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Commentary

Criminalizing Pregnancy Loss and Jeopardizing Care: The Unintended Consequences of Abortion Restrictions and Fetal Harm Legislation

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Across the country, increasing numbers of states have enacted laws that restrict access to abortion and have enforced existing laws that can criminalize pregnant people who experience pregnancy loss. These policies could have the unintended consequences of restricting access to care for people who experience miscarriages or stillbirths. Pregnancy loss refers to the spontaneous loss of an intrauterine pregnancy; clinically speaking, it is called a miscarriage before 20 weeks gestational age and a stillbirth after 20 weeks (Prager, Micks, & Dalton, 2019). Pregnancy loss is common. An estimated 10%–30% of pregnancies end in miscarriage (Mayo Clinic, 2019; Wilcox et al., 1988), and less than 1% end in stillbirth (Centers for Disease Control and Prevention, 2019).

Some of the most extreme measures restricting abortion were signed into law in 2019. For example, Alabama passed a near-total ban on abortion, and five states passed abortion bans after detectable cardiac activity (typically at 6 weeks gestational age) (Nash, Mohammed, Cappello, & Naide, 2019). These efforts overlap with a growing number of "fetal harm" laws. For example, the push for "personhood" legislation, which would grant full legal protection to the earliest stages of development, has increased. This commentary outlines how growing efforts to restrict abortion may create a legal and medical environment that criminalizes pregnancy loss, and limits clinicians' ability to provide the highest quality care to those who experience pregnancy loss.

Criminalizing Pregnancy Loss

Although most pregnancy loss is unpreventable, fetal harm legislation has been used to charge women with feticide, manslaughter, reckless homicide, child abuse, and first-degree murder after having a miscarriage or stillbirth. Thirty-eight states have "fetal homicide" laws that distinguish the death of the developing pregnancy from the death of the pregnant person (National Conference of State Legislatures, 2018). This language was intended to increase protections to the pregnant person in cases of violent crimes against them. However, these laws have also been used against the pregnant person in cases of pregnancy loss. In 10 states, fetal harm laws lack explicit exemptions for pregnant women, making them particularly vulnerable to criminalization. Even in states with exemptions for pregnant women, arrests have been made in cases of pregnancy loss (If/When/How, 2019).

Recent media attention has focused on extreme cases like that of the pregnant woman in Alabama who was charged with manslaughter after being shot and having a stillbirth (Mervosh, 2019). But this was just one of the most recent of such cases. From 1973 to 2005, the National Advocates for Pregnant Women identified 68 legal cases in which women were charged with crimes related to a pregnancy loss or a neonatal death thought to have resulted from their actions or inactions during pregnancy (Paltrow & Flavin, 2013). Similar cases have ensued in recent years, in states as conservative as Alabama and as liberal as California (Griffith, 2019). Charges have been filed in the context of experiencing physical trauma in pregnancy (i.e., gun violence, car accidents, falling down stairs, attempted suicide), as well as declining medical advice in pregnancy (i.e., opting for a home delivery, or declining a cesarean section) (Weigel, Sobel, & Salganicoff, 2019). Although it is each patient's right to decline medical intervention, these cases highlight how the "fetal protection" justification has been used in clinical care

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and the judicial system to override the autonomy of the pregnant person.

Substance use is the most common reason people are criminalized for pregnancy loss. Forty-five states have prosecuted women for drug use in pregnancy, and 23 states and Washington, DC, consider substance use in pregnancy child abuse (Guttmacher Institute, 2019b; Miranda, Dixon, & Reyes, 2015). In Alabama alone, 479 pregnant women as of 2015 were charged for substance use under their Chemical Endangerment Law. This law calls for a 10- to 99-year prison sentence in cases of pregnancy loss. Typically, pregnant people charged under such laws have used illicit drugs, but even those taking prescribed drugs, like methadone (for medication assisted treatment) or injectable contraceptives, have been criminalized (Martin, 2015; Paltrow & Flavin, 2013). This legal approach to addressing substance use stands in opposition to the stance taken by leading medical organizations; the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Society of Addiction Medicine, the American Public Health Association, the American Nurses Association, the American College of Nurse Midwives, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association all oppose these drug policies, because they deter women from seeking prenatal care and substance use disorder treatment (National Advocates for Pregnant Women, 2018).

Altering the Patient–Provider Relationship

Almost all medical professionals are mandated reporters of child abuse. Therefore, significant trust concerns arise from laws qualifying substance use in pregnancy as child abuse. Patient–provider confidentially may be jeopardized, and people who use drugs may be fearful to seek medical care for pregnancy loss, until or unless they are in emergent situations. This is a concern not only in cases of substance use, but also suspected self-managed abortion. Self-managed abortion refers to when a pregnant person attempts to end their pregnancy outside of a health care setting, using nonprescribed medications or other means.

Six states directly criminalize self-managed abortion. At least 20 states have opened criminal investigations or made arrests for suspected self-managed abortion, using fetal harm laws (If/When/How, 2019). In these states, patients may be investigated to prove they did not intend to end their pregnancies. There are documented cases of health care providers reporting their patients to law enforcement for suspected self-managed abortion (ACLU of Maine, 2010; Conrad, 2015). This once again poses a deterrent to care and raises confidentiality concerns. In recent years, there has been an increase in the share of medical facilities caring for patients after attempted self-managed abortion (18% of nonhospital facilities in 2017). This finding suggests that investigations into those experiencing pregnancy loss may increase (Jones, Witwer, & Jerman, 2019).

Limiting Treatment Options for Pregnancy Loss

Pregnancy loss can be clinically managed in one of three ways: expectant management (i.e., the patient waits for the pregnancy tissue to pass on its own if they are medically stable), medical management (i.e., medications help facilitate the passage of the pregnancy tissue), or procedural/surgical management (i.e., a procedure is done to remove the pregnancy tissue from the uterus) (Weigel et al., 2019). Treatment decisions are typically driven by patient preference, and the presence or absence of any complications (excessive bleeding, pain, or infection).

The same medications and procedures used in pregnancy loss are also used in abortions. Therefore, laws restricting treatment methods for abortion may unintentionally limit treatment options for pregnancy loss. For example, the medications mifepristone and misoprostol are more effective in miscarriage management than misoprostol alone (Schreiber et al., 2018). But mifepristone may not be readily available to treat these patients, owing to its use in medication abortions. The U.S. Food and Drug Administration has greatly restricted access to mifepristone by placing a Risk Evaluation and Mitigation Strategy on the medication, despite its safe clinical profile. The U.S. Food and Drug Administration requires clinicians to become certified prescribers of mifepristone, and that mifepristone be dispensed only from certified clinics or hospitals, rather than commercial pharmacies (i.e., CVS, Walgreens) (U.S. Food and Drug Administration, 2019). If an individual experiencing a miscarriage presents to a care setting without certified providers or mifepristone stocked on site, they may not receive optimal medical treatment because of these Risk Evaluation and Mitigation Strategy barriers.

Many states ban abortion procedures that are also used to manage pregnancy loss. Twenty-one states prohibit dilation and extractions. Two states prohibit dilation and evacuations (D&Es), and six states have D&E bans that are temporarily blocked by court order (Guttmacher Institute, 2019a). Even though these laws are designed to prohibit procedures on “living” fetuses, patients experiencing pregnancy loss may still be affected; cases of inevitable pregnancy loss (i.e., the cervix is dilated but a heartbeat may still be present) may be denied surgical management until cardiac activity is undetectable. This limitation may result in delays in care and deteriorating health status in the pregnant person (i.e., worsening bleeding, infection). Even in pregnancy loss cases without cardiac activity, fear of legal ramifications may cause providers to be reluctant to perform these procedures, even if they are in the best interest of the patient. State penalties for physicians who violate these bans vary, from a fine in Arizona, to life imprisonment in North Dakota (AZ Rev Stat; ND Century Code).

Training Implications for Providers

Recent legislation restricting abortions, in particular laws aimed at abortion providers, could decrease the number of clinicians being trained in abortion care and the methods in which they are trained. This restriction in turn could indirectly impact pregnancy loss patients, because the clinical training to safely manage pregnancy loss is nearly identical to that needed to perform abortions. This includes training in prescribing misoprostol and mifepristone, and performing procedures like uterine aspirations and D&Es.

Minimal or no training in abortion may lead to insufficient training in pregnancy loss management. Limited research exists on this subject, but two studies seem to support this idea. Dalton et al. (2011) found that physicians with prior abortion training were significantly more likely than those without abortion training to offer office-based uterine evacuation to patients with early pregnancy loss. The alternatives are uterine evacuation in the operating room, which may be more costly or require general anesthesia, and expectant or medical management, which may be less safe in cases with complications. Similarly, among U.S. OBGYN residents, those at programs with routine abortion training were significantly more likely to receive training in D&Es than those with optional or no abortion training (Steinauer et al., 2018). Although it may seem as if abortion training is unnecessary to achieve proficiency in pregnancy loss management, research suggests it is important for learning surgical management options. Notably, abortion training is unavailable at 16% of OBGYN residency programs and 64% of family medicine residency programs, and trainees at Catholic-owned or -affiliated hospitals are prohibited from performing abortions (Herbitter et al., 2011; Turk, Preskill, Landy, Rocca, & Steinauer, 2014).

Looking Forward

The impacts of abortion restrictions on people experiencing pregnancy loss merit more recognition and discussion than they currently receive. Even in the present day, fetal harm laws without exemptions for pregnant women have been used to criminalize pregnancy loss, a fact that goes unnoticed by much of the general public, health care professionals, and, importantly, many policymakers. The newest wave of abortion bans and personhood legislation could make people experiencing pregnancy loss increasingly vulnerable to investigation and criminal charges, particularly for people using drugs in pregnancy or suspected of a self-managed abortion. Although laws punishing substance use in pregnancy are designed to discourage drug use, they can also function as a barrier to seeking prenatal care and substance use disorder treatment. Laws restricting methods to terminate pregnancies also limit treatment options for pregnancy loss and could result in jail sentences for clinicians. For many, pregnancy loss comes with significant grief and stigma; fear of legal action could have the unintended consequence of deterring these individuals from obtaining needed prompt, high-quality, and compassionate care.

References

AZ Rev Stat. (2018). § *13-3603.01*.

ND Century Code. (2017). § *14-02.6-02 Partial-Birth Abortion*.

ACLU of Maine. (2010). Iowa police almost prosecute woman for her accidental fall during pregnancy … seriously. Available: www.aclumaine.org/en/news/iowa-police-almost-prosecute-woman-her-accidental-fall-during-pregnancy seriously. Accessed: December 19, 2019.

Centers for Disease Control and Prevention. (2019). What is stillbirth?. Available: www.cdc.gov/ncbddd/stillbirth/facts.html. Accessed: February 6, 2020.

Conrad, D. (2015). This doctor called police on the woman whose miscarriage led to a "feticide" conviction. Public Radio International. Available: www.pri.org/stories/2015-04-03/doctor-who-called-police-purvi-patel-listed-pro-life-medical-association-member. Accessed: April 16, 2020.

Dalton, V. K., Harris, L. H., Bell, J. D., Schulkin, J., Steinauer, J., Zochowski, M., & Fendrick, A. M. (2011). Treatment of early pregnancy failure: Does induced abortion training affect later practices? *American Journal of Obstetrics and Gynecology*, 204(6). 493.e1–493.e6.

Griffith, J. (2019). Woman charged with murder after delivering a stillborn baby with meth in its system. NBC News. Available: www.nbcnews.com/news/us-news/woman-charged-murder-after-delivering-stillborn-baby-meth-its-system-n1078266?fbclid=IwAR0DfdI_g3BO4nQuqoBdB8gUrH_lcgp4dToFPgfqpP95-z8QvsUypK1c3VM. Accessed: April 16, 2020.

Guttmacher Institute. (2019a). Bans on specific abortion methods used after the first trimester. Available: www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester. Accessed: December 17, 2019.

Guttmacher Institute. (2019b). Substance use during pregnancy. Available: www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy. Accessed: December 17, 2019.

Herbitter, C., Greenberg, M., Fletcher, J., Query, C., Dalby, J., & Gold, M. (2011). Family planning training in US family medicine residencies. *Family Medicine*, 43(8), 574–581.

If/When/How. (2019). Roe's unfinished promise. Available: www.ifwhenhow.org/resources/roes-unfinished-promise/. Accessed: April 16, 2020.

Jones, R. K., Witwer, E., & Jerman, J. (2019). Abortion incidence and service availability in the United States, 2017. Available: www.guttmacher.org/report/abortion-incidence-service-availability-us-2017. Accessed: April 16, 2020.

Martin, N. (2015). Take a Valium, Lose Your Kid, Go to Jail. *ProPublica*. Available: https://www.propublica.org/article/when-the-womb-is-a-crime-scene. Accessed: April 16, 2020.

Mayo Clinic. (2019). Miscarriage: Symptoms and causes. Available: www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298. Accessed: February 6, 2020.

Mervosh, S. (2019). Alabama woman who was shot while pregnant is charged in fetus's death. The New York Times. Available: www.nytimes.com/2019/06/27/us/pregnant-woman-shot-marshae-jones.html. Accessed: April 16, 2020.

Miranda, L., Dixon, V., & Reyes, C. (2015). how states handle drug use during pregnancy. Available: https://projects.propublica.org/graphics/maternity-drug-policies-by-state. Accessed: December 17, 2019.

Nash, E., Mohammed, L., Cappello, O., & Naide, S. (2019). State policy trends 2019: A wave of abortion bans, but some states are fighting back. Available: www.guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back. Accessed: December 17, 2019.

National Advocates for Pregnant Women. (2018). Medical and public health statements addressing prosecution and punishment of pregnant women. Available: http://advocatesforpregnantwomen.org/main/publications/fact_sheets/medical_and_public_health_group_statements_opposing_prosecution_and_punishment_of_pregnant_women_revised_june_2018.php. Accessed: December 17, 2019.

National Conference of State Legislatures. (2018). State laws on fetal homicide and penalty-enhancement for crimes against pregnant women. Available: www.ncsl.org/research/health/fetal-homicide-state-laws.aspx. Accessed: December 17, 2019.

Paltrow, L. M., & Flavin, J. (2013). Arrests of and forced interventions on pregnant women in the united states, 1973-2005: Implications for women's legal status and public health. *Journal of Health Politics, Policy and Law*, 38(2), 299–343.

Prager, S., Micks, E., & Dalton, V. (2019). Pregnancy loss (miscarriage): Risk factors, etiology, clinical manifestations, and diagnostic evaluation. Available: www.uptodate.com/contents/pregnancy-loss-miscarriage-risk-factors-etiology-clinical-manifestations-and-diagnostic-evaluation. Accessed: February 6, 2020.

Schreiber, C. A., Creinin, M. D., Atrio, J., Sonalkar, S., Ratcliffe, S. J., & Barnhart, K. T. (2018). Mifepristone pretreatment for the medical management of early pregnancy loss. *New England Journal of Medicine*, 378, 2161–2170.

Steinauer, J. E., Turk, J. K., Pomerantz, T., Simonson, K., Learman, L. A., & Landy, U. (2018). Abortion training in US obstetrics and gynecology residency programs. *American Journal of Obstetrics and Gynecology*, 219(1). 86.e1–86.e6.

Turk, J. K., Preskill, F., Landy, U., Rocca, C. H., & Steinauer, J. E. (2014). Availability and characteristics of abortion training in US ob-gyn residency programs: A national survey. *Contraception*, 89(4), 271–277.

U.S. Food and Drug Administration. (2019). Approved Risk Evaluation and Mitigation Strategies (REMS): Mifepristone. Available: www.accessdata.fda.gov/scripts/cder/rems/index.cfm?event=RemsDetails.page&REMS=390. Accessed: December 17, 2019.

Weigel, G., Sobel, S., & Salganicoff, A. (2019). Understanding pregnancy loss in the context of abortion restrictions and fetal harm laws. Available: www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-

in-the-context-of-abortion-restrictions-and-fetal-harm-laws/. Accessed: March 17, 2020.
Wilcox, A., Weinberg, C., O'Connor, J., Baird, D., Schlatterer, J., Canfield, R., Armstrong, E., & Nisula, B. (1998). Incidence of Early Loss of Pregnancy. *N Engl J Med*, 319, 189–194.

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