is the mental and emotional trauma. "The death of a child is, undisputedly, a highly traumatic life event."¹³⁶ This is "death, one of life's greatest sorrows" occurring when "the opposite, joy at birth, was expected."¹³⁷ Stillbirth disrupts the pregnant person's worldview,¹³⁸ especially given the

132. Julie Carr Smyth, *Ohio Prosecutor Says He's Duty Bound to Bring Miscarriage Case to a Grand Jury*, ASSOCIATED PRESS (Dec. 20, 2023, 3:49 PM), <https://apnews.com/article/brittany-watts-miscarriage-prosecution-ohio-6ba1agb758fa26358c89e0694a3b4e54> [<https://perma.cc/7F5B-A83E>].

133. Kukura, *supra* note 130, at 2919.

134. Smyth, *supra* note 132.

135. ACOG, *Management of Stillbirth*, *supra* note 2, at e123.

136. Frances M. Boyle, John C. Vance, Jake M. Najman & M. John Thearle, *The Mental Health Impact of Stillbirth, Neonatal Death or SIDS: Prevalence and Patterns of Distress Among Mothers*, 43 SOC. SCI. & MED. 1273, 1274 (1996).

137. Kirkley-Best & Kellner, *supra* note 108, at 421.

138. Denney-Koelsch & Côté-Arsenault, *Introduction to Perinatal Palliative Care*, in PERINATAL PALLIATIVE CARE: A CLINICAL GUIDE, *supra* note 110, at 3, 3 (describing how stillbirth disrupts the worldview of parents and attending health care providers); *see also* Jill Wieber Lens, *Children*,

general erasure of pregnancy loss and the fact that she's been taught for decades that she has control over her reproduction.

There's the physical trauma. Even if closer to twenty weeks pregnant, this is still childbirth. It's still labor with possibly painful contractions. It's still pushing a baby out of your vagina, although the baby's size will depend on the length of pregnancy. It's not only physical childbirth, it's also the same emotional and hormonal experience but there's no alive and healthy baby to balance out the more difficult parts.

All of this possible trauma can affect people's reactions and behavior within the experience. "Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, . . . physical arousal, and blunted affect."¹³⁹ Reactions can easily include "numbness or lack of emotions."¹⁴⁰

Emphasis on the trauma would be extremely helpful to anticriminalization efforts. If there was more emphasis on the trauma of pregnancy loss, there would be less rush to judgment based on a person's reactions. For instance, medical providers need to be educated that numbness and flat affect can be due to trauma, not desired causation. The birthing person may be full of grief, but that grief is masked by her trauma-caused numbness. Trauma is more than sufficient reason to reject any rules about the correct way to react to pregnancy loss. Accentuation of trauma may also help to alleviate the biases that can encourage a health care provider to call the cops.

Health care providers need this education and so does society.¹⁴¹ Society also needs this education on the trauma of pregnancy loss such that society isn't so quick to judge a person's reactions to pregnancy loss. Trauma can help explain conduct—not bringing the baby to the hospital, leaving the baby in the toilet, going to a hair appointment—that otherwise might make someone suspect causation. Trauma can also help alleviate the influence of biases.

Not that long ago, a similar revolution in understanding of trauma occurred with domestic violence. That new understanding began with battered woman syndrome,¹⁴² which emphasized how trauma contributed to responses to domestic violence, responses including killing the abuser. For instance, there was suspicion that the woman was not really a victim of abuse because, if she was, she would have left. It seems like a reasonable inference, until battered

Wrongful Death, and Punitive Damages, 100 B.U. L. REV. 437, 486–88 (2020) (describing that the death of a child, including an unborn child, disrupts the parent's worldview).

139. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS., HHS PUB. NO. (SMA) 14-4816, TIP 57: TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVICES 61 (2014).

140. *Id.*

141. Some literature has proposed trauma-informed care for stillbirth. *See, e.g.*, Shandeigh N. Berry, Tracy Winsor & Laura Huene, *A Proposed Framework for Perinatal Loss Trauma Informed Care*, 29 J. NEONATAL NURSING 916, 916–21 (2023); Shandeigh N. Berry, *The Trauma of Perinatal Loss: A Scoping Review*, 2 TRAUMA CARE 392, 392–407 (2022).

142. *See generally* LENORE E. WALKER, *THE BATTERED WOMAN* (1979).

woman syndrome rebutted it and explained why women who were being abused often did not leave. Once better educated on battered woman syndrome, legislatures and courts overwhelmingly allowed expert testimony on the syndrome to help rebut biases and stereotypes about how someone would act if in an abusive relationship.¹⁴³

Similarly, courts have admitted evidence of “rape trauma syndrome” to dispel misconceptions about the proper behavior of a victim of rape. For instance, a jury may not believe the person was raped if they delay in reporting the rape to police. Courts have admitted evidence of this syndrome to rebut jury inferences based on the victim’s behavior and to “disab[us] the jury of some widely held misconceptions about rape and rape victims, so that it may evaluate the evidence free of constraints of popular myths.”¹⁴⁴

Certainly, both battered woman syndrome and rape trauma syndrome have been criticized.¹⁴⁵ The point is not the specific substance of the syndromes, however. The point is the emphasis on breaking stereotypes about expected behavior. The same is true about inferring causation of pregnancy loss due to behavior or reactions during and after.

3. Occurrence (Uncaused) in Undesired Pregnancies

Another reason grief has become culturally required and presumed by ACOG is that the circumstances of pregnancy loss have changed. Those changed circumstances have essentially created a presumption that pregnancy loss occurs only in desired pregnancies. The presumption resulted from the legalization of abortion. Before *Roe*, the answer for an undesired pregnancy was to figure out a way to get an abortion or to hope for pregnancy loss.¹⁴⁶ This is why, historically, a possible and acceptable reaction to miscarriage was relief if not celebration.

But after *Roe*, as historian Lara Freidenfelds explains, that changed.¹⁴⁷ After *Roe*, women didn’t have to just hope for pregnancy loss. Undesired pregnancies were ended (which assumes entirely too much about access to

143. See, e.g., *Weiland v. State*, 732 So. 2d 1044, 1054 (Fla. 1999) (allowing testimony regarding “battered spouse syndrome evidence to rebut the common myths concerning battered women and explain[] the very real dangers faced by women in these relationships”); MASS. GEN. LAWS ch. 233, § 23F (2022) (allowing evidence of battered woman syndrome to explain “whether the defendant displayed characteristics common to victims of abuse”).

144. *People v. Bledsoe*, 681 P.2d 291, 298 (Cal. 1984).

145. See, e.g., EDWARD W. GONDOLF & ELLEN R. FISHER, *BATTERED WOMEN AS SURVIVORS: AN ALTERNATIVE TO TREATING LEARNED HELPLESSNESS* 11 (1988); Clare Dalton, *Domestic Violence, Domestic Torts and Divorce: Constraints and Possibilities*, 31 NEW ENG. L. REV. 319, 345-47 (1997); Adele M. Morrison, *Changing the Domestic Violence (Dis)Course: Moving from White Victim to Multi-Cultural Survivor*, 39 U.C. DAVIS L. REV. 1061, 1078-86 (2006); Susan Stefan, *The Protection Racket: Rape Trauma Syndrome, Psychiatric Labeling, and Law*, 88 NW. U. L. REV. 1271, 1301 (1994).

146. FREIDENFELDS, *supra* note 80, at 144.

147. *Id.*

abortion care), whereas desired pregnancies continued.¹⁴⁸ Pregnancies can only end in pregnancy loss if they are not terminated. And thus, the usual context for pregnancy loss is in a desired pregnancy, or at least a pregnancy where one chose to continue it. This created an expectation of and a cultural norm of grief.

It's important to note that these cultural norms are problematically simplistic—the idea that grief would follow pregnancy loss in a desired pregnancy, and no grief would follow pregnancy loss in an undesired pregnancy. Nothing about pregnancy loss is that simple. At least one study shows that some women “with intended and strongly desired pregnancies, experienced only mild disappointment or feelings of inconvenience or even relief.”¹⁴⁹ And some women who didn't want their pregnancies reported grief after pregnancy loss.¹⁵⁰ Still, the cultural norms persist.

Regardless, following *Roe*, the norm was that undesired pregnancies ended in a legal abortion. This belief also erased the reality that terminated pregnancies could have just as easily ended in pregnancy loss. This was (and is) the reality; the embryo terminated at six weeks could just as easily have miscarried at eight weeks due to abnormality. The chance of pregnancy loss in pregnancies decreases dramatically after twelve weeks, and thus any pregnancies terminated after twelve weeks were likely to end in live childbirth had the abortion not happened. But over ninety percent of abortions are before thirteen weeks.¹⁵¹ So, it's wrong to assume live childbirth for pregnancies had they not been terminated. But that reality is erased. Instead, there is an assumption, especially on the antiabortion side, that every aborted baby would have been born alive and healthy.¹⁵²

Put these two ideas together. Undesired pregnancies are terminated post-*Roe*, and terminated pregnancies would have ended in live and healthy childbirth had they not been terminated. And thus, if undesired pregnancy ends in pregnancy loss, the undesiredly pregnant person must have done something to cause it.

A West Virginia prosecutor caused alarm in the summer of 2025 when he shared what he called a “warning” to women in West Virginia of possible arrest after miscarriage.¹⁵³ He mentioned that prosecutors would evaluate

148. *Id.*

149. Rachel Flink-Bochacki et al., *Family Planning and Counseling Desires of Women Who Have Experienced Miscarriage*, 131 *OBSTETRICS & GYNECOLOGY* 625, 628 (2018).

150. *Id.*

151. Usha Ranji, Karen Diep, Bryana Castillo Sanchez & Alina Salganicoff, *Key Facts on Abortion in the United States*, KFF (July 15, 2025), <https://www.kff.org/womens-health-policy/key-facts-on-abortion-in-the-united-states> [https://perma.cc/D83J-5FMY].

152. LENS, *supra* note 14, at 159–61.

153. Jessica Farrish, *Prosecutor Warns of Potential Charges Against Women Who Miscarry in West Virginia*, WVNS 59NEWS (June 4, 2025, 2:27 PM), <https://www.wvnstv.com/news/local-news/prosecutor-warns-of-potential-charges-against-women-who-miscarry-in-west-virginia> [https://perma.cc/HN2E-XYTA].

numerous factors in determining whether to file a criminal charge, including if the pregnant person was “relieved” and “had been telling people, ‘I’d rather get ran over by a bus than have this baby.’”¹⁵⁴ Because relief must mean causation.¹⁵⁵

Not surprisingly, law enforcement and prosecutors often rely on evidence that the pregnant person was unsure of her desire for the pregnancy, or if she had any doubts about her desire for the pregnancy. Liz Kukura describes that police relied on this in Anne Bynum’s case, an Arkansas woman arrested for abuse of a corpse.¹⁵⁶ Bynum had “determined that having another child was ‘not feasible’ as a single mother on her minimum-wage salary.”¹⁵⁷ She concealed the pregnancy for fear that her mother would kick her out of the house and decided to give the baby up for adoption.¹⁵⁸ Bynum’s child was stillborn at seven months pregnant.¹⁵⁹ She gave birth at home late one night and went to the emergency room the next morning with the stillborn baby.¹⁶⁰ And the prosecutor relied heavily on Bynum’s lack of desire for her pregnancy.¹⁶¹

Kukura similarly discusses the arrest of Latice Fisher.¹⁶² Fisher was a Mississippi woman who had not wanted to be pregnant again; she already had three children and could not afford another.¹⁶³ While pregnant, she researched abortion medication on the internet; police found evidence of that search history.¹⁶⁴ The fetal autopsy, however, found no evidence of causation of the baby’s stillbirth.¹⁶⁵

Pregnancy Justice’s research shows this problematic phenomenon on a broader scale. Its most recent report described case files for homicide and abuse of a corpse “referenc[ing] their [pregnant persons’] possession of abortion medication or their attempts to obtain an abortion.”¹⁶⁶ Again, evidence of doubts of wantedness of pregnancy, or considerations of abortion are meant to show causation in pregnancy loss. Pregnancy Justice vividly

154. *Id.*

155. Days later, the West Virginia Prosecuting Attorneys Association countered the prosecutor’s statements, instead stating that West Virginia women experiencing miscarriage cannot and should not face criminal prosecution. Susan Rinkunas, *Prosecutor Group Clarifies that Women Shouldn’t Actually Call the Cops After a Miscarriage*, JEZEBEL (June 10, 2025, 3:19 PM), <https://www.jezebel.com/prosecutor-group-says-actually-women-shouldnt-call-the-cops-after-a-miscarriage> [<https://perma.cc/G7W4-WGJ2>].

156. Kukura, *supra* note 130, at 2911.

157. *Id.*

158. *Id.* at 2919.

159. *Id.* at 2911.

160. *Id.*

161. *Id.* at 2920.

162. *Id.* at 2912–13.

163. *Id.*

164. *Id.* at 2913.

165. *Id.*

166. BACH & WASILCZUK, *supra* note 30, at 18.

describes how “pregnant people’s contemplation of abortion can be weaponized against them,”¹⁶⁷ not in charges for violating abortion statutes (as those statutes usually don’t apply to pregnant people), but for allegedly violating other laws.

Prosecutors went even a step further in their prosecution of Anne Bynum for abuse of a corpse after her child’s stillbirth. They presented evidence that Bynum had had an abortion in a prior pregnancy, purportedly to show some nefarious conduct in this pregnancy.¹⁶⁸ Bynum’s conviction was later reversed because it was error to admit evidence of her prior abortion.¹⁶⁹ It was error and “Bynum was clearly prejudiced by the introduction of this irrelevant evidence, as shown by the four-minute verdict and maximum prison sentence allowed by law.”¹⁷⁰

Like in Bynum’s case, the Maryland Supreme Court recently found evidence of thoughts of abortion irrelevant in the prosecution of Moira E. Akers for murder and child abuse of her newborn; Akers maintained that the baby was stillborn.¹⁷¹ Specifically, the court found internet searches about abortion “months before she gave birth” to fail to meet even the low threshold for relevancy and also “not probative of an intent to kill or harm a baby at delivery many months later.”¹⁷² Simply put, the court found no logical connection between early thoughts of abortion and an intent to kill the child once born.

These cultural (and apparently legal) rules related to undesired pregnancy and pregnancy loss need rewritten. The reality is that pregnancy loss—without inducement either by a doctor or by the pregnant person—can and does happen in undesired pregnancies,¹⁷³ and will happen much more often after *Dobbs* and the decreasing availability of legal abortion. People may not feel grief after pregnancy loss. They may even feel relief.

In that way, history is repeating itself. Historians Shannon Withycombe and Lara Freidenfelds have both researched extensively the history of pregnancy loss in the 1800s and early 1900s. “In late nineteenth-century America, women had much less control over when and how many pregnancies they had, and so miscarriage was more likely to be a relief, very welcomed, or a reason to

167. *Id.*

168. *See* Bynum v. State, 546 S.W.3d 533, 542 (Ark. Ct. App. 2018). This sentiment also reinforces self-blame that women can feel after pregnancy loss—that the pregnancy loss is punishment for a prior abortion.

169. *Id.* at 543–44.

170. *Id.* at 543.

171. Akers v. State, 331 A.3d 853, 857 (Md. 2025).

172. *Id.* at 875–79. Limiting the reach of this decision, however, is that the Maryland Supreme Court relied on the legality of and right to abortion in Maryland. *Id.*

173. Moreover, there’s nothing inherently suspicious in a pregnant person feeling ambivalent about pregnancy. Kukura, *supra* note 130, at 2915–18.

celebrate.”¹⁷⁴ Relief and even celebration were normal—and *not* a reason to suspect causation.¹⁷⁵

That relief or even celebration does not mean causation of pregnancy loss (in addition to the effects of trauma on reactions) is a crucially important lesson for health care providers. There should be no rush to call the police if a person exhibits relief at a pregnancy loss. That is a common and sometimes rational response when the pregnancy was undesired.¹⁷⁶ It’s not a reason to immediately suspect causation.

It’s also an important lesson for society more generally. *Dobbs* changes the landscape of available options for undesired pregnancies. *Dobbs* means more undesired pregnancies will continue. And some of them will end in pregnancy loss. The fact that the pregnancy was undesired, however, is no reason to suspect anything criminal or anything causation-wise of the pregnant person.

4. Normalizing Pregnancy Loss on the Toilet

One pregnancy-loss cultural rule related closely to ideas of how to react yet deserves its own discussion is that the bodily, physical experience of pregnancy loss must occur in circumstances consistent with the good, grieving mother. The rule exists even though most overlook that bodily, physical experience; most don’t want to think about or acknowledge the reality that the dead baby must still physically come out of the body. We don’t want to think about it, but culturally, we do judge if the pregnancy loss occurs—if the dead baby comes out—in less than pristine circumstances.

The required pristine circumstances are not defined, but it is clear what is not culturally acceptable—the involvement of the toilet. A common refrain within stories of criminalized pregnancy loss is the involvement of the toilet.

Media coverage that Brittany Watts “miscarried” on the toilet at her home was extensive. (Coverage that it was a miscarriage was incorrect. She was twenty-two weeks pregnant meaning she had a stillbirth.) Initial media coverage emphasized the toilet—and that Watts flushed the toilet and then

174. WITHYCOMBE, *supra* note 92, at 30; *see also* FREIDENFELDS, *supra* note 80, at 43 (“Early pregnancy loss was relied upon as an important component of fertility control. . . . And women did not typically express guilt or grief when pregnancies failed, even into the second trimester.”).

175. *See* FREIDENFELDS, *supra* note 80, at 27 (explaining the honor in acting to space out pregnancies to preserve the woman’s and children’s health); Katherine Parkin, “*Joy Turned to Sorrow*”: *Stillborns in Howard County, Indiana, 1890–1940*, 45 J. FAM. HIST. 64, 67 (2020) (“[C]ommunity newspapers never reflect a suspicion that women who delivered stillborns had intentionally terminated their pregnancies.”).

176. Kaelyn Forde, *When Miscarriage Is a Relief*, GLAMOUR (Oct. 28, 2019), <https://www.glamour.com/story/when-miscarriage-is-a-relief> [<https://perma.cc/V3RA-H4PE>] (“If someone experiences a miscarriage, it is a cultural norm to see it as a devastating loss’ But feeling relieved when a pregnancy ends—perhaps it was not planned, not viable, not financially or socially feasible—is normal too.”).

plunged and scooped the remains out of the toilet.¹⁷⁷ The police found the fetus lodged in toilet pipes.¹⁷⁸ The police removed the toilet and brought it to the county coroner, and the coroner chiseled the pipes to obtain the fetus.¹⁷⁹ At a hearing, the local prosecutor emphasized that Watts “flushed, plunged and scooped out the toilet following her miscarriage” and then “left home knowing it was clogged.”¹⁸⁰ That prosecutor similarly emphasized “the fact that the baby was put into a toilet, large enough to clog up a toilet, left [the baby] in that toilet and [Watts] went on [with] her day.”¹⁸¹

In October 2024, New York City local news reported that a woman might be arrested after “miscarrying” in a toilet at a restaurant.¹⁸² (Again, not a miscarriage as the woman was at least twenty-two weeks pregnant and the baby weighed 543 grams, well more than the usual 350-gram weight at twenty weeks.¹⁸³ The medical examiner also apparently “believed the baby may have taken one or two breaths,” which would also mean this is not a pregnancy loss.¹⁸⁴) The media reported that the formerly pregnant woman had been identified and might be arrested “after workers found the 1.2-pound fetus in a clogged toilet.”¹⁸⁵ The NYPD Chief of Detectives explained at a press conference that after she left the bathroom, “employees [were] alerted that the bathroom [was] dirty.”¹⁸⁶ The next day the employees found the toilet clogged.¹⁸⁷

Amari Marsh, a twenty-two-year-old college student in South Carolina, was charged with “homicide by child abuse” after she had a miscarriage on the toilet.¹⁸⁸

177. Chris McBride, *Rights Group: Watkins' Response Is Disappointing*, TRIB. CHRON. (Dec. 23, 2023), <https://www.tribtoday.com/news/local-news/2023/12/rights-group-watkins-response-is-disappointing> [<https://perma.cc/DgDS-3BU3>].

178. *Id.*

179. *Id.*

180. Smyth, *supra* note 132.

181. Nadine Grimley, *Woman's Miscarriage Leads to 'Abuse of Corpse' Case Before Grand Jury*, WKBN FIRST NEWS 27 (Nov. 2, 2023, 6:11 PM) (alteration in original), <https://www.wkbn.com/news/local-news/warren-news/trumbull-county-grand-jury-to-hear-abuse-of-corpse-case> [<https://perma.cc/49LD-EJEC>]; Maria Sole Campinoti, Holly Yan, Zenebou Sylla & Samantha Beech, *Ohio Woman Who Suffered Miscarriage at Home Will Not Be Criminally Charged, Grand Jury Says*, CNN (Jan. 11, 2024, 8:32 PM), <https://www.cnn.com/2024/01/11/us/brittany-watts-miscarriage-no-criminal-charges> [<https://perma.cc/4YNA-5W8E>].

182. Mira Wassef, *Woman May Be Arrested After 1.2-Pound Fetus Found in Clogged Restaurant Toilet: NYPD*, PIX 11 (Oct. 8, 2024, 5:11 PM), <https://pix11.com/news/local-news/manhattan/woman-may-be-arrested-after-1-2-pound-fetus-found-in-clogged-restaurant-toilet-nypd> [<https://perma.cc/6A42-7Q8J>].

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. Jessica Valentí, *Georgia Ban Kills Young Mother*, ABORTION, EVERYDAY (Sept. 16, 2024), <https://jessica.substack.com/p/georgia-ban-kills-young-mother> [<https://perma.cc/F3Q4-YUS3>].

Media reports emphasized Marsh “gave birth” in the “toilet and covered the fetus with toilet paper.”¹⁸⁹ Similarly, Latice Fisher was arrested after her stillborn baby was found in the toilet.¹⁹⁰ Fisher was thirty-six weeks pregnant when, one night, she felt like she needed to have a bowel movement and “ended up delivering the baby stillborn at home.”¹⁹¹ Emergency medical technicians arrived and “found the fetus in the toilet with the umbilical cord attached.”¹⁹²

The media likes to highlight the toilet as an improper place to give birth.¹⁹³ But the toilet is actually a very common place for pregnancy loss. Put simply, where is the most natural place to go when you feel fluid rushing out, or if you feel like you need to have a bowel movement?

Numerous other governments, which also have government-provided health care, have information available reassuring people of the normalcy of pregnancy loss on the toilet. An Australian government website explains: “Some women miscarry while on the toilet. This can also happen if you are out and about, or in hospital. There is no right or wrong way to handle this.”¹⁹⁴ In the UK, a National Health Service Foundation Trust explains: “If you miscarry at home sometimes the remains of your pregnancy will be passed on the toilet.”¹⁹⁵ The sources also help women realize what this will be like, as in how the fetus may be visible. The NHS material explains: “You may look at

189. *Id.*

190. Kukura, *supra* note 130, at 2913; Patricia Hurtado & Francesca Maglione, *In a Post-Roe World, More Miscarriage and Stillbirth Prosecutions Await Women*, FORTUNE (July 5, 2022, 3:45 PM), <https://fortune.com/2022/07/05/roe-v-wade-miscarriage-abortion-prosecution-charge> [<https://perma.cc/55PB-7NDH>].

191. Kukura, *supra* note 130, at 2913.

192. *Id.*

193. The same is true for the involvement of dumpsters. The media eagerly shared the news of a fetus found in a Walmart dumpster in Georgia in the summer of 2024. Alexandra Koch, *Fetus Found in Grovetown Walmart Dumpster Product of Miscarriage, Says Sheriff's Investigator*, AUGUSTA CHRON. (July 25, 2024, 4:21 PM), <https://www.augustachronicle.com/story/news/crime/2024/07/25/more-released-about-fetus-found-in-grovetown-walmart-dumpster/74547057007> [<https://perma.cc/F85S-LNSS>]. A sheriff later explained to the media that the woman had experienced the miscarriage in a public place earlier in the day and disposed of the fetus in the dumpster to ensure her other children did not see it, an explanation that the sheriff apparently approved of, and no arrest was made. *Id.* No sufficient explanation, however, apparently happened in the spring of 2025 again in Georgia. This time, police arrested Selena Maria Chandler-Scott for abandonment of a dead body and concealment of a death when she put her fetal remains in a dumpster after her late miscarriage. Bracey Harris, *Woman's Arrest After Miscarriage in Georgia Draws Fear and Anger*, NBC NEWS (Apr. 5, 2025, 6:00 AM), <https://www.nbcnews.com/news/us-news/georgia-arrest-miscarriage-fetal-personhood-rcna199400> [<https://perma.cc/Q9X7-EJQW>]. The charges were later dropped. *Id.*

194. *Miscarriage*, DEP'T HEALTH & AGED CARE, AUSTRALIAN GOV'T (Nov. 2023), <https://www.pregnancybirthbaby.org.au/miscarriage> [<https://perma.cc/8KQQ-9VV4>].

195. *Options for Your Pregnancy Remains Following Miscarriage*, ROYAL UNITED HOSPS. BATH NHS FOUND. TR. (Aug. 2024), https://www.ruh.nhs.uk/patients/patient_information/MAT063_FetaL_remains.pdf [<https://perma.cc/T3L8-LVBP>].

what has passed and see a pregnancy sac and/or a very early baby (medically called a fetus).”¹⁹⁶

Other commentary about the process of miscarriage can also be found in English popular media. A UK Glamour article reassures that, unless a procedure is scheduled at the hospital, “there is little control over when your baby, or fetus, may leave your body while experiencing a miscarriage.”¹⁹⁷

Another important part of this normalization is the emphasis on possibly flushing the toilet. One NHS Trust material describes: “If the miscarriage is completed at home there is no obligation to dispose of the pregnancy remains in any particular way. You might want to flush the toilet, many people do this automatically. Or you may want to take a closer look, that is natural too.”¹⁹⁸ A different Trust pamphlet recounts similar information about flushing or taking a closer look and adds: “There is no right or wrong answer. It is important you do what you feel is best for you.”¹⁹⁹

The UK Glamour article similarly explains that flushing the toilet “is a natural reaction to a shocking event” and “nothing to feel shame or guilt about.”²⁰⁰ Many women who have experienced this did flush as it “feels like the only thing they could do.”²⁰¹ In her recent lawsuit, Brittany Watts similarly alleges that after she gave birth on the toilet, she “did what was reasonable: she flushed the toilet.”²⁰² It’s reasonable, but can still be emotionally difficult. Women “often place shame and personal blame on ourselves when we lose a pregnancy at any stage. For many, the additional guilt and trauma of flushing their miscarried baby, or fetus, in the toilet is something that can be extremely hard to talk (or even think) about.”²⁰³

Pregnancy loss on the toilet is normal in England and Australia. It’s also normal in the United States. But we don’t have these sort of materials to help affirm that normality. There are no government websites, which is also partially explained by the lack of government-provided health. A recent Guardian piece about criminalization in America quoted an Alabama woman, Mary Morgan, who had five miscarriages within six years. She explained: “They have no idea

196. *Id.*

197. Pippa Vosper, *‘I Did the Only Thing I Could Think of at that Time’: The Guilt and Trauma of Flushing a Pregnancy Loss in the Toilet*, GLAMOUR (Aug. 16, 2022), <https://www.glamourmagazine.co.uk/article/pregnancy-loss-flushing> [<https://perma.cc/6TPG-8DUS>].

198. *Options for Your Pregnancy Remains Following Miscarriage*, *supra* note 195.

199. *Management of Your Miscarriage*, LIVERPOOL WOMEN’S NHS FOUND. TR. (Oct. 1, 2018), https://www.uhliverpool.nhs.uk/application/files/5617/5386/2178/Management_of_your_miscarriage.pdf [<https://perma.cc/26FL-5S7V>].

200. Vosper, *supra* note 197.

201. *Id.*

202. Complaint, *supra* note 24, at 3.

203. Vosper, *supra* note 197.

how many women have had miscarriages – and I’m just gonna say it, have had them on the toilet, because I’m telling you, that’s a thing.”²⁰⁴

It happens, but there’s little guidance for women in the United States. As Linda Layne has criticized: “Why wasn’t I better prepared for the miscarriages I had at home? Why hadn’t someone told me how to cope with all the blood or what I might do with the embryo?”²⁰⁵ Watts’s lawsuit similarly alleges that despite knowing of the high chance of her experiencing pregnancy loss at home, none of her medical providers “told her how to manage her impending miscarriage at home” and she “was never told what her fetal remains would look like or how to dispose of them.”²⁰⁶ A woman named Rebecca shared similar sentiments in a 2024 Guardian article. She shared her story, including the guilt she felt for flushing after her 2014 miscarriage:

“I thought about fishing it out of the bloody water,” she said. “I didn’t really want to hold it in my hand. I also didn’t know what I would do with it afterwards. Am I gonna put it in the trash? Am I gonna dig a hole in the backyard? What the hell am I supposed to do? I had no idea.” It was around 3 or 4 in the morning; her husband was trying to get some sleep before work. She was exhausted and in shock. “Ultimately, I flushed it. I didn’t want to,” Rebecca said. As she thought about it all again, she kept repeating herself: “I didn’t know what I was supposed to do.”²⁰⁷

U.S. women are not prepared for the reality of pregnancy loss on the toilet, and then they are villainized for it—further alienating the many, many people who experience pregnancy loss on the toilet. The villainization only reinforces the guilt many likely already feel, blaming themselves for the pregnancy loss itself and also for its location on the toilet.

The American villainization of the woman who experiences pregnancy loss on the toilet (as if she had a choice) echoes broader pre-*Dobbs* debates on the disposition of fetal remains post abortion. This debate was at its strongest after a group calling itself the Center for Medical Progress in 2015 accused Planned Parenthood of selling fetal tissues, organs, and body parts for medical research.²⁰⁸ All investigations cleared Planned Parenthood of any wrongdoing, but the media coverage sparked extensive legislative responses requiring

204. Carter Sherman, *I Didn’t Know What I Was Supposed to Do’: US Women Who Miscarry Are in Dangerous Legal Limbo Post-Roe*, GUARDIAN (Jan. 24, 2024, 10:00 AM), <https://www.theguardian.com/society/2024/jan/24/us-miscarriage-laws-abortion-rights-options> [<https://perma.cc/49XE-LT4C>].

205. Layne, *supra* note 111, at 579.

206. Complaint, *supra* note 25, at 8.

207. Sherman, *supra* note 204.

208. Evan D. Bernick & Jill Wieber Lens, *Original Public Meaning and Pregnancy’s Ambiguities*, 122 MICH. L. REV. 1443, 1481–82 (2024).

“respectful” disposal of fetal remains.²⁰⁹ Many were legitimately concerned that this would also require people experiencing pregnancy loss to cremate their fetal remains. Similarly, these laws villainize women who weren’t cremating, especially including those women who experience pregnancy loss on the toilet and flush.

Normalization is possible, however, even in the United States. Layne advocates for doctor–patient conversations. “Having someone initiate discussion beforehand about what it might look like, how one might feel, what one might want to do . . . would be a great help, both at the time of the loss and in terms of healthy grieving afterward.”²¹⁰ Layne advocates not only for education to pregnant patients about the chance of pregnancy loss, but also the physical mechanics,²¹¹ including the uncontrollable possible involvement of the toilet.

Another recent-ish development that could help is the miscarriage and abortion hotline. A few doctors created this hotline in 2019 for people to call if they have questions about their miscarriage or abortion.²¹² This is a specific resource for people to call and ask, “how much blood is too much?” or “where is the best place for me to be, the toilet?” Consistent with the fall of *Roe*, the hotline is especially suited to answer questions related to self-managed medication abortion.²¹³ But the two physical experiences are the same, and the hotline still specifically also exists for persons with questions about miscarriage. This hotline can help people in the moment, to reassure them of the normalcy of their experience.

But more is needed to normalize the involvement of the toilet; that more is at the least the same type of clinical and popular reassurance that is more common in other countries. Health care providers need to be educated that the involvement of the toilet, and a flush, are not evidence of indifference, much less reason for suspicion—and thus not a reason to call the police. Society needs a similar lesson. It would also be extremely helpful if the media did not sensationalize the fact that the pregnant person went to the one place, the toilet, most everyone goes when they have stomach pain.

209. Elizabeth Kimball Key, *The Forced Choice of Dignified Disposal: Government Mandate of Interment or Cremation of Fetal Remains*, 51 U.C. DAVIS L. REV. 305, 309–10, 319 (2017). Numerous states have long required formal disposition of the stillborn baby’s body. See Lens, *Miscarriage*, *supra* note 3, at 1102–03.

210. Layne, *supra* note 111, at 590.

211. *Id.*

212. Meryl Davids Landau, *People Are Flocking to a Hotline with Their Miscarriage and Abortion Questions*, EVERYDAY HEALTH (Sept. 23, 2022), <https://www.everydayhealth.com/sexual-health/people-flocking-to-hotline-with-miscarriage-and-abortion-questions> [<https://perma.cc/XT9K-CQ53>].

213. Marin Cogan & Victoria Chamberlin, *What an Abortion Hotline Reveals About Reproductive Care After Roe*, VOX (Feb. 6, 2023, 5:00 AM), <https://www.vox.com/the-goods/23580117/linda-prine-abortion-pills-medication-dobbs-roe> (on file with the *Iowa Law Review*).

B. STANDARDIZING MEDICAL CARE

Raising awareness about the realities of pregnancy loss can help reduce the suspicion and blame that often follow loss currently. Another measure that could specifically discourage health care provider suspicion and blame is to clearly define what health care providers *should* be doing for patients giving birth to their stillborn child. What the United States needs is standardized bereavement care for patients experiencing stillbirth.

This Section details three areas of bereavement care that are especially lacking in U.S. care guidelines as compared to the guidelines in England and Australia. They include empowerment of the pregnant person with respect to decisions on childbirth, encouraging parents to spend time with their stillborn child, and facilitating the creation of mementos. These three areas are especially important with respect to criminalization because they are areas where mistreatment by providers is especially likely. For instance, a health care provider may seek to punish a woman they suspect of causation by forcing vaginal delivery or denying the woman time with her child. Literature on criminalization often jumps to the harms of the arrest, the prosecution, and the jail time. Mistreatment during medical care is minimal compared to jail time, but it can still produce long-term mental health consequences.

Standardization is an anticriminalization measure because it aims to curb the effects of bias within medical care. Standardization is a current strategy within efforts to minimize the extreme racial disparity in maternal mortality in the United States. The thought is logical (and supported by research). A lack of standardization invites variation in care, including variation influenced by biases about class and race and good versus bad mothers. Standardization, on the other hand, dictates proper care and minimizes bias-influenced variation.

Health care providers' focus should be not on judging the woman's reaction or actions and calling the police. The focus should be on ensuring the pregnant person receives the best possible care such that she has the best possible long-term outcomes. Standardizing care helps that.

1. Learning from Other Countries' Care Guidelines

Anyone even adjacent to the stillbirth community is well aware of how lacking the current guidelines for medical care for stillbirth in the United States are. The current inadequacies are even more apparent when one quickly peruses the extent of the guidelines in other countries, specifically in England and in Australia.

A comprehensive review of the distinctions in bereavement guidelines is not possible in this context, but the following highlights three areas where standardization is especially needed: decisions regarding the method of childbirth; the encouraging of parents to spend time with their baby; and the creation of mementos. These are three areas especially ripe for mistreatment by health care providers, mistreatment seeking to punish women by forcing vaginal delivery, and depriving them of time with and mementos of their baby.

i. Childbirth Method Decisions

A first area with potential for mistreatment is within childbirth itself; it's the possible mistreatment of forcing a method of childbirth. This type of mistreatment is an example of obstetric violence, an umbrella label to capture unwanted medical care within obstetrical care, including childbirth. Obstetric violence also recognizes "birth justice," which is the right to give birth as desired. The usual concern for obstetric violence is forced, unwanted medical procedures, like C-sections. As I've discussed in prior work, the concern with forced delivery is flipped, however, in cases of stillbirth.²¹⁴ There, the concern is forced vaginal delivery of the patient's dead baby.

There are many reasons why a women may want a C-section instead of giving birth vaginally to their stillborn child. Some women are daunted at the idea of vaginal delivery, rationally wondering "how am I supposed to do this"—how am I supposed to give birth to my baby who is dead? In studies, women report desiring a C-section because of the mistaken belief that it might enable the baby to be resuscitated.²¹⁵ Others report fear that the baby could still feel pain and would feel less pain with a C-section.²¹⁶ Others simply desire a C-section as a means to gain some control over a situation in which they lack any control.²¹⁷ Others also specifically report resentment when doctors bring up a possibility of a next pregnancy when advising against a C-section (as the next baby would likely also need to be delivered via C-section).²¹⁸

Experts caution that with stillbirth, "it is manifestly important that women feel in control of the decision-making process and that the mode of delivery isn't imposed."²¹⁹ And it's rational to especially worry that the woman will lack that control and instead have a mode of childbirth imposed when health care providers suspect the pregnant person is at fault. Those health care providers may think it's appropriate to force her to give birth vaginally as punishment, either by denying other options or providing options but forcing vaginal delivery.

England's guidelines, created by the Royal College of Obstetricians and Gynaecologists ("RCOG"), consistently highlight the importance of control for the birthing parent.²²⁰ For example, the RCOG guidelines accentuate that

214. See Lens, *Miscarriage*, *supra* note 3, at 1091–92.

215. D. Siassakos et al., *All Bereaved Parents Are Entitled to Good Care After Stillbirth: A Mixed-Methods Multicentre Study (INSIGHT)*, 125 *BJOG* 160, 166 (2018).

216. *Id.*

217. Paul Richard Cassidy, *Care Quality Following Intrauterine Death in Spanish Hospitals: Results from an Online Survey*, 18 *BMC PREGNANCY & CHILDBIRTH* 1, 9 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC5763533/pdf/12884_2017_Article_1630.pdf [<https://perma.cc/37GP-72EA>].

218. Siassakos et al., *supra* note 215, at 164.

219. Cassidy, *supra* note 217, at 10.

220. CHRISTY BURDEN, ABI MERRIEL, DANYA BAKHBAKHI, ALEXANDER HEAZELL & DIMITRIOS SIASSAKOS, ROYAL COLL. OF OBSTETRICIANS & GYNAECOLOGISTS, CARE OF LATE INTRAUTERINE FETAL DEATH AND STILLBIRTH: GREEN-TOP GUIDELINE NO. 55, at e4 (2024) [hereinafter RCOG Stillbirth Guideline], <https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.17844> [<https://perma.cc/MKX6-X4GZ>].

doctor–patient “discussions should aim to support maternal/parental choice”²²¹ and that “a crucial component is to determine the feelings and emotional needs of the women and their companions. This empathetic approach seeks to identify and understand parents’ thoughts and wishes but without trying to shape them.”²²² More specific to labor and delivery, the guidelines state that “the mode of birth should be an informed decision between the parents and an appropriately experienced obstetrician. Vaginal birth is recommended for most women, but caesarean birth will need to be considered for some.”²²³ The guidelines focus on educating the birthing parent—providing detailed information on “both physical and psychological aspects of a vaginal birth versus a caesarean birth” and the risks and benefits of both to enable this informed decision.²²⁴ The guidelines also caution clinicians that “for some parents, in the context of late IUID [intrauterine fetal demise], a caesarean birth might be requested for reasons not anticipated by staff” and cites a study in which forty-seven percent of women surveyed described vaginal delivery with late IUID as “emotionally distressing.”²²⁵

Australia’s guidelines explain that the “optimal mode of birth” “is one that combines medical considerations and parent values, preferences and wishes.”²²⁶ The guidelines also note that parental involvement in decisions about birth “can help to increase their sense of empowerment and control and will allow for practical, social, and emotional planning.”²²⁷ More specific to methods of birth, the guidelines tell clinicians to “[a]dvise parents that labour and vaginal birth may provide physical and emotional benefit, compared to a caesarean birth without obstetric indication,” but cautions that “parents’ values, preferences, and wishes need to be respected.”²²⁸

Studies support this approach—that providing information regarding the benefits of vaginal birth and perhaps also resolving misconceptions about a C-section leading to positive (as possible) birth experiences. “[W]hen supported and given good information about potential physiological, psychological and social benefits most women see the value in a vaginal birth, and many have positive and valuable experiences.”²²⁹

221. *Id.*

222. *Id.*

223. *Id.* at e5.

224. *Id.*

225. *Id.* at e6.

226. THE CTR. OF RSCH. EXCELLENCE IN STILLBIRTH & PERINATAL SOC’Y OF AUSTRAL. & N.Z., CARE AROUND STILLBIRTH AND NEONATAL DEATH: CLINICAL PRACTICE GUIDELINE § 3, at 7 (2024) [hereinafter Australia Stillbirth Guideline], <https://learn.stillbirthre.org.au/wp-content/uploads/2024/10/CASaND-Guideline-2024-3-1.pdf> [<https://perma.cc/UgCK-SQFY>].

227. *Id.*

228. *Id.* § 3, at 8.

229. Cassidy, *supra* note 217, at 9.

ACOG's stillbirth guidelines, on the other hand, lack this emphasis on empowering the birthing parent. The guidelines state that the childbirth method should depend on the gestational age of pregnancy, the woman's medical history, and "maternal preference."²³⁰ In resolving "maternal preference," the guidelines recommend the use of "[s]hared decision making" between the doctor and patient.²³¹ Shared decision-making can be empowering. But the guidelines also say: "Health care providers should weigh the risks and benefits of each strategy in a given clinical scenario and consider available institutional expertise," and, "[i]n general, cesarean delivery for fetal demise should be reserved for unusual circumstances because it is associated with potential maternal morbidity without any fetal benefit."²³² This is medically accurate with respect to increased physical health risks for the woman and the lack of any medical benefit to the fetus, but it also does not in any way acknowledge the possibility of mental benefit for the woman (or the possibility of mental harm from vaginal delivery).

One empowering thing in ACOG's guidelines, that's not also found in RCOG's guidelines,²³³ is the mention of a non-childbirth option—a dilation and evacuation ("D&E").²³⁴ A D&E is a surgical procedure in which the doctor removes the baby in body parts. A D&E is physically safer and has lower risks of complications for the woman compared to childbirth, either vaginal or especially a C-section. But even ACOG's guidelines specifically condition offering a D&E on the availability of "an experienced health care provider."²³⁵ Availability is becoming increasingly difficult because a D&E is also used for second-trimester abortion. Abortion bans have meant less training on abortion procedures, even though those same procedures are used for pregnancy loss. Thus, even though ACOG's guidelines recognize essentially a birth justice right to a D&E, a woman may very well lack access to a doctor who can and will perform a D&E both because of chilling from abortion bans and lack of training.

Mistreatment in forcing a method of birth is especially troubling, but other more subtle methods of mistreatment also exist. They include being deprived of a private space during and after birth. Many stillbirth moms report in studies the distress they experienced upon hearing women in next-door rooms giving birth to their living children, or hearing the song the labor and delivery unit played every time a child was born (alive).²³⁶

230. ACOG, *Management of Stillbirth*, *supra* note 2, at e122.

231. *Id.*

232. *Id.* at e122–23.

233. A D&E is not an option in RCOG guidelines because a D&E "is not widely available in the NHS because there are few gynaecologists with the necessary skills." AIMEE LOUISE MIDDLEMISS, *INVISIBLE LABOURS: THE REPRODUCTIVE POLITICS OF SECOND TRIMESTER PREGNANCY LOSS IN ENGLAND* 38 (2024).

234. ACOG, *Management of Stillbirth*, *supra* note 2, at e122.

235. *Id.*

236. Kelley & Trinidad, *supra* note 107, at 5–6.

The RCOG guidelines recognize the importance of a separate space. “Maternity units should aim to develop a special labour ward room for women who are physically well with an otherwise uncomplicated late IUFD that pays special heed to emotional and practical needs without compromising safety” and is “away from the sounds of other women and babies.”²³⁷

There’s nothing in ACOG’s guidelines about a private space. Admittedly, private spaces may not be feasible. But there’s nothing even in ACOG guidelines suggesting a sticker to be put on the door of the room to help prevent a worker from accidentally asking questions about the newborn (live) baby.

Health care providers are least likely to be worried about the additional traumas of forcing vaginal delivery or denying private spaces when they also suspect the birthing parent of causation. Clarity in ACOG’s guidelines can help minimize the influence of these biases, and hopefully at least improve the medical care people receive when giving birth to their stillborn child.

ii. Encouraging Parents to Spend Time with Their Child

Another area of medical care with high potential of mistreatment concerns ensuring the parents are given time with their stillborn baby after birth. This exceedingly important component of care after stillbirth is enabling and encouraging parents to spend time with their baby—to make memories. Consistently, other countries’ guidelines for care for stillbirth highlight the importance of encouraging parents to spend time with their child.

Australia’s bereavement-specific guidelines explain that “[s]pending time and engaging with their baby can help parents to create a social identity for the baby, and for themselves as parents, while simultaneously providing an opportunity to say goodbye.”²³⁸ The guidelines are clear that health care providers are to “[e]nable parents . . . to spend as much time as they wish in private with their baby who is dying or who has died.”²³⁹ This includes “offering all parents the opportunity to see and hold their baby immediately after birth, including skin-to-skin contact with their baby.”²⁴⁰ Importantly, the guidelines also instruct providers to “[p]repare parents for seeing and holding their baby by giving information about the baby’s physical appearance, size, tone, and temperature.”²⁴¹ Parents should be offered opportunities to hold and spend time with their baby more than once, so additional times should be offered even if parents initially decline.²⁴² It can be more than just time with the baby also. For instance, Australia’s guidelines instruct health care providers

237. RCOG Stillbirth Guideline, *supra* note 220, at e12.

238. Australia Stillbirth Guideline, *supra* note 226, § 3, at 9.

239. *Id.* § 3, at 10.

240. *Id.*

241. *Id.*

242. *See id.*

to “[v]alidate parenthood and support memory making by . . . normalising and supporting parenting activities such as bathing and dressing their baby.”²⁴³

England’s RCOG guidelines also recognize the importance of this time, although less intensely. The guidelines state that “[t]he opportunity to spend time with a baby, and to make memories with a baby should be actively supported and offered.”²⁴⁴ The guidelines explain “[i]t is reasonable to offer parents a chance to see their baby more than once” and to explain “that they can change their mind at any point,” but also that a parent’s decision “should be respected.”²⁴⁵ The RCOG guidelines also include a link to a “[c]reating memories – offering choices” document created by England’s National Bereavement Care Pathway that can help parents make decisions.²⁴⁶

The United States’ guidelines are especially lacking on this important bereavement practice. ACOG’s guidelines mention holding the baby only twice—and neither in the context of recognizing the importance of holding the baby within caring for the parents. The first mention is under the heading “Methods of Delivery.”²⁴⁷ That mention is that holding the baby will not be possible with a D&E, and thus parents should consider that fact when evaluating whether they want a D&E (assuming there’s a provider willing to do one).²⁴⁸ The second mention of holding the baby is within the section on fetal autopsy, stating that one should be offered and that “[p]arents should be given the opportunity to hold the baby and perform cultural or religious activities before the autopsy.”²⁴⁹

Neither of these mentions conveys to health care providers the importance of the opportunity to hold the baby for the parents’ mental health benefits. To the contrary, the reader would likely wonder, “Why is this guideline mentioning holding the baby?” By not conveying or even explaining the importance of holding the baby, this guideline, issued in March 2020, still contains remnants of standard of care before the 1980s, when the baby was taken away after birth to encourage the parents to move on and get pregnant again. There’s also unsurprisingly nothing in ACOG’s guidelines obviously about health care providers explaining and preparing parents to hold the baby. Again, without instructions about the importance of spending time with the baby, health care providers are especially likely to deprive suspicious birthing parents of this crucial bereavement practice.

Admittedly, ACOG’s guidelines do include a Table 4 that lists “Principles of Bereavement Care,” which say:

243. *Id.*

244. RCOG Stillbirth Guideline, *supra* note 220, at e21.

245. *Id.*

246. *Id.*

247. ACOG, *Management of Stillbirth*, *supra* note 2, at e122.

248. *See id.*

249. *Id.* at e118.

Recognition of parenthood and the role of memory making is vitally important as it is thought to assist with the actualization of grief and the slow transition of the parents' relationship with their baby from one of presence to one of memory. One of the greatest regrets that bereaved parents have reported is the lack of memories of their baby.²⁵⁰

But there's nothing in the guidelines about assisting parents to ensure they have those memories (or defining "memory making" or citing any studies about the importance of memory making).

iii. Creation of Mementos

Related closely to the care in encouraging parents to spend time with their stillborn baby, and another likely ripe for mistreatment, is the creation of mementos. Again, research says mementos are important, and both Australia's and England's guidelines emphasize that importance.

Australia's guidelines state that caregivers are to "[o]ffer and facilitate opportunities to gather tangible mementos of the baby (for example photographs, identification tags, cot cards, locks of hair, handprints and footprints)" and that the offer should be made to parents "more than once."²⁵¹ Also, in case parents do not wish for mementos but later change their mind, the guidelines advise the creation and awareness of "processes for storing mementos . . . for parents who may wish to collect them later when/if they are ready."²⁵² More specific to photos, the guidelines tell clinicians to "[f]acilitate access to a professional photographer who has experience in compassionate bereavement photography, if desired by parents" and include a link to tips for taking bereavement photos for health care providers in case no such photographer is available.²⁵³ The guidelines also explain that photos can help "validat[e] their baby's existence, their parenthood, and their baby's place in the family unit," "support[] creation of a family legacy and a continuing bond," and "creat[e] a permanent and tangible record that can provide parents with comfort and reassurance and relieve fears of forgetting their baby over time."²⁵⁴

England's guidelines are similar on the importance of mementos. To quote, "[m]aternity units should have the facilities for producing good-quality photographs, palm and footprints and locks of hair with presentation frames."²⁵⁵ RCOG advises that "[a]rtifacts of remembrance should be offered to parents to keep."²⁵⁶ The RCOG guideline also refers clinicians to the National Bereavement Care Pathway for Stillbirth, which explains that "[m]any parents

250. *Id.* at e123.

251. Australia Stillbirth Guideline, *supra* note 226, § 3, at 12.

252. *Id.*

253. *Id.* at 11–12.

254. *Id.* at 11.

255. RCOG Stillbirth Guideline, *supra* note 220, at e21.

256. *Id.*

treasure the photographs taken of their baby and of the time they spent together.”²⁵⁷ The pathway also mentions other types of mementos like hand and foot prints, a record of the baby’s weight and height, the baby’s cot card, identification bracelet, a lock of hair, and the baby blanket the baby was wrapped in.²⁵⁸

As already mentioned, there is mention in the ACOG guidelines that “[o]ne of the greatest regrets that bereaved parents have reported is the lack of memories of their baby.”²⁵⁹

But there’s nothing in ACOG’s guidelines about enabling memory making and the type of mementos that can be created and help with that memory making.

2. Preventing Variation in Care and Curbing Criminalization

After just this brief comparison to England’s and Australia’s guidelines regarding bereavement care for stillbirth, there’s little doubt that ACOG’s guidelines are lacking. What’s less clear, however, is how helpful standardization of care could be within anticriminalization efforts.

Notably, standardization is a current strategy to help address the influence of bias within medical care. The thought is that standardization helps minimize variation in care, including variations motivated by the type of class and racial biases that are perhaps behind many health care provider phone calls to police.

Research supports this. Numerous studies have demonstrated racial disparities in drug testing of pregnant patients, disparities that doctors were more likely to test Black pregnant women than non-Black pregnant women. “Testing patients for drug use during pregnancy is fraught with biases. Patient and provider characteristics can contribute to differential screening and testing, resulting in criminalization and stigmatization.”²⁶⁰ Doctors at a Philadelphia hospital hoped that a standardized policy based on medically relevant indications would help reduce racial disparities in testing. It did. A study published in 2023 looked at the results of the adoption of such a standardized policy, replacing a prior practice of provider discretion. The study’s results showed that “[t]he implementation of clear guidelines with medically relevant indications for biological testing reduces overall testing and decreases disparities based on race without increasing the risk of [neonatal

257. NAT’L BEREAVEMENT CARE PATHWAY FOR PREGNANCY & BABY LOSS, STILLBIRTH: FULL GUIDANCE DOCUMENT 18 (2022), <https://www.nbcpathway.org.uk/wp-content/uploads/2024/03/NBCP-Stillbirth-July-2022.pdf> [<https://perma.cc/52M6-E329>].

258. *Id.* at 19.

259. ACOG, *Management of Stillbirth*, *supra* note 2, at e123.

260. Jessica A. Peterson, Nathanael C. Koelper, Cara Curley, Sarita R. Sonalkar & Abike T. James, *Reduction of Racial Disparities in Urine Drug Testing After Implementation of a Standardized Testing Policy for Pregnant Patients*, AM. J. OBSTETRICS & GYNECOLOGY MATERNAL FETAL MED., May 2023, at 1, 5 (footnote omitted).

abstinence syndrome].”²⁶¹ Racial disparities in testing decreased, but “disparities based on insurance type persisted.”²⁶² The study’s authors suspected this was due to the indication of “limited or lack of prenatal care” given that Medicaid can be difficult to obtain such that timely prenatal care can begin.²⁶³

A 2020 study on labor induction found similar results. The study first noted the role of implicit bias in disparities in care and that “[t]o target differential management, studies in non-obstetrical populations have indicated disparity reduction through care standardization.”²⁶⁴ This study aimed for this same result within standardization of care for women undergoing labor induction. The result was a thirty-five percent decrease in C-section deliveries for Black women with no significant adverse effects on maternal morbidity.²⁶⁵ The study’s authors posited that “if implicit bias is at work in obstetrics and providers are managing patients’ labor courses differently by race, a standardized labor induction protocol could lead to nondifferential treatment, thereby reducing complications and disparities that occur secondary to management variation.”²⁶⁶

Experts working on maternal mortality and its extreme racial disparities are similarly focusing on standardization. The Alliance for Innovation on Maternal Health (“AIM”), supported via grants from the Health Resource and Services Administration within the U.S. Department of Health and Human Resources, has developed numerous patient safety bundles.²⁶⁷ They include bundles for obstetric hemorrhage, sepsis, perinatal mental health conditions, and severe hypertension in pregnancy. AIM describes that the bundles “include[] actionable steps that can be adapted to a variety of facilities and resource levels,” and that the goals of the bundles is to “improve the way care is provided to improve outcomes.”²⁶⁸ Many believe and hope that standardizing care will “mitigate variation in care and disparate outcomes.”²⁶⁹ The bundles thus far have had promising results.²⁷⁰

261. *Id.* at 6.

262. *Id.* at 5.

263. *See id.* at 5.

264. Rebecca F. Hamm, Sindhu K. Srinivas & Lisa D. Levine, *A Standardized Labor Induction Protocol: Impact on Racial Disparities in Obstetrical Outcomes*, AM. J. OBSTETRICS & GYNECOLOGY MATERNAL FETAL MED., Aug. 2020, at 1.

265. *Id.* at 4.

266. *Id.* at 7.

267. *Patient Safety Bundles*, ALL. FOR INNOVATION ON MATERNAL HEALTH, <https://saferbirth.org/patient-safety-bundles> [<https://perma.cc/FY2Y-7MV8>].

268. *Id.*

269. Laura Williamson, ‘*Safety Bundles*’ May Reduce Pregnancy-Related Deaths, Particularly Among Black Women, AM. HEART ASS’N (Apr. 11, 2024), <https://www.heart.org/en/news/2024/04/11/safety-bundles-may-reduce-pregnancy-related-deaths-particularly-among-black-women> [<https://perma.cc/ADS8-HAXJ>].

270. *See generally* Catherine Squire Eppes et al., *Enhancing Obstetric Safety Through Best Practices*, 30 J. WOMEN’S HEALTH 265 (2021) (finding that bundles decreased maternal mortality and more efficiently handled maternal emergencies).

Standardization of care alleviates the influence of bias by telling the health care providers what they *should* be doing. The same can be true within stillbirth bereavement care. This is a patient experiencing something that can be extremely traumatic. The focus should be on ensuring the patient has the best mental and physical outcomes, not on calling the police.

Moreover, standardization can help ensure that women suspected of causation are still at least treated with care during pregnancy loss. The possibility of mistreatment by health care providers is extremely problematic. One usually jumps to the harm of the criminalization process, but there are also harms from mistreatment during medical care for stillbirth. Research is clear that “the provision of care for families when a child is stillborn is vitally important to prevent short and long-term negative outcomes.”²⁷¹ The treatment received in the hospital is “believed to have a significant effect on how” parents are eventually able to adapt to or resolve their grief.²⁷² Similarly, the care and “support received by the mother following the death of her child was the single most important factor in predicting the nature of the grief process that she would experience.”²⁷³ And all health care worker “[b]ehaviours and actions” and “verbal and non-verbal communications with and around parents can have a memorable impact.”²⁷⁴ Mistreatment by medical providers can mean long-term mental health consequences.

And there’s every reason to suspect that medical providers may treat those they suspect of causation of pregnancy loss differently than they would treat those they do not suspect. In her book, Grace Howard discusses research showing that women who test positive for drug use during pregnancy “often had negative experiences at the hospital” with hospital staff treating them with less support and even abusively.²⁷⁵ Even women in drug treatment reported as being treated as “just a junkie” when giving birth.²⁷⁶ Similarly, Howard recounts Dorothy Roberts’s work explaining that women who tested positive for drug use at a hospital in South Carolina “felt the hospital nurses intentionally neglected them and withheld pain medication when they were in labor, seemingly as a punishment for using drugs.”²⁷⁷

Specific to stillbirth, the minimal research that exists of stillbirth parents’ lived experiences of the treatment they receive from health care providers

271. Alison Ellis et al., *Systematic Review to Understand and Improve Care After Stillbirth: A Review of Parents’ and Healthcare Professionals’ Experiences*, BMC PREGNANCY & CHILDBIRTH 2 (Jan. 25, 2016), <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0806-2> [https://perma.cc/6WSR-7M58].

272. Kirkley-Best & Kellner, *supra* note 108, at 424.

273. Ellis et al., *supra* note 271, at 2.

274. *Id.* at 10.

275. HOWARD, *supra* note 26, at 134.

276. *Id.*

277. *Id.*

suggests that biases influence the medical care received, with Black stillbirth parents often reporting feeling mistreated.²⁷⁸

Anecdotes support the likelihood of mistreatment. In her lawsuit, Watts specifically alleges that she indicated her preference for a D&E over labor induction, yet no doctor offered her one nor did any doctor inform her of an ability to obtain a D&E from a different hospital.²⁷⁹ Maybe no doctor was experienced with the D&E procedure,²⁸⁰ or maybe they disregarded Watts's wishes to punish her. Watts also alleges that "while the hospital staff should have been treating Ms. Watts with great care, Defendant Moschell, a nurse, decided to call the police to falsely report Ms. Watts had committed a crime."²⁸¹ The lack of sufficient guidelines of *how* to treat Ms. Watts enabled this mistreatment.

The same is true for Chelsea Becker and Adora Perez. Becker remembers her health care providers treating her with suspicion.²⁸² Becker explained that she briefly held her baby, confused and wondering whether he would be alive had the doctors done an emergency C-section²⁸³—a very rational wonder given his heart was still beating when Becker arrived at the hospital and for two hours after. It's unclear whether Becker only "briefly" held her baby because of her own desire or due to provider mistreatment. Regardless, she should have been offered numerous opportunities to spend time with him; guidelines should be clear on the importance of offering numerous opportunities. Becker has also shared that "the hospital had left her baby on a table at the other end of the room for hours on end."²⁸⁴ And "[t]hat image of me lying in the hospital bed with my deceased son left on a table, seemingly abandoned, is an image I will never forget."²⁸⁵ This should not have been a part of her medical care. ACOG guidelines need to be clear on that.

278. Jackelyn Y. Boyden, Karen Kavanaugh, L. Michele Issel, Kamal Eldeirawi & Kathleen L. Meert, *Experiences of African American Parents Following Perinatal or Pediatric Death: A Literature Review*, 38 DEATH STUD. 374, 377 (2014).

279. Complaint, *supra* note 24, at 6–7.

280. See *supra* notes 233–35 and accompanying text (discussing the decreased availability of a D&E). Of note is that the hospital where Watts sought treatment is a Catholic hospital, likely also affecting the availability of a D&E. See Daniella Silva, *Ohio Woman Who Miscarried at Home Won't Be Criminally Charged, Grand Jury Says*, NBC NEWS (Jan. 11, 2024, 1:22 PM), <https://www.nbcnews.com/news/us-news/ohio-woman-miscarried-home-will-not-criminally-charged-grand-jury-says-rcna132093> [<https://perma.cc/SB7W-EM3P>].

281. Complaint, *supra* note 24, at 3.

282. Sam Levin, *She Was Jailed for Losing a Pregnancy. Her Nightmare Could Become More Common*, GUARDIAN (June 28, 2022, 12:56 PM), <https://www.theguardian.com/us-news/2022/jun/03/california-stillborn-prosecution-roe-v-wade> [<https://perma.cc/PU7C-SWQG>].

283. *Id.*

284. *Id.*

285. *Id.*

Adora Perez has similarly shared that her health care providers knew of her past history of drug use and drug use during pregnancy.²⁸⁶ Her health care providers were “kind” to her at first, telling her “to take her time holding her son.”²⁸⁷ But later in the night, those same providers sedated her and took her son away for testing.²⁸⁸ Perez woke up and saw her son was gone and immediately started crying that she once again lost her son.²⁸⁹ Even more heartbreaking, Perez doesn’t have a picture of Hades.²⁹⁰ She clings to the memory of holding him, fears forgetting what he looked like, and feels guilty that she may forget what he looked like.²⁹¹ Proper health care would have included the creation of mementos. Perez should have a picture of her son. Standardized care would increase the chances that she today would have one.

Again, ACOG’s guidelines are extremely lacking with respect to proper bereavement care. That lack of guidance encourages variation in care, including variation influenced by bias. Standardizing care can help alleviate the biases that lead health care providers to call the police and likely mistreat the pregnant person that they should be caring for.

ACOG’s guidelines need revision, but change is more difficult in a country like the United States without government-provided health care. The government-run National Health Services can mandate changes to standard of care in England quite easily, as can the government-run system in Australia. But in the United States, guidelines created by professionals and governments do not tend to dictate medical standards of care (save for banning abortion and gender-affirming care for transgender children).

In the summer of 2024, however, one government entity did suggest to ACOG that it revisit its guidelines for care during stillbirth. The National Institute of Child Health and Human Development (“NICHD”) Stillbirth Working Group of Council released a report with many recommendations, including development and standardization of bereavement care for stillbirth.²⁹² Whether any changes will come from it is another question, but still. The NICHD Stillbirth Working Group specifically recommended the creation of an AIM bundle for care during stillbirth, believing that such a bundle could standardize care.²⁹³

286. Cecilia Nowell, *She Used Drugs While Pregnant. Should She Be in Prison?*, CUT (Sept. 20, 2021), <https://www.thecut.com/2021/09/feature-adora-perez-stillbirth-prison.html> (on file with the *Iowa Law Review*).

287. *Id.*

288. *Id.*

289. *Id.*

290. *Id.*

291. *Id.*

292. NAT’L INST. OF CHILD HEALTH & HUM. DEV., WORKING TO ADDRESS THE TRAGEDY OF STILLBIRTH: IMPLEMENTATION RECOMMENDATIONS 8 (2024), https://www.nichd.nih.gov/sites/default/files/inline-files/NICHD_Stillbirth_WG_Report_July_2024_508.pdf [<https://perma.cc/VA99-CR6G>].

293. *Id.* at 11–12.

Unfortunately, even if guidelines were standardized, they lack any enforcement mechanism. There is the possibility of liability for medical malpractice, but damages for denying a parent time with their child would be purely noneconomic and possibly minimal. One thing that could be helpful though is requirement of use by the Joint Commission. Hospital accreditation by the Joint Commission is usually required for reimbursement of federal Medicare funds.²⁹⁴ Not coincidentally, hospitals often adopt any guidelines required by the Joint Commission.

III. PAUSING THE ANTICRIMINALIZATION CALLS FOR REPEAL

Holistic anticriminalization nonlegal reforms are needed. But what about legal reforms? Legal reform may be incomplete, but couldn't legal reforms—the commonly called-for repeal of fetal personhood laws—still accompany holistic reform efforts?

Fetal personhood laws are those that treat the fetus the same as a living person, including wrongful death claims and murder statutes. If a fetus dies due to tort, the parent often has a wrongful death claim no different than if their living child dies due to tort. The state can prosecute someone who kills a fetus no different than it can prosecute someone who kills a living child. Many anticriminalization advocates believe that repeal is needed because such laws “enshrine the logic of a dual personhood into our legal and political systems” and that “repealing these statutes is crucial to healing the harms” from pregnancy criminalization.²⁹⁵

Repealing fetal personhood statutes is not only an incomplete solution. It is also harmful. That harm is to the families bereaved by tortiously and criminally caused pregnancy loss. The perspective of these families is often overlooked in anticriminalization efforts, and in efforts to protect abortion rights. But one cannot tell the story of these fetal personhood laws without also telling the stories of the many bereaved parents and families who saw their pregnancy losses as the deaths of their babies—and fought for legal reforms to tort and criminal laws to recognize the deaths as such. Repealing fetal personhood statutes invalidates and devalues the experiences of families bereaved after pregnancy loss.

Families bereaved after pregnancy loss are more than unavoidable collateral damage. Fetal personhood laws should remain in place to validate their harms. Other legal reforms, however, can and should accompany this Article's described holistic measures. Anticriminalization efforts should focus on affirming these laws' inapplicability to pregnant people and follow California's lead in the creation of other tangible deterrents.

294. *What Is Accreditation?*, JOINT COMM'N, <https://www.jointcommission.org/en-us/accreditation/what-is-accreditation> [https://perma.cc/7KNW-ULEA].

295. KAVATTUR ET AL., *supra* note 13, at 49.

A. *THE HARMS OF REPEALING FETAL PERSONHOOD LAWS*

It's impossible to deny that antiabortion motivations were sometimes behind fetal personhood statutes. Sometimes that was extremely obvious, like in the opinions of Justice Parker of the Supreme Court of Alabama.²⁹⁶ Antiabortion motivations also seem obvious when Jonathan Mitchell, the author of Texas's SB8 six-week abortion ban, is filing wrongful death lawsuits in Texas for abortions.²⁹⁷ Even when less explicit, it is now well known that applying tort and criminal laws to fetal death was an explicit part of long-term antiabortion strategy.²⁹⁸ And even if not involved in the creation of the laws, antiabortion advocates were happy to capitalize on them.

But that's not the whole story behind fetal personhood statutes.²⁹⁹ Often overlooked is the role played by bereaved parents in the creation of those statutes—parents who after pregnancy loss wanted to sue for the death of their child, who after pregnancy loss wanted to see the killer brought to justice. These laws were also about the bereaved families who fought for some recognition of their child. And that bereaved parent perspective is often lost within calls to repeal fetal personhood statutes.

In the wrongful death context, bereaved parents viewed stillbirth as their child's death. They didn't want to sue for some nondescript bodily injury; they wanted to sue for the death of their child. They sued for wrongful death, aiming to get the court to declare that the wrongful death statute applied also to the death of an unborn child. These efforts started long before *Roe*.

296. See generally *Hamilton v. Scott*, 97 So. 3d 728 (Ala. 2012) (Parker, J., concurring); *Ex parte Ankrom*, 152 So. 3d 397 (Ala. 2013) (Parker, J., concurring); *Stinnett v. Kennedy*, 232 So. 3d 202 (Ala. 2016) (Parker, J., concurring).

297. See, e.g., Eleanor Klibanoff, *Galveston Man Drops Wrongful Death Claims Against Women Who Allegedly Helped His Ex-Wife Get an Abortion*, TEX. TRIB. (Oct. 11, 2024, 8:00 AM), <https://www.texastribune.org/2024/10/11/texas-abortion-assistance-lawsuit-dropped> [<https://perma.cc/K64P-C4E3>]; Susan Rinkunas, *Texas Man Sues California Doctor to Try to Prevent Girlfriend from Getting Abortion Pills*, JEZEBEL (July 23, 2025, 6:36 PM), <https://www.jezebel.com/texas-man-sues-california-abortion-pill-provider-for-wrongful-death-over-girlfriends-alleged-abortion> [<https://perma.cc/PS37-447N>]; Carter Sherman, *Texas Woman Files Wrongful Death Suit Saying She Was Dosed with Abortion Pills*, GUARDIAN (Aug. 11, 2025, 8:26 PM), <https://www.theguardian.com/us-news/2025/aug/11/texas-lawsuit-abortion-pill> [<https://perma.cc/C7WY-E2NC>].

298. Donley & Lens, *supra* note 44, at 1659; see Kenneth A. De Ville & Loretta M. Kopelman, *Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy*, 27 J.L. MED. & ETHICS 332, 335 (1999).

299. This argument in this Section is limited to statutes motivated by bereaved parents and that actually aid bereaved parents, albeit sometimes intangibly, like wrongful death and murder/homicide statutes. There are other fetal personhood statutes that don't do anything to aid bereaved parents. For instance, Arkansas's state constitutional amendment states it is the public policy of the state to "protect the life of every unborn child from conception until birth," but language like this does nothing practically. *Knowlton v. Ward*, 889 S.W.2d 721, 726 (Ark. 1994). When the fetal personhood statute lacks any benefit for bereaved parents and is instead purely expressive, I would fully support its repeal.

In 1963, Richard and Karen Kwaterski were in a car accident caused by a tortious driver.³⁰⁰ Karen was eight months pregnant at the time, and the car accident killed the Kwaterskis' unborn son. They sued for their child's wrongful death, seeking damages for "the loss of society and companionship of the child" and for burial expenses.³⁰¹ The Wisconsin Supreme Court agreed that wrongful death law should apply to their viable son's stillbirth.³⁰² The reasoning emphasized that the child was viable, the illogic of applying wrongful death law to tortious death just after birth but not before, and that "[a] family who loses a child before it is born suffers a very grievous loss."³⁰³

In 1966, Nancy Baldwin was in a car accident caused by a tortious driver.³⁰⁴ She was thrown from the car and severely injured. She was also twenty-eight weeks pregnant. The accident killed the baby.³⁰⁵ Two days later, Baldwin gave birth to her stillborn child, named Michael Allen Baldwin.³⁰⁶ She and her husband argued that state wrongful death law should also apply to her child's stillbirth, and West Virginia's highest court agreed, devoting much ink to the illogic that the wrongful death claim exists for a baby who dies due to tort just after birth, but not one who dies due to tort just before birth.³⁰⁷

These two cases were not alone. Minnesota was the first state to apply wrongful death law to viable stillbirths in 1949.³⁰⁸ The Wisconsin Supreme Court's 1967 decision in agreement noted that ten other state courts had ruled similarly.³⁰⁹ In 1975, the Washington Supreme Court similarly applied wrongful death law to tortiously caused viable stillbirths and noted the "definite trend" in allowing this recovery.³¹⁰ This decision was 1975, post-*Roe*, but it's describing a "definite trend" that started long before *Roe*. The timing alone shows that the ideas behind applying wrongful death law to viable pregnancy losses was not about a quest to make abortion illegal (it already was).

That bereaved-parent-perspective motivation for wrongful death law was also on display when the Iowa Supreme Court applied wrongful death law to viable stillbirth ten years after *Roe*. This case also involved a car accident. Donna Dunn, her two-year-old daughter, and the baby in her womb (she was seven and one-half months pregnant) were all killed by a tortious driver.³¹¹

300. *Kwaterski v. State Farm Mut. Auto. Ins. Co.*, 148 N.W.2d 107, 108 (Wis. 1967).

301. *Id.*

302. *Id.* at 112.

303. *Id.* at 110–11.

304. *Baldwin v. Butcher*, 184 S.E.2d 428, 429 (W. Va. 1971).

305. *Id.*

306. *Id.*

307. *Id.* at 434–35.

308. See *Verkennes v. Corniea*, 38 N.W.2d 838, 841 (Minn. 1949); *Kwaterski*, 148 N.W.2d at 109–10 (describing other courts' application of state wrongful death law to viable stillbirths).

309. *Kwaterski*, 148 N.W.2d at 109–10.

310. *Moen v. Hanson*, 537 P.2d 266, 267 (Wash. 1975).

311. *Dunn v. Rose Way, Inc.*, 333 N.W.2d 830, 831 (Iowa 1983).

Dunn's husband filed three claims for wrongful death.³¹² This was after *Roe*; maybe Dunn wanted to attempt to chip away at the legality of *Roe*. Or maybe Dunn just wanted to seek full compensation for the injury he suffered—the deaths of his wife, daughter, and unborn child. The Iowa Supreme Court viewed the claim similarly, explaining: “What is involved here is a right of recovery given to a parent,” and “the parents’ loss certainly does not vanish because the deprivation occurred prior to birth.”³¹³

It's similarly impossible to tell the story of fetal personhood homicide statutes without the involvement of bereaved parents and family. A famous example, and the law that motivated many similar state laws, is the federal Unborn Victims of Violence Act, which creates a separate offense for the harming or killing of an “unborn child” within certain federal crimes.³¹⁴ Scott Peterson killed his wife Laci when she was eight months pregnant with their son.³¹⁵ After their deaths, Laci's mom, Sharon Rocha, lobbied for the Unborn Victims of Violence Act, also known as “Laci and Conner's Law.”³¹⁶ Rocha explained: “Our grandson (Conner) did live. . . . He had a name, he was loved and his life was violently taken from him before he ever saw the sun.”³¹⁷ President Bush signed the law in 2004.³¹⁸

Lobbying to state legislatures followed. In 2006 in Florida, Laura Davis was killed by her boyfriend.³¹⁹ Laura was twenty-six weeks pregnant.³²⁰ The boyfriend took a plea deal for second-degree murder. Laura's mother, Donna Davis, spent the next eight years of her life lobbying Florida legislators to apply homicide laws to all caused pregnancy loss regardless of gestational age.³²¹ Florida's Unborn Victims of Violence Act became law in 2014.³²²

Also in 2006, Chelsea Ann Brooks was murdered in Wichita, Kansas.³²³ She was pregnant and due in less than a month. The baby was a girl, whom Chelsea had already named Alexa.³²⁴ Chelsea's killer was charged with homicide

312. *Id.*

313. *Id.* at 833.

314. 18 U.S.C. § 1841 (2018).

315. Michael Doyle, *Laci Law Impact Remains Unclear*, *MODESTO BEE* (Aug. 31, 2008, 7:52 AM), <https://www.modbee.com/news/local/article3113582.html> [<https://perma.cc/LX8T-BX36>].

316. *Id.*

317. *Id.*

318. *Id.*

319. Britt Kennerly, *A Mom's Promise Is Finally Fulfilled*, *FLA. TODAY* (May 4, 2014), <https://plus.lexis.com/api/permalink/5358e423-e36-4f18-bbad-00cb95c503f> (on file with the *Iowa Law Review*).

320. *Id.*

321. *Id.*

322. *Id.*

323. Roxana Hegeman, *Wichita Family Mourns Pregnant Teen's Death*, *LAWRENCE J.-WORLD* (June 18, 2006, 12:00 AM), https://www2.ljworld.com/news/2006/jun/18/wichita_family_mourns_pregnant_teens_death [<https://perma.cc/L9CB-937E>].

324. *See id.*

for her death, but Kansas law lacked any sort of charge for the fetal death.³²⁵ Chelsea's mother explained that "[t]wo lives were taken from us . . . and we will do whatever it takes to make sure that the law, in the future, recognizes all life, even if it is too late for our girls."³²⁶ Lobbying by Chelsea's family, including a website gathering signatures in support, led to the passage of Alexa's Law in 2010.³²⁷

North Carolina's law is called Ethen's Law, named after the child of Jennifer Nielsen.³²⁸ Nielsen was attacked when she was eight months pregnant.³²⁹ Her murder remains unsolved, but her death sparked the legal change allowing for the prosecution of the killer for both her death and her unborn son's death.³³⁰

After his wife and unborn son were killed, Joe Daly and his family pushed for changes to Ohio law, which ended with the passage of Daly Law.³³¹ Suzanne Daly was killed in a car crash.³³² She was pregnant with her son, whom they had named Austin Joseph.³³³ The crash was caused by a sixteen-year-old driving a stolen vehicle on the wrong side of the road.³³⁴ The sixteen-year-old was charged with aggravated vehicle homicide and other charges, but only with respect to Suzanne's death.³³⁵ Joe and his sister pushed for legislative change and the legislature changed homicide and assault laws to also apply to fetal death and fetal injury.³³⁶

Bereaved parents played a significant role in the creation of fetal personhood statutes, seeking recognition of the death of their child whether through tort recompense or the possibility of criminal punishment. Repealing those statutes erases that recognition. Repealing those statutes communicates to bereaved families that their harm was something less than the death of their child. It forces legal devaluation for those who would seek tort recourse for

325. *Id.*

326. *Id.*

327. See John Hanna, 'Alexa's Law' Advances; Critics Question Need for It, LAWRENCE J.-WORLD (Feb. 16, 2007, 12:00 AM), https://www2.ljworld.com/news/2007/feb/16/alexas_law_advance_s_critics_question_need_it [<https://perma.cc/FLL7-VYX9>]; KAN. STAT. ANN. § 21-5419 (West 2025).

328. *Ethen's Law to Go into Effect This Week; Protects Unborn Babies*, WECT NEWS 6 (Dec. 2, 2011, 8:55 PM), <https://www.wect.com/story/16148267/ethans-law-to-protect> [<https://perma.cc/PL E9-C3MC>].

329. *Id.*

330. Jeff Reeves, *10 Years Later, Jenna Nielsen's Brutal Murder Still Unsolved*, CBS 17 (Nov. 1, 2017, 5:20 PM), <https://www.cbs17.com/news/10-years-later-jenna-nielsens-brutal-murder-still-unsolved> [<https://perma.cc/H295-QXUM>].

331. Rick McCrabb, *Changing Ohio Fetus Law 'Was About Doing What Was Right,'* DAYTON DAILY NEWS (June 4, 2016), <https://www.daytondailynews.com/news/local/changing-ohio-fetus-law-was-about-doing-what-was-right/rKIBsv8osWKRmGbp73qDK> [<https://perma.cc/XF8D-QW8K>].

332. *Id.*

333. *Id.* ("Daly named his son Austin because he found a list of potential baby names and his wife had circled Austin.")

334. *Id.*

335. *Id.*

336. *Id.*

their death of their (unborn) child as they would be forced to sue for something less than that death. The lack of criminal consequences communicates to those parents a lack of state concern and validation of that harm.

Repealing wrongful death and criminal laws as applied to fetal death is not inconsequential—it involves tangible harm to bereaved families. This is harm not only to the bereaved families who worked to get these laws passed, but also the future bereaved families who would have benefitted from these fetal personhood laws. Repealing would deny and invalidate that bereaved parent perspective and make bereaved parents yet again collateral damage in efforts to protect reproductive rights.³³⁷

B. REEXAMINING THE PERSONHOOD IN “FETAL PERSONHOOD” STATUTES

Harms exist in potential repeal, but what about the harm created by the existence of the statutes? As mentioned, many believe that these laws maintain some sort of fetal personhood, an idea where the fetus can be viewed as a person and elevated as more important than the pregnant person. These are very legitimate concerns. But perhaps some of this reaction is about antiabortion narratives of these statutes as opposed to what the statutes actually do. Similarly, remembering the roles of bereaved families also helps to answer some of the (very legitimate) concerns about the laws.

An initial question is whether these statutes do truly create fetal personhood. The answer to that question, however, depends on how one defines personhood.³³⁸ For Fourteenth Amendment purposes, being a person would mean having due process rights, including the right to not be killed by the state (without due process first).³³⁹

Neither wrongful death nor murder statutes provide the fetus any rights. These statutes do not empower the fetus as its own person; they do not convey to the fetus any of the rights a living person has. In fact, these statutes do not empower the fetus in any way. The fetus can't sue for wrongful death; a wrongful death cause of action belongs to the family member, in this case the parent(s).³⁴⁰ Applying murder law to fetal death similarly does not enable the fetus to sue anyone nor create a right to not be killed. The murder law hopefully deters people from causing pregnancy loss, but that's not a right to not be killed.

337. Donley & Lens, *supra* note 44, at 1659–61 (describing instances of opposition to pregnancy loss measures by abortion rights advocates and groups).

338. MARY ZIEGLER, PERSONHOOD: THE NEW CIVIL WAR OVER REPRODUCTION, at viii (2025) (describing the often conflated two parts of “fetal personhood” that a fetus is: (1) a person; (2) with rights).

339. See U.S. CONST. amend. XIV, § 1.

340. Donley & Lens, *supra* note 44, at 1688. But see Jessica Valenti, *Conservatives Are Coming for Prenatal Tests*, ABORTION, EVERY DAY (Feb. 28, 2025), <https://jessica.substack.com/p/conservatives-are-coming-for-prenatal> [<https://perma.cc/F6GY-8ZAV>] (characterizing a bill in Florida that “would allow people to sue for the wrongful death of an ‘unborn child’” as “effectively codifying fetal personhood in Florida” (emphasis omitted)).

The power of these statutes is not what they do but their expression and symbolism—of the fetus as a separate person and deserving of protection no different than a living person and possibly at the expense of the pregnant woman.

That’s a broad interpretation, however, and one removed from context. A precise read specific to the contexts is that these statutes mean that tortiously or criminally caused fetal death is similar enough to tortious or criminally caused (living person) death to be treated similarly. The statutes express that, at least in these contexts, fetal death and (living) human death are similar enough to be treated similarly.

For instance, wrongful death law applied to fetal death expresses that the parent suffered a loss equivalent to the death of a living child and thus should have the same civil recourse whether the child dies tortiously before or after birth. That’s not the same as expressing that the unborn child is equivalent to a child overall. It’s instead saying that, to the parent, pregnancy loss was at least close enough to the tortious death of a living child that the parent should have the same tort claim for both (and the legal claim leaves room for different amounts of damages).

The homicide statute states that the intentional killing of a fetus is similar enough to the intentional killing of a living person such that they should be punished similarly. Again, not the same as expressing that the unborn child is equivalent to a living person. Put more plainly, a legislature or court could just as easily define “person” in both to also include a dog. It would be a redefinition or interpretation based on a finding that the killing of a dog is similar enough to the killing of a person such that they should be treated the same. Perhaps, it’s because dogs and persons are similar. Or perhaps dogs and persons are different, but the killing of a dog is similarly serious. Regardless, would anyone think that dogs are now persons? Likely not.

But even if these statutes express fetal personhood, it was always a lesser idea of personhood, subordinate to the pregnant woman’s personhood. That’s literally in the statutes. More specifically, all but a few of these statutes have express exemptions dictating situations when the fetal death is *not* similar enough to be treated the same as the (living) person death, i.e., situations where the fetus is apparently not a person. Wrongful death law commonly does not apply to fetal death if due to a legal abortion or allegedly due to the pregnant woman’s conduct.³⁴¹ Similarly, murder statutes commonly don’t apply to legal abortions,³⁴² the pregnant woman’s conduct,³⁴³ or physician acts “committed pursuant to a usual and customary standard of

341. See, e.g., ARK. CODE ANN. § 16-62-102(a)(3)(A)–(B) (Supp. 2023); 740 ILL. COMP. STAT. 180/2.2 (2024); MO. REV. STAT. § 1.205(4) (2016); TEX. CIV. PRAC. & REM. CODE ANN. § 71.003(c) (West 2008).

342. See, e.g., ARK. CODE ANN. § 5-1-102(13)(B)(ii)(a); CAL. PENAL CODE § 187(b)(1) (West 2025); TEX. PENAL CODE ANN. § 19.06(2) (West 2019); S.C. CODE ANN. § 16-3-1083(B)(1) (2015).

343. See, e.g., ARK. CODE ANN. § 5-1-102(13)(B)(iii); TEX. PENAL CODE ANN. § 19.06(1); S.C. CODE ANN. § 16-3-1083(B)(3).

medical practice during diagnostic testing or therapeutic treatment.”³⁴⁴ These exemptions wouldn’t exist if these statutes created true fetal personhood.³⁴⁵

Again, obviously, exceptions like these do not exist for the tortious or criminal deaths of living people. There is no exception in wrongful death statutes specifically negating applicability to any particular tortfeasor. There is no exception to murder (of living person) statutes for legal abortions. There is no exception to murder (of living person) statutes for standard physician practices. The “personhood” these statutes recognize for living people is broader than any personhood these statutes recognize for unborn life.

Moreover, Greer Donley and I have previously argued that any personhood created by wrongful (fetal) death claims is subjective, limited to the parents’ subjective value of that unborn life.³⁴⁶ Under tort law, the fetal death is a wrong not to the fetus, but instead to the parent. And the parent can seek legal recourse for their child’s wrongful death, no different than they could seek legal recourse for their living child’s wrongful death. The parent can sue, but the parent must show that they suffered an injury—they suffered an injury based on the lost parent–child relationship, the usual damages available for wrongful death.³⁴⁷ The jury determines the amount of damages for that lost relationship. The jury may award minimal damages, or it may award extensive damages.³⁴⁸ Each parent’s subjective value of their unborn child can be different, and damages for wrongful death are tailored to that particular parent.³⁴⁹

The same was true when the Alabama Supreme Court applied wrongful death law to frozen embryos in the spring of 2024.³⁵⁰ Couples sued a fertility clinic after blatant negligence on the clinic’s part led to the destruction of their embryos.³⁵¹ The question, though, is what are the embryos? Property?

344. ARK. CODE ANN. § 5-1-102(13)(B)(ii)(b); *see also* N.D. CENT. CODE ANN. § 12.1-17.1-07 (2025) (murder statute inapplicable to fetal death due to medical treatment “under the supervision of a licensed physician to which the pregnant woman has consented” and fetal death due to “acts or omissions that are committed pursuant to usual and customary standards of medical practice during diagnostic or therapeutic treatment performed by or under the supervision of a licensed physician”); TEX. PENAL CODE ANN. § 19.06(3) (murder statute inapplicable to “a lawful medical procedure performed by a physician . . . with the requisite consent as part of an assisted reproduction” technology); S.C. CODE ANN. § 16-3-1083(B)(2) (murder statute inapplicable if fetal death due to “medical treatment of the pregnant woman or her unborn child”).

345. Differences may also exist in criminal consequences for causing injury or death to a living person versus to a fetus. *See infra* notes 379–82 and accompanying text (discussing distinctions in Georgia law); *see also* S.C. CODE ANN. § 16-3-1083(A)(2)(d) (making the death penalty inapplicable to fetal death).

346. *See* Donley & Lens, *supra* note 44, at 1685–89.

347. *Id.* at 1688–89.

348. *Id.* at 1689.

349. Donley and I argue that recognition of this type of subjective fetal value can and should be recognized, and that it does not threaten abortion rights as subjectivity rejects the idea of set fetal value as of conception. *Id.* at 1689–96.

350. *LePage v. Ctr. for Reprod. Med., P.C.*, 408 So. 3d 678, 682–89 (Ala. 2024).

351. *Id.* at 681.

People? The couples tried to sue for wrongful death, law that only applies to the death of a “person.”³⁵² Long ago, the Alabama Supreme Court interpreted “person” to include pregnancy loss at any time in pregnancy.³⁵³ (Only Alabama and West Virginia did so judicially; other state supreme courts insisted on legislative change.³⁵⁴) The Alabama Supreme Court then said “person” also includes an embryo not yet in the uterus but instead in the freezer.³⁵⁵ The decision created potential wrongful death liability for fertility clinic negligence. The case in no way empowered the embryo; the embryo remains without rights. All the case meant is that injured plaintiffs could sue for the death of their unborn child despite its then frozen status, likely more closely matching the plaintiffs’ view of their injury as of their child’s death (although problematically severely overestimating the chances any particular embryo would eventually be a living child).

Wrongful death laws could easily misvalue subjective valuation.³⁵⁶ For instance, a plaintiff may consider the frozen embryo to be something closer to property, or a plaintiff may consider her pregnancy loss to be a pregnancy loss, something less than the death of her child. If the state applies wrongful death law to all pregnancy losses, however, the plaintiff will be forced to sue for the death of her child even though that’s not how she valued the pregnancy loss. An undervaluation can also occur if the state limits wrongful death law for pregnancy loss post viability and a plaintiff gave birth to her stillborn child (who she considers her child) at twenty-one weeks of pregnancy, pre-viability. An ideal tort system would allow the plaintiff to define her injury—an embryo, a pregnancy loss, her unborn child, her child who she had already named.³⁵⁷ No state has that ideal, flexible system currently. Still, the plaintiff always has control over whether she files suit. And the plaintiff has some room to maneuver in defining her injury even within the current system by what she argues to the jury. Regardless, the only “personhood” expressed by wrongful death laws is subjective as experienced by the plaintiff suing.

The symbolic personhood that criminal statutes create is not, however, subjective.³⁵⁸ Murder statutes empower the state to prosecute the person who allegedly killed the prenatal life. Murder statutes do not empower the parent; the parent has no control over whether the state chooses to prosecute. Murder statutes also do not necessarily validate the parent’s valuation of their unborn

352. *Id.*

353. *Mack v. Carmack*, 79 So. 3d 597, 611–12 (Ala. 2011).

354. *See, e.g., Chatelain v. Kelley*, 910 S.W.2d 215, 219 (Ark. 1995), *overruled by Aka v. Jefferson Hosp. Ass’n, Inc.*, 42 S.W.3d 508 (Ark. 2001).

355. *LePage*, 408 So. 3d at 686.

356. *Fox & Lens*, *supra* note 84, at 84–90 (explaining possible disconnects between how law defines reproductive loss versus the lived experiences of reproductive loss).

357. *Id.* at 90.

358. *Donley & Lens*, *supra* note 44, at 1695–96.

child; prosecutions for murder could occur even if the parent did not value the fetus as her child. Murder statutes and prosecutions instead objectively value the fetus, embracing the idea of set fetal value as of conception.³⁵⁹ That is much more dangerous from anticriminalization and abortion rights perspectives.

This is where it's important to remember the role of bereaved parents in creating criminal fetal death statutes. These statutes, at least not all of them, were not about the state objectively valuing the fetus. These statutes were about parents fighting for legal recognition of their (unborn) child's death, and the state confirmed that valuation with the statute.

A common anticriminalization concern about these laws is that they don't mention the pregnant person, and instead "concern only the fetus."³⁶⁰ This concern has also been expressed in the recent arrest of a Texas man for capital murder after he allegedly put mifepristone in his pregnant partner's drink and some cookies, causing her to lose the pregnancy one day later.³⁶¹ He wanted her to have an abortion; she wanted to continue the pregnancy.³⁶² The only charge is capital murder for the fetus.³⁶³ There is no charge for his conduct to the pregnant partner, increasing the claims that this arrest is about attempts to create fetal personhood (although the laws have existed this way in Texas for decades).³⁶⁴

But if there hadn't been a pregnant person, the crime wouldn't have happened. The pregnant person is the very reason these laws exist. In the just mentioned Texas arrest, the pregnant person wanted to continue the pregnancy. (And if she had taken the abortion medication voluntarily, Texas criminal law is clear that she could not be charged with any criminal laws.³⁶⁵) True, the pregnant person is not at the "center" of the prosecution as she's not the one who was killed, but that's true of all crimes. Crimes are prosecuted by the state, including in cases where the pregnant person may not have thought of her pregnancy as an unborn child and wouldn't desire her pregnancy loss to be prosecuted as murder. But again, that's true of all crimes; the victim doesn't control prosecution.

In Grace Howard's recent criticism of these laws, she acknowledged the role of bereaved families and noted that "[m]any of the bills were named after individual unborn victims, using the names they would have been given had

359. *Id.*

360. HOWARD, *supra* note 26, at 34.

361. Jessica Shuran Yu & Hayden Betts, *Texas Capital Murder Case Attempts to Severely Punish Abortion Pill Use by Treating a Fetus as a Person*, TEX. TRIB. (June 30, 2025, 5:00 AM), <https://www.texastribune.org/2025/06/30/texas-abortion-pill-capital-murder-charge-fetal-personhood> [https://perma.cc/9RE2-PFNW]. Assumedly, even anticriminalization advocates would agree with some type of criminal charges against this Texas man. What those approved-of charges would be, however, is not clear.

362. *Id.*

363. *Id.*

364. *Id.*

365. TEX. PENAL CODE ANN. § 19.06 (West 2019).

they been born.”³⁶⁶ But she then suggested that the use of the child’s name in the law is “[p]erhaps . . . a further recognition of the personhood that these laws essentially create.”³⁶⁷

A much more plausible explanation is that the use of the child’s name was due to the family’s involvement in the creation of the statute. Howard discounts that parents still can and do name their dead baby, despite the lack of that name on a birth certificate.³⁶⁸ And Howard underestimates the importance of names to the parents. That name is proof of existence, and stillbirth parents often long to hear someone else mention their child’s name, to provide some acknowledgement of the child’s existence despite death in the womb.³⁶⁹ That a law is named after their child likely means a lot to the bereaved family.³⁷⁰

Another misplaced criticism of fetal personhood criminal statutes occurred in October 2024 when a Georgia football player named Colbie Young was arrested for allegedly assaulting his pregnant ex-girlfriend.³⁷¹ Young was arrested for battery and assault of an unborn child.³⁷² Prominent abortion rights supporters criticized that Young was arrested for assaulting a fetus and not the pregnant person.³⁷³ It wasn’t true. The battery charge was for hitting the woman, and the assault of the fetus was for the fetus. Georgia law created separate laws for assault or battery of the unborn child (as opposed to amending the general laws to also apply to the fetus).³⁷⁴ The battery charge thus did not say “battery of a person” and the “assault of an unborn child” charge did.

366. HOWARD, *supra* note 26, at 33.

367. *Id.*

368. There is a place on the fetal death certificate, issued for stillbirths, for parents to include their baby’s name if desired. CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. STANDARD REPORT OF FETAL DEATH 1 (2003), https://www.cdc.gov/nchs/data/dvs/FDEATH1_1-03finalACC.pdf [<https://perma.cc/XX5D-8TJ5>].

369. See Kelley & Trinidad, *supra* note 106, at 9–10.

370. Moreover, it’s very common for legislatures to name bills after dead children. To quote Sean Hannon Williams: “Legislators fall over themselves in races to name bills after dead children.” Sean Hannon Williams, *Dead Children*, 67 ALA. L. REV. 739, 742 (2016). It’s not super surprising for this law to similarly be named after the deceased albeit unborn child.

371. Charles Odum, *Georgia WR Colbie Young Arrested on Charges of Battery and Assault on an Unborn Child*, ASSOCIATED PRESS (Oct. 8, 2024, 5:55 PM), <https://apnews.com/article/georgia-c-olbie-young-arrest-a7c7a5b9d73624a747fb7dff7f70400c> [<https://perma.cc/F3V5-64XT>].

372. *Id.*

373. Jessica Valenti, *Woman Investigated for Pregnancy Loss..in New York*, ABORTION, EVERY DAY (Oct. 10, 2024), <https://jessica.substack.com/p/woman-investigated-for-pregnancy> [<https://perma.cc/9PZY-MR2Z>] (“That’s right: After Colbie Young allegedly abused his ex-girlfriend, he wasn’t arrested for hurting her—only her pregnancy.”). I am hopeful that this was confusion due to grammar. Headlines stated Young was arrested “on charges of battery and assault on an unborn child” with no comma after battery, suggesting maybe that the battery was also on an unborn child. See Odum, *supra* note 371.

374. See GA. CODE ANN. § 16-5-28 (2019) (assault); *id.* § 16-5-29 (battery).

Moreover, the Georgia laws that Young was charged under specifically express a lesser personhood for the fetus. Young was arrested for battery, and Georgia law specifically mandates that battery against a pregnant woman is “a misdemeanor of a high and aggravated nature,” increasing the possible criminal consequence.³⁷⁵ Assault of the fetus, on the other hand, is a plain misdemeanor (as is battery of a fetus) with no increased possible consequence.³⁷⁶ Apparently assaulting or battering a fetus is a less serious crime. And, similar to what’s mentioned above, the Georgia laws for battery and assault of an unborn child again contain exemptions also expressing lesser personhood. The laws don’t apply to a consented-to abortion, “medical treatment of the pregnant woman or her unborn child,” or to the pregnant woman more generally.³⁷⁷ If that’s personhood, it is a lesser and subordinate personhood.

The intent of this Section is not to dismiss the very legitimate concerns many have about fetal personhood laws. The intent of the Section is instead to actually examine the laws and their contexts, and to remember bereaved families’ roles in the creation of at least some of these laws. Perhaps with those focuses, the personhood expressed by fetal personhood laws is less threatening than would otherwise seem.

C. *MAINTAINING INAPPLICABILITY TO THE PREGNANT PERSON
AND A POTENTIAL CIVIL CAUSE OF ACTION*

There are other anticriminalization legal solutions short of repealing fetal personhood laws. These are solutions to help defeat both the practical and symbolic dangers of these laws.

Anticriminalization advocates, for instance, should seek to fortify efforts to ensure inapplicability of tort and criminal laws to the pregnant person. Express inapplicability to the pregnant woman is extremely common with wrongful death law, meaning the pregnant woman cannot be sued in tort for her own pregnancy loss.³⁷⁸

375. *Id.* § 16-5-23.1(h).

376. *See id.* §§ 16-5-28(c), 16-5-29(c).

377. *Id.* §§ 16-5-28(d), 16-5-29(d).

378. *See supra* note 341 and accompanying text.

Express inapplicability to the pregnant person is also quite common for criminal laws. But inapplicability is not express in all state laws,³⁷⁹ and it is specifically under threat in the states where it is express.³⁸⁰

In 2023, bills were introduced in at least seventeen states to amend abortion statutes to eliminate the inapplicability to the pregnant woman language.³⁸¹ Abortion bans usually provide for criminal punishment only of the doctor, and not the pregnant woman.³⁸² These bills, likely motivated by the increasing self-management of abortion, however, would allow criminal punishment also of the woman. Bills were also introduced to amend tort wrongful death and criminal homicide fetal-death statutes to eliminate the inapplicability to the pregnant woman language.³⁸³ These bills would allow tort and criminal consequences for the pregnant woman. Wrongful death inapplicability is likely more at risk than criminal law inapplicability given the increased palatability of requiring pregnant people to pay civil damages versus instituting criminal consequences.

Inapplicability to the pregnant person is thus under threat. Efforts should focus on instituting and reaffirming inapplicability. The California Legislature recently did so, shortly after *Dobbs* and after the prosecutions of Chelsea Becker and Adora Perez made headlines. The California Legislature made civil and criminal fetal death legal consequences (very) expressly inapplicable to pregnant people.³⁸⁴

379. According to Pregnancy Justice, of the thirty-eight states that apply their murder laws to fetal death, twenty-eight states have explicit language precluding applicability to the pregnant person. KATHERINE FLEMING, PREGNANCY JUST., WHEN FETUSES GAIN PERSONHOOD: UNDERSTANDING THE IMPACT ON IVF, CONTRACEPTION, MEDICAL TREATMENT, CRIMINAL LAW, CHILD SUPPORT, AND BEYOND 9–10 (2022), <https://www.pregnancyjusticeus.org/wp-content/uploads/2023/05/fetal-personhood-with-appendix-UPDATED-1.pdf> [<https://perma.cc/7B69-48EE>]. Pregnancy Justice also believes that inapplicability was implied in two more of the thirty-eight states, including California. *Id.* at 10. California has also since added such explicit language. *See infra* note 384.

380. *See* PREGNANCY JUST., TRENDS IN CRIMINALIZATION AND LEGAL RIGHTS FOR PREGNANT PEOPLE: 2024-2025 LEGISLATIVE SESSIONS IN REVIEW 2 (June 2025), <https://www.pregnancyjusticeus.org/wp-content/uploads/2025/07/2025-Policy-Brief.pdf> [<https://perma.cc/7UF2-KCBN>].

381. BACH & WASILCZUK, *supra* note 30, at 20.

382. *Id.* (“[I]t remains true that criminal abortion statutes have so far exempted pregnant people from prosecution.”).

383. *See, e.g.*, H.B. 3537, 126th Gen. Assemb., Reg. Sess. (S.C. 2025); H.B. 1174, 94th Gen. Assemb., Reg. Sess. (Ark. 2023); H.B. 2709, 88th Leg., Reg. Sess. (Tex. 2023).

384. *See* CAL. HEALTH & SAFETY CODE § 123467(a) (2024) (“Notwithstanding any other law, a person shall not be subject to civil or criminal liability or penalty, or otherwise deprived of their rights under this article, based on their actions or omissions with respect to their pregnancy or actual, potential, or alleged pregnancy outcome, including miscarriage, stillbirth, or abortion, or perinatal death due to causes that occurred in utero.”). Note that faced with the dangers after *Dobbs* and the Becker and Perez prosecutions, California did not opt to eliminate “fetal personhood” statutes, which for California have only been its homicide laws as California is one of the few states that doesn’t apply wrongful death law to any pregnancy losses. California instead affirmed inapplicability to pregnant people.

Anticriminalization efforts should include similar efforts to affirm inapplicability but also do so by affirming the reasons why inapplicability is needed. To the casual onlooker, especially one who might be inclined to suspect causation, it looks as if the pregnant person gets a free pass at murdering her child.

But that's not a purpose of inapplicability. The purpose of inapplicability is to ensure pregnant people are not deterred from seeking and obtaining prenatal care, including to get help with any drug addiction related issues.³⁸⁵ The inapplicability exists to prevent the *more* stillbirths and infant deaths that will occur if pregnant people are deterred from seeking prenatal care due to fears of criminal consequences.³⁸⁶ Inapplicability is not a free pass for the pregnant woman to harm her baby. To the contrary, inapplicability is about protecting the baby. Raised awareness of this motivation will help aid anticriminalization efforts to affirm inapplicability of tort and criminal fetal death laws to the pregnant person.

The California Legislature also had another idea, creating a private cause of action. Under the new law, “[a] party whose reproductive rights are protected by this article and whose reproductive rights are interfered with . . . may bring a civil action against an offending state actor in a state superior court.”³⁸⁷ Had this existed previously, Becker or Perez could have sued Keith Fagundes, the district attorney who prosecuted them. The law enables the plaintiff to recover the amount of her actual damages, punitive damages, a \$25,000 civil fine, an award of attorney’s fees, and injunctive relief if needed.³⁸⁸

This is something that could theoretically deter prosecutors. It’s much more tangible, possible deterrence than what otherwise exists. Ideally, this solution would not depend on the pregnant person suing. But it is something.

These legal reforms are also symbolic. California law defines murder as “the unlawful killing of a human being, or a fetus, with malice aforethought.”³⁸⁹ Perhaps this law enshrines some notion of fetal personhood. But criminally speaking, this objective idea of personhood does not exist as against the pregnant person; the fetal death murder law is inapplicable to her. And the newly created cause of action affirms the primacy of her rights over that objective idea of personhood.

These legal reforms—affirming inapplicability to the pregnant person and a private cause of action—are less dramatic than repealing “fetal personhood” laws. But they can still be practically and symbolically effective anticriminalization measures.

385. See *supra* Section I.B.

386. See *supra* Section I.B.

387. CAL. HEALTH & SAFETY CODE § 123469(a).

388. *Id.* § 123469(b)(1)–(4).

389. CAL. PENAL CODE § 187(a) (2025).

CONCLUSION

Suspicion and blame after pregnancy loss is nothing new. But it has become more tangible, and dangerously so, in the form of arrest. Changing the words in laws will do little to curb that suspicion and blame. Anticriminalization efforts must thus be about much more than laws. Anticriminalization efforts must also be very much about pregnancy loss itself. This Article argues that two high priority anticriminalization measures must be raising awareness about the realities of pregnancy loss and pushing for the standardization of medical care for stillbirth.

The Article also calls for pause in efforts to repeal “fetal personhood” laws. Repeal will tangibly harm families bereaved by tortiously or criminally caused pregnancy loss. These bereaved families are more than collateral damage in anticriminalization (or abortion rights protecting) efforts. Legal reform efforts should instead focus on creating and fortifying legal inapplicability for pregnant people and creating potential causes of action for anyone whose pregnancy loss ends with criminalization.