

Understanding Pregnancy Loss in the Context of Abortion Restrictions and Fetal Harm Laws

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ISSUE BRIEF

Key Takeaways

- Pregnancy loss is extremely common. Approximately 10-20% of pregnancies that have been confirmed by testing result in a miscarriage by 13 weeks gestational age. Estimates are as high as 31% to 50% when including individuals who miscarry before knowing they are pregnant.
- Miscarriages are often conflated with induced abortions in the news and law. This has resulted in a long history in the U.S. in which some pregnant people have been criminalized for pregnancy loss, and there are ways in which abortion restrictions may have unintended consequences on pregnancy loss management.
- Under fetal harm legislation, women have been charged with crimes related to pregnancy loss in cases when they have experienced physical trauma, declined medical advice, or used drugs in pregnancy.
- A medical and legal environment in which pregnant people may be criminalized for pregnancy loss can leave some reluctant to seek needed care and vulnerable to legal harm.
- Some patients may have limited treatment options available in cases of pregnancy loss due to restrictions on abortion. FDA protocol (REMS) prohibits pharmacies from dispensing mifepristone (a drug also used for abortions) and requires providers to receive certification to prescribe the medication even though the safety profile of mifepristone is well documented. Furthermore, state bans on certain surgical methods for abortion may also limit the treatment options offered for pregnancy loss.
- Several states have laws criminalizing self-managed abortion; these laws have the potential to make people experiencing pregnancy loss vulnerable to investigation, and jeopardize patient-provider confidentiality.

Introduction

Miscarriages are extremely common (<https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Early-Pregnancy-Loss>), occurring in up to an estimated 30% of all pregnancies. However, pregnancy loss is often poorly understood and conflated with induced abortions; for example, terms like “induced miscarriage” have been used to imply intent to end pregnancy, while “spontaneous abortion” is a medical term for a miscarriage. This brief clarifies how pregnancy loss is distinct from abortion, while highlighting the similarities in their management. It also focuses on how abortion policies may impact miscarriage care. At a time when abortion restrictions (<https://www.guttmacher.org/article/2019/05/unprecedented-wave-abortion-bans-urgent-call-action>) around the country are increasing, laws may limit providers’ ability to manage pregnancy loss and that women experiencing pregnancy loss may be investigated to prove their miscarriages were unintentional. This brief examines how policies aimed at limiting abortion may have negative consequences on people experiencing pregnancy loss.

A Note on Terminology: a basic understanding of human development

(<https://medlineplus.gov/ency/article/002398.htm>) is important in understanding pregnancy loss, its policy implications and its portrayal in the media.

Pregnancies are dated using **gestational age** (GA), calculated by the time since the individual's last menstrual period (LMP) or by ultrasound if LMP is unknown. **Fertilization**, when a sperm fuses with an egg, occurs approximately 2 weeks after menses, meaning GA predates fertilization by ~2 weeks. Therefore, from 0-2 weeks GA, the individual is not yet pregnant.

Around 4 weeks GA, the fertilized egg **implants** in the uterus. This roughly coincides with the first missed period, and when a home pregnancy test (<https://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/home-pregnancy-tests/art-20047940>) would turn positive. Around 6 weeks GA, the developing heart is called a primitive heart tube (<https://opentextbc.ca/anatomyandphysiology/chapter/19-5-development-of-the-heart/>) due to its tubular shape, and develops detectable spontaneous cardiac activity (<https://medlineplus.gov/ency/article/002398.htm>). Appendix (<https://www.kff.org/report-section/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws-appendices>) A outlines a brief timeline of cardiac development.

From 5-10 weeks GA, the term "**embryo**" describes the developing pregnancy, while "**fetus**" is used from 11 weeks GA onwards. Additional terms are defined in the Glossary (<https://www.kff.org/report-section/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws-glossary>).

Sources: U.S National Library of Medicine. Fetal Development. (<https://medlineplus.gov/ency/article/002398.htm>) Updated 10/02/2019; ACOG. How Your Fetus Grows During Pregnancy. (<https://www.acog.org/Patients/FAQs/How-Your-Fetus-Grows-During-Pregnancy?IsMobileSet=false>) April 2018;

Rice University. Development of the Heart. (<https://opentextbc.ca/anatomyandphysiology/chapter/19-5-development-of-the-heart/>). Anatomy and Physiology.

What is pregnancy loss?

How pregnancy loss is categorized largely depends on when in the pregnancy it occurred. The U.S. medical community most often defines (<https://www.uptodate.com/contents/pregnancy-loss-miscarriage-risk-factors-etiology-clinical-manifestations-and-diagnostic-evaluation>) **miscarriage** (also called spontaneous abortion) as the spontaneous loss of a nonviable, intrauterine pregnancy before 20 weeks gestational age (GA), while **stillbirth** (also called fetal death and intrauterine fetal demise) describes this event at ≥ 20 weeks GA. A late stillbirth or late intrauterine fetal demise occurs after 28 weeks. Pregnancy loss serves as an umbrella term for all gestational ages (see Glossary (<https://www.kff.org/report-section/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws-glossary>) for definitions of non-viable and intrauterine). Consensus around these terms does not fully exist; for example, other countries (<https://www.nhs.uk/conditions/miscarriage/>) use different gestational ages to distinguish miscarriage from stillbirth, while many journalists use miscarriage to describe pregnancy loss at any stage of pregnancy. The terms miscarriage and stillbirth have been found to be preferred by people experiencing these events, therefore will be used in this brief as opposed to alternative terms (Appendix (<https://www.kff.org/report-section/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws-appendices>) B).

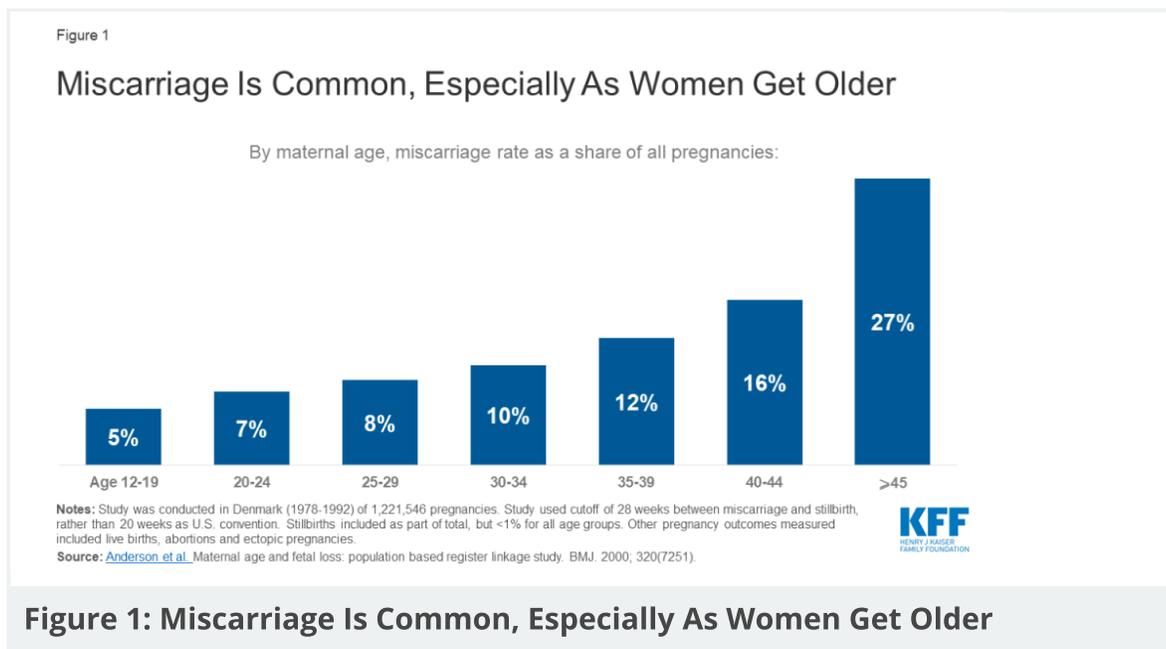
Common symptoms of pregnancy loss include vaginal bleeding and cramping, which may prompt presentation to a healthcare facility. Alternatively, some miscarriages and stillbirths have no symptoms and are discovered during routine prenatal care (for example, when cardiac activity cannot be found).

How are miscarriages different from abortions?

Medical providers often refer to miscarriages as spontaneous abortions, or by its subcategories (<https://www.aafp.org/afp/2005/1001/p1243.html>) including missed, incomplete and inevitable abortions (see Glossary (<https://www.kff.org/report-section/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws-glossary>)). These terms are distinct from a voluntary termination of a pregnancy, commonly referred to as an abortion, or as an “induced or therapeutic” abortion in medical terms. Despite this, lawmakers have used “induced miscarriage” or “procuring a miscarriage” to describe intentional attempts to terminate a pregnancy, exemplifying how miscarriage and abortion are easily conflated. To clarify, miscarriages and stillbirths refer to the spontaneous death of an embryo or fetus, but not to the elective termination of pregnancy.

How common is pregnancy loss?

Miscarriages are extremely **common** (<https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Early-Pregnancy-Loss>), despite **public perception** (<https://www.ncbi.nlm.nih.gov/pubmed/26000502>) that pregnancy loss is rare. Approximately **10-20%** (<https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298>) of pregnancies confirmed by testing result in a miscarriage by 13 weeks GA, but estimates are as high as **31%** (<https://www.ncbi.nlm.nih.gov/pubmed?term=3393170>) to **50%** (<https://medlineplus.gov/ency/article/001488.htm>) when including individuals who miscarry before knowing they are pregnant.¹ (<https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/view/footnotes/#footnote-441084-1>) The vast majority of all pregnancy losses occur before 13 weeks (~**80%** (<https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Early-Pregnancy-Loss?IsMobileSet=false>)). Pregnancy loss later in pregnancy is less common; approximately **1% of all pregnancies** (<https://www.uptodate.com/contents/pregnancy-loss-miscarriage-risk-factors-etiology-clinical-manifestations-and-diagnostic-evaluation>) end in miscarriage between 13-20 weeks and less than **1% of pregnancies** (<https://www.cdc.gov/ncbddd/stillbirth/facts.html>) end in stillbirth after 20 weeks. Miscarriages are increasingly common as maternal age increases (**Figure 1**). A significant portion of women will experience a pregnancy loss in their lifetime, but most will go on to have **healthy pregnancies** (<https://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/pregnancy-after-miscarriage/art-20044134>) thereafter.



What causes pregnancy loss?

More often than not, the cause of a pregnancy loss (<https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Early-Pregnancy-Loss>) is unknown even after thorough evaluation. Of those with a suspected cause, the majority of miscarriages are attributed to genetic abnormalities (50-70%), and less commonly uterine cavity distortion (fibroids, adhesions, etc.), autoimmune and clotting disorders. Similarly, most stillbirths are caused by genetic abnormalities, problems with the placenta, fetal growth restriction or infection.² (<https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/view/footnotes/#footnote-441084-2>) **Risk factors** (<https://www.uptodate.com/contents/pregnancy-loss-miscarriage-risk-factors-etiology-clinical-manifestations-and-diagnostic-evaluation>) for pregnancy loss include maternal age <20 or >35 years old, non-Hispanic Black race, diabetes, obesity, tobacco use (both maternal and paternal exposure) and certain illicit drug use. However, risk factors *do not cause* pregnancy loss, thus a pregnant person with one or more of these risk factors should not be faulted for their pregnancy loss. Providing psychological support for those experiencing these events is important, as many people feel guilty, alone or ashamed (<https://www.ncbi.nlm.nih.gov/pubmed/26000502>).

How do abortion restrictions impact how pregnancy loss is managed?

Recent legislation restricting abortion and increasing laws and regulations designed to provide “fetal protection” can impact patients experiencing pregnancy loss. Below we outline how restrictions aimed at abortion may have consequences for pregnancy loss care, focusing on training, treatment and legal implications.

Training

Depending on the stage in pregnancy, the patient preferences, and the clinical scenario, patients experiencing pregnancy loss can be treated (<https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Early-Pregnancy-Loss>) with (1) expectant management, (2) medications, like misoprostol with or without mifepristone, or (3) a surgical procedure, either uterine aspiration or dilation and evacuation (D&E) (**Table 1**).

Table 1: How Pregnancy Loss Can Be Managed at Various Stages in Pregnancy

	Method	Description	Example situations
Earlier in pregnancy	Expectant Management	Wait for nonviable pregnancy tissue to pass on its own from the uterus. Safe up to ~8 weeks GA.	For individuals who want to non-invasively manage their miscarriage at home and are medically stable, without contraindications. About 80% of miscarriages will complete on their own in 8 weeks.
	Medical Management (for miscarriage)	Facilitate passage of nonviable pregnancy tissue from the uterus, typically with misoprostol +/- mifepristone.	In early pregnancy, allows shorter time course than expectant management in patients without complications. Treatment with misoprostol results in complete passage of the non-viable pregnancy within 2 days in most cases.
	Uterine aspiration/ Suction curettage	Dilation of cervix and aspiration of nonviable pregnancy tissue from uterus. Can be used up to 14-16 weeks gestation.	For individuals who are medically unstable, or have incomplete miscarriage after expectant or medical management or desire prompt resolution of miscarriage. Typically an office procedure.
	Dilation and evacuation (D&E)	Dilation of cervix and evacuation of stillborn with suction and/or forceps, typically used from 14 weeks up until 28 weeks GA.	Ensures prompt passage of stillborn, does not require laboring, will typically be performed in an operating room with sedation.
Later in pregnancy	Labor induction (for stillbirth)	Induce onset of labor, typically with misoprostol +/- mifepristone. Patient will vaginally deliver stillborn.	For individuals with a stillbirth, who prefer to deliver stillborn (opportunity to view or hold). Performed in a hospital.

NOTES: Example situations are not an exhaustive list of indications for each management type. Pain control and need for Rhogam should be addressed for all patients, and grief counseling if needed. Many of the management methods can also be employed for induced abortions.

SOURCES: ACOG practice bulletins on [Early Pregnancy Loss](https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Early-Pregnancy-Loss?IsMobileSet=false) (<https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Early-Pregnancy-Loss?IsMobileSet=false>) and [Management of Stillbirth](https://starlegacyfoundation.org/wp-content/uploads/acog-management-of-stillbirth1.pdf) (<https://starlegacyfoundation.org/wp-content/uploads/acog-management-of-stillbirth1.pdf>). National Academies of Sciences, Engineering and Medicine. [The Safety and Quality of Abortion Care in the U.S](https://www.nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states) (<https://www.nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states>). 2018. Improving Education in Reproductive Health. [Early Pregnancy Loss Management](https://www.innovating-education.org/course/abortion-complete-course/). (<https://www.innovating-education.org/course/abortion-complete-course/>)

Almost all of the methods used to manage miscarriages and stillbirths are identical to those used in therapeutic abortions. Therefore, the clinical training necessary to safely manage a patient experiencing a pregnancy loss is very similar to that needed to perform abortions. As such, medical residents at religiously affiliated hospitals or in states with restrictive abortion laws may struggle to obtain the necessary training and caseload to become proficient in these skills. Although miscarriage is common and it may seem as if physicians would easily obtain this training through managing pregnancy loss alone, research on this topic suggests otherwise; a [study](https://www.ajog.org/article/S0002-9378(18)30292-8/fulltext) ([https://www.ajog.org/article/S0002-9378\(18\)30292-8/fulltext](https://www.ajog.org/article/S0002-9378(18)30292-8/fulltext)) comparing

U.S. OBGYN residency programs found that residents at programs with routine abortion training were significantly more likely to receive training in D&Es (a management option for pregnancy loss) as compared to those with optional or no abortion training. Another [study \(https://www.ajog.org/article/S0002-9378\(11\)00145-1/abstract\)](https://www.ajog.org/article/S0002-9378(11)00145-1/abstract) found physicians with prior abortion training almost three times more likely to provide in-office uterine evacuations to patients experiencing pregnancy loss as compared to physicians without prior abortion training; lack of training was cited as a barrier to providing this service in cases of pregnancy loss by 16% of physicians without abortion training and just 2% of physicians with abortion training. When miscarriages present in emergency settings with significant bleeding or infection, it is imperative the clinician has the skills to promptly and safely treat that individual. Little to no training in abortion care may negatively affect providers' ability to safely manage (<https://rewire.news/article/2019/07/05/medical-residents-struggle-to-find-abortion-training-as-statewide-restrictions-tighten/>) pregnancy loss.

Treatment

Limiting Medical Treatment Available

While miscarriages can be managed with misoprostol alone, the combination of misoprostol and mifepristone is more effective (<https://www.nejm.org/doi/full/10.1056/NEJMoa1715726>). In fact, the American College of Obstetricians and Gynecologists (ACOG) recommends combination therapy, but mifepristone's availability is limited due to its use in medication abortions. Mifepristone is subject to Risk Evaluation and Mitigation Strategy (REMS (<https://www.accessdata.fda.gov/scripts/cder/remis/index.cfm?event=RemsDetails.page&REMS=390>)) restrictions,³ (<https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/view/footnotes/#footnote-441084-3>) requiring it be dispensed only by certified providers in certain clinics and hospitals (<https://www.nejm.org/doi/10.1056/NEJMs1612526>), rather than from a retail pharmacy. This can be problematic for many emergency rooms, primary care or prenatal clinics where patients may be diagnosed with miscarriages, but cannot be adequately treated because their healthcare setting (<https://www.npr.org/sections/health-shots/2019/01/10/666957368/a-drug-that-eases-miscarriages-is-difficult-for-women-to-get>) does not stock (<https://www.aclu.org/legal-document/chelius-v-azar-complaint?redirect=legal-document/chelius-v-wright-complaint>) mifepristone or lacks certified providers. For comparison, all doctors in Canada (<https://www.cbc.ca/news/health/mifegymiso-abortion-pill-health-canada-1.4391267>) can prescribe mifepristone and it can be picked up in pharmacies. The REMS on Mifepristone impacts not only abortion care, but also limits miscarriage treatment as well.

Some medications are used in pregnancy loss, abortions and pregnancy. What do these drugs do?

Misoprostol: Softens/relaxes the cervix and causes uterine contractions. Multiple uses (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760893/>) in obstetrics and gynecology for labor induction, pregnancy loss, medication abortion, postpartum hemorrhage and before surgical procedures. Also used to prevent gastric ulcers.

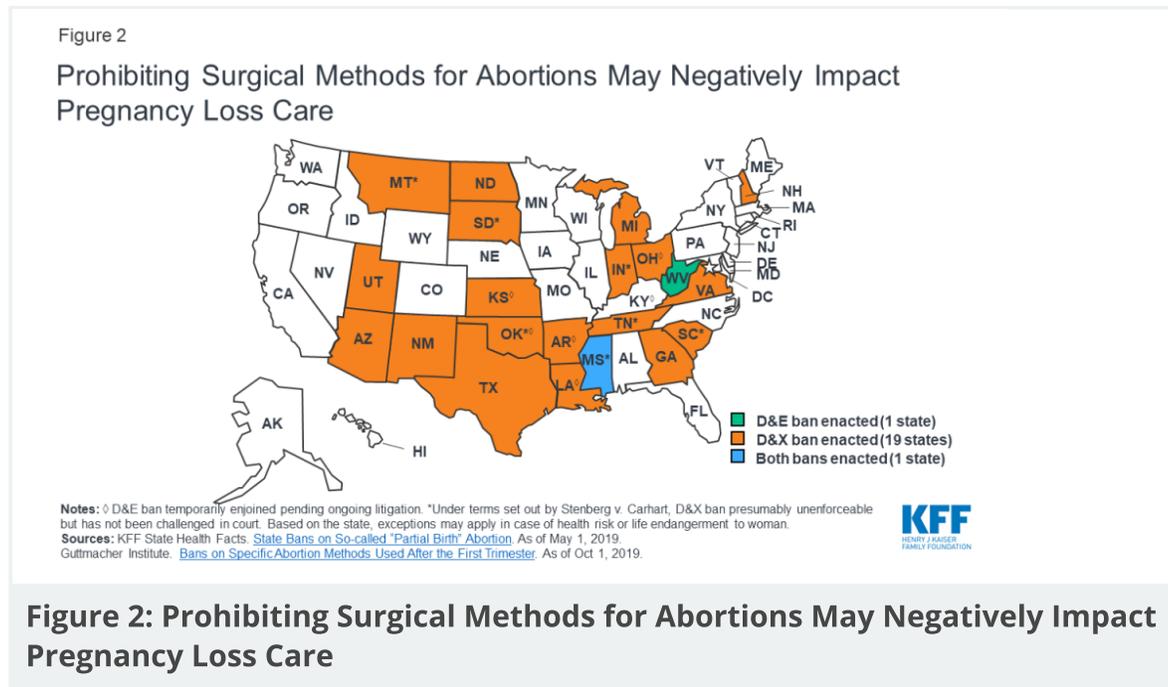
Mifepristone (Mifeprex (<https://medlineplus.gov/druginfo/meds/a600042.html>)): Blocks the action of progesterone, causing the uterine lining to destabilize and stops progression of existing pregnancy. Used in medication abortions, miscarriages and less frequently, for emergency contraception, endometriosis, fibroids and to induce labor.

Oxytocin (Pitocin (<https://www.rxlist.com/pitocin-drug.htm#description>)): Causes uterine contractions. Used to induce labor, treat postpartum hemorrhage and pregnancy loss, and sometimes to help uterus contract after abortions.

Limiting Surgical Treatment Available

Many states prohibit certain surgical methods for abortion, which may limit services for pregnancy loss. Based on the Partial-Birth Abortion Ban Act (<https://www.congress.gov/bill/108th-congress/senate-bill/3>) of 2003 and *Gonzalez v. Carhart* (2007), 20 states (<https://www.kff.org/womens-health-policy/state-indicator/partial-birth-abortion-bans/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>) have enacted bans on so-called “partial birth abortion,” except when necessary to save the life of the mother. “Partial birth abortion” is not a medical term, but is used by policymakers to refer to the rarely used dilation and extraction (D&X) procedure (see Glossary (<https://www.kff.org/report-section/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws-glossary>)). D&X can be used in abortion but also in stillbirth management if the intact stillborn is desired by the family for personal reasons (religious, burial ceremony, etc.) or medical reasons to assess cause of death. These policies have also been interpreted more broadly to prohibit D&E procedures, used commonly in pregnancy loss and abortion

management; D&E bans (<https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester>) are enacted in Mississippi (<http://billstatus.ls.state.ms.us/documents/2016/pdf/HB/0500-0599/HB0519SG.pdf>) and West Virginia (http://www.wvlegislature.gov/Bill_Text_HTML/2016_SESSIONS/RS/bills/SB10%20intr.pdf), and temporarily enjoined in six other states (AR, KS, KY, LA, OH, OK) (**Figure 2**).



D&X and D&E bans include language prohibiting these procedures on a “living unborn child” or “living fetus” [non-medical terms], therefore do not explicitly prohibit these procedures for use in stillbirths. Under less common circumstances, however, fetal cardiac activity may be present during cases of miscarriage (Glossary (<https://www.kff.org/report-section/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws-glossary/>)), preventing the above procedures from being used where bans apply. For example, a patient with a pre-viable fetus at 20 weeks gestation may have a completely dilated cervix (meaning the pregnancy loss is inevitable) and be bleeding significantly, but denied surgical management until the fetus no longer has a heartbeat or until the situation is life threatening. A study of Catholic-owned hospitals (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/>) documented several cases of patients who were actively miscarrying and denied uterine evacuation while cardiac activity was still detectable, leading to delays in care and transfers to outside hospitals. It is therefore possible that surgical bans on abortion may limit medical decision making in nuanced cases of pregnancy loss.

Bans on D&Es and D&Xs for abortion may also cause providers to shy away from their use even for pregnancy loss management; providers may be fearful to provide these services due to perceived legal ramifications and may become less practiced and proficient in D&E procedures over time, even when performed for pregnancy loss. For stillbirths, the alternative to surgical management is induction

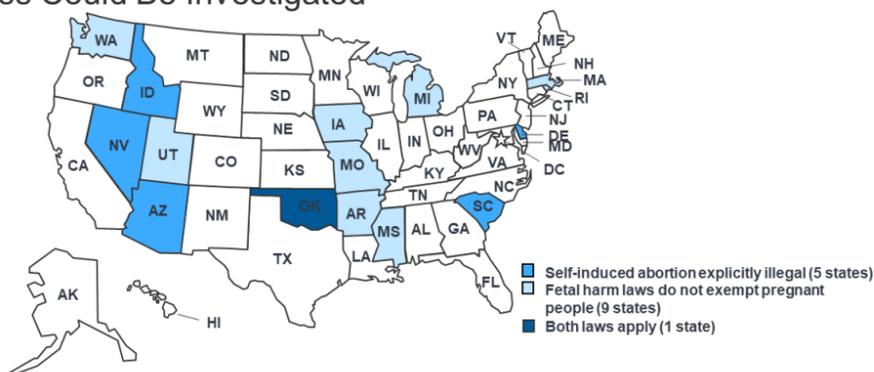
of labor with medications; this has been shown to be less safe ([https://www.ajog.org/article/S0002-9378\(16\)31180-2/fulltext](https://www.ajog.org/article/S0002-9378(16)31180-2/fulltext)) for the mother than D&Es and often requires a multi-day hospitalization.

Confidentiality and Privacy Concerns: Altering the Patient-Provider Relationship

People experiencing pregnancy loss may be deterred from seeking medical care, particularly in places hostile to abortion. For example, individuals may be investigated to ensure there was no intent to terminate the pregnancy. As of 2019, If/When/How (<https://www.ifwhenhow.org/resources/roes-unfinished-promise-2019-update/>) Legal Team⁴ (<https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/view/footnotes/#footnote-441084-4>) found 6 states with laws retained from before *Roe v. Wade* that directly criminalize self-managed abortions (AZ, DE, ID, NV, OK, SC),⁵ (<https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/view/footnotes/#footnote-441084-5>) and examples of their enforcement (<https://www.ifwhenhow.org/resources/roes-unfinished-promise/>) after 1973. Meanwhile 10 states have laws criminalizing fetal harm without explicit exemptions for pregnant people (**Figure 3**); these have been applied in cases of attempted maternal suicide and self-managed abortion, among other examples. These aforementioned laws are presumably enforceable until repealed or enjoined; in at least 20 states since *Roe v. Wade*, criminal investigations or arrests have been made for alleged self-managed abortion (**Figure 4**), however it is unclear how many of these women were ultimately charged, and how many were found to be self-managed abortions verses pregnancy losses.

Figure 3

Criminalization of Self-Managed Abortion Means Pregnancy Loss Could Be Investigated



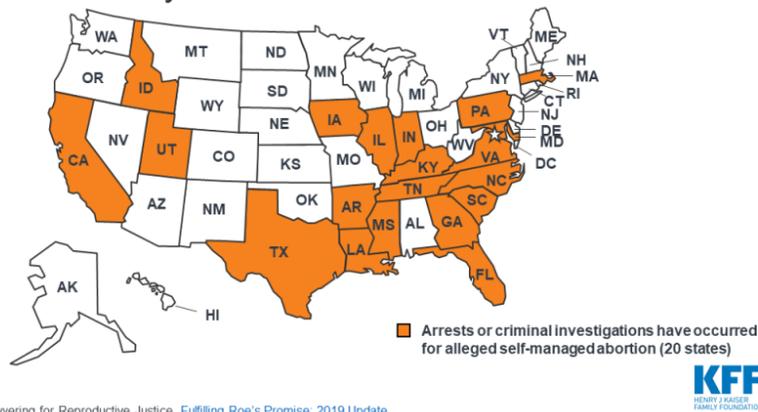
Source: If/When/How: Lawyering for Reproductive Justice. [Fulfilling Roe's Promise: 2019 Update](https://www.ifwhenhow.org/resources/roes-unfinished-promise-2019-update/)

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Figure 3: Criminalization of Self-Managed Abortion Means Pregnancy Loss Could Be Investigated

Figure 4

Alleged Self-Managed Abortion Prompts Arrests and Criminal Investigations in Many States



Source: If/When/How: Lawyering for Reproductive Justice. [Fulfilling Roe's Promise, 2019 Update](#)

Figure 4: Alleged Self-Managed Abortion Prompts Arrests and Criminal Investigations in Many States

These laws can be problematic for patients experiencing pregnancy loss, as they could prompt healthcare providers to report patients to law enforcement after pregnancy loss. There have been several cases where hospital workers (<https://www.aclumaine.org/en/news/iowa-police-almost-prosecute-woman-her-accidental-fall-during-pregnancyseriously>) have called the police (<https://www.pri.org/stories/2015-04-03/doctor-who-called-police-purvi-patel-listed-pro-life-medical-association-member>) on patients after suspecting intent to end their pregnancy, calling patient-provider confidentiality into question. This could make pregnant people who ever expressed ambivalence about their pregnancy vulnerable to investigation; a recent study (<https://link.springer.com/article/10.1007/s13178-018-0359-4>) showed ~30% of women entering prenatal care considered an abortion for their current pregnancy.

Several states have proposed requiring reporting of miscarriages. Kansas (http://kslegislature.org/li_2014/b2013_14/measure/hb2613/) proposed a requirement for miscarriages and stillbirths to be reported to the state, while Virginia (<https://leg1.state.va.us/cgi-bin/legp504.exe?091+sum+SB962>) attempted to mandate reporting of pregnancy loss to law enforcement, including the name of the mother and the location of the pregnancy remains. Mandated reporting could affect patient-provider (<https://www.acog.org/About-ACOG/News-Room/News-Releases/2018/Criminalization-of-Self-Induced-Abortion-Intimidates-and-Shames-Women-Unnecessarily>) confidentiality, and may result in some some women delaying seeking care until they are in emergency situations. Many medical groups, including ACOG (<https://www.acog.org/Clinical-Guidance-and-Publications/Position-Statements/Decriminalization-of-Self-Induced-Abortion>), the American Medical Association (<https://policysearch.ama-assn.org/policyfinder/detail/Oppose%20the%20Criminalization%20of%20Self%20Induced%20Abortion?uri=%2FAMADoc%2FHOD.xml-H-5.980.xml>), and Physicians for Reproductive Health

(<https://prh.org/wp-content/uploads/2018/12/Self-Managed-Abortion-Position-Statement-2018.pdf>), oppose criminalization of self-managed abortion and oppose mandated reporting by clinicians if a self-managed abortion is suspected.

How can abortion restrictions result in the criminalization of pregnancy loss?

We highlight below how legislation surrounding personhood, fetal homicide and substance use in pregnancy has been used to criminalize women who experience pregnancy loss and the clinicians that manage their care.

WHAT IS “FETAL PROTECTION” LEGISLATION?

“Personhood” laws seek to grant full personhood, and thus full protection under the law, to the earliest stages of human development, including fertilized eggs. The push for “personhood” laws has increased in recent years

(<https://www.propublica.org/article/the-personhood-movement-timeline>); in May 2019, Alabama

([https://ballotpedia.org/Alabama_Amendment_2,_State_Abortion_Policy_Amendment_\(2018\)](https://ballotpedia.org/Alabama_Amendment_2,_State_Abortion_Policy_Amendment_(2018))),

passed into law the Human Life Protection Act, defining a person as including an “unborn child in utero at any stage of development.” Georgia

(<http://www.legis.ga.gov/Legislation/en-US/display/20192020/HB/481>) similarly included personhood language in the LIFE Act, which would ban abortion after the detection of cardiac activity, but neither the Alabama (<https://www.aclu.org/press-releases/alabama-abortion-ban-blocked>) and Georgia laws are currently in effect while being challenged in court. Colorado

(https://ballotpedia.org/Colorado_Definition_of_22Personhood22_Initiative,_Amendment_67_28201429), Mississippi

(https://ballotpedia.org/Mississippi_Life_Begins_at_the_Moment_of_Fertilization_Amendment,_Initiative_26_28201129), Oklahoma (https://www.huffpost.com/entry/oklahoma-personhood-fetal-personhood-bill_n_1465657?guccounter=1), North Dakota

(<https://www.bloomberg.com/news/articles/2013-03-22/north-dakota-lawmakers-send-personhood-amendment-to-voters>) and Kansas

(http://kslegislature.org/li/b2019_20/measures/documents/hcr5004_00_0000.pdf) have also introduced legislation to grant personhood rights as early as fertilization, however were not enacted.

Other types of “fetal protection” legislation exist. As of May 2018, 38 states had fetal homicide laws (<http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx>) distinguishing the death of the developing pregnancy from the death of the pregnant person; in 29 states, these laws apply to all stages of pregnancy. While these laws are typically applied against people who commit violent crimes *towards* pregnant women, they can also be used *against* pregnant people themselves in states without explicit exemptions. According to an analysis (<https://www.repository.law.indiana.edu/cgi/viewcontent.cgi?article=11110&context=ilj>) of state fetal homicide laws, as of 2014 at least 7 states did not include maternal exemptions for current pregnancies in their fetal harm laws.

One consequence of (<https://www.aclu.org/other/whats-wrong-fetal-rights>) “fetal protection” legislation is that by granting full rights to a fertilized egg, embryo or fetus, or by failing to provide sufficient exemptions to pregnant women in fetal harm laws, the rights and protections of the pregnant individual (<https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/14/03/renouncing-laws-to-recognize-fetuses-as-independent-of-pregnant-women>) may inevitably decrease. Because the pregnant person and their developing pregnancy can be regarded by the law as two separate entities, if a person experiences a pregnancy loss and they are thought to be at fault in any way, they could be charged with a crime using fetal protection legislation. This exposes pregnant people to possible investigations as to how their actions (substance use, medication use, exercise, diet, lifestyle, etc.) or inactions (missing prenatal care appointments, not taking prenatal supplements, etc.) during pregnancy may have led to their pregnancy loss. It remains uncertain whether fetal protection legislation may be used in the future to protect or criminalize pregnant individuals.

HOW HAS PREGNANCY LOSS BEEN CRIMINALIZED USING SUCH LEGISLATION?

There is a long history in the U.S. in which women have been criminalized for their own miscarriages or stillbirths. The National Advocates for Pregnant Women identified more than 400 criminal and civil cases (<https://read.dukeupress.edu/jhpl/article/38/2/299-343/13533>) from 1973-2005 in which a woman’s pregnancy was a necessary factor in the charge against her; sixty-eight of these cases involved a miscarriage, stillbirth or infant death attributed to the woman’s actions or inactions during pregnancy. While many of these cases did not mention any intent to end the pregnancy, they still resulted in charges including feticide, manslaughter, reckless homicide, child abuse and first-degree murder. The women involved were overwhelmingly low-income and women of color, highlighting racial and economic disparities in the legal system and healthcare. Below, we outline how individuals have been charged with crimes relating to their pregnancy losses after experiencing trauma, declining medical advice and using both legal and illicit drugs in pregnancy.

Experiencing Physical Trauma in Pregnancy

Employing fetal protection legislation, multiple women who experienced physical trauma during pregnancy have been charged with manslaughter after subsequent pregnancy loss or neonatal death. Various states have charged women with crimes related to their pregnancy loss in the setting of being shot in the abdomen (<https://www.nytimes.com/2019/06/27/us/pregnant-woman-shot-marshae-jones.html>), unintentionally falling down stairs (<https://rewire.news/article/2010/02/15/pregnant-dont-fall-down-stairs/>), attempting suicide (<https://www.usatoday.com/story/news/nation/2013/08/02/woman-freed-after-plea-agreement-in-babys-death/2614301/>) and being in car accidents (<https://www.nycourts.gov/ctapps/Decisions/2015/Oct15/179opn15-Decision.pdf>), as it was thought they put their fetuses in harm’s way. While several of these charges were

eventually dropped, some of these women have served jail time or prison sentences. This occurred recently in [Alabama](https://www.nytimes.com/2019/06/27/us/pregnant-woman-shot-marshae-jones.html) (<https://www.nytimes.com/2019/06/27/us/pregnant-woman-shot-marshae-jones.html>) for a woman who experienced a stillbirth at 5 months after being shot in the abdomen; she was initially charged with manslaughter of the fetus, as she was thought to have provoked the fight that resulted in her being shot.⁶ (<https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/view/footnotes/#footnote-441084-6>)

Declining Medical Advice in Pregnancy

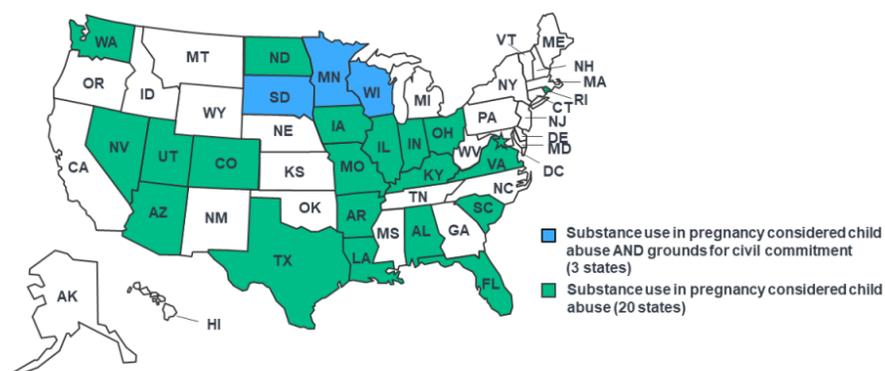
Several women who experienced stillbirths have been charged with murder under the rationale that if they had sought or adhered with medical care earlier they would have delivered healthy babies. In one such case, a woman who opted for a midwife-assisted [home delivery](https://www.upi.com/Archives/1982/05/07/Couple-charged-in-death-of-stillborn-child/4018389592000/) (<https://www.upi.com/Archives/1982/05/07/Couple-charged-in-death-of-stillborn-child/4018389592000/>) delivered a stillborn and was charged with reckless homicide for not presenting to the hospital for a cesarean delivery. Another woman pregnant with twins (one lived, one delivered stillborn) was charged with murder for declining a [recommended cesarean section](https://www.law.uh.edu/healthlaw/perspectives/Reproductive/040325Rowland.html) (<https://www.law.uh.edu/healthlaw/perspectives/Reproductive/040325Rowland.html>). These cases highlight how being pregnant may be used in medical decision making and the law to limit maternal rights and autonomy. Even if court ordered, [ACOG](https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Refusal-of-Medically-Recommended-Treatment-During-Pregnancy?IsMobileSet=false) (<https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Refusal-of-Medically-Recommended-Treatment-During-Pregnancy?IsMobileSet=false>) opposes forced medical interventions on pregnant women, as they believe coercion exploits power differentials, and violates patients' rights and bodily integrity, particularly in the case of surgery.

Substance Use in Pregnancy

The most common reason women are blamed for pregnancy loss is due to substance use. According to an investigation by [ProPublica](https://projects.propublica.org/graphics/maternity-drug-policies-by-state) (<https://projects.propublica.org/graphics/maternity-drug-policies-by-state>), 45 states prosecuted women for drug use during pregnancy from 1973-2015, regardless of if the pregnancy was harmed or not. In Minnesota, South Dakota and [Wisconsin](https://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html) (<https://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html>), women who use drugs can be involuntarily detained in a treatment program during pregnancy, while [23 states and D.C.](https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy) (<https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy>) consider substance use in pregnancy to be child abuse (**Figure 5**); as almost all medical professionals are mandated reporters of child abuse, this has significant implications on confidentiality when pregnant individuals seek medical care.

Figure 5

Many States Criminalize Substance Use in Pregnancy



Source: Guttmacher Institute. [Substance Use During Pregnancy](#). As of Aug 1, 2019. ProPublica. How States Handle Drug Use During Pregnancy. As of Sept 30, 2015.

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Figure 5: Many States Criminalize Substance Use in Pregnancy

Child abuse laws in South Carolina are particularly vague when it comes to pregnancy; in *Whitner v. State* (<https://caselaw.findlaw.com/sc-supreme-court/1238430.html>), child abuse was determined to include “maternal acts endangering or likely to endanger the life, comfort or health of a viable fetus”. Which “maternal acts” constitute child abuse has been left open to interpretation, but have often been applied in the context of illegal drug use.

Alabama also penalizes pregnant people who use drugs. Under [Alabama’s Chemical Endangerment Law](#) (<https://codes.findlaw.com/al/title-26-infants-and-incompetents/al-code-sect-26-15-3-2.html>), drug use during pregnancy constitutes a Class A felony in the event of a pregnancy loss, with a 10-99 year prison sentence. They define knowingly exposing a child (including a fertilized egg, embryo or fetus) to a “controlled substance” or “chemical substance” as a crime, and as of 2015, [479 pregnant women](#) (<https://www.propublica.org/article/when-the-womb-is-a-crime-scene>) were charged under this law due to in utero exposure to marijuana (24%), cocaine (22%), methamphetamines (18%) and opiates (14%). Other controlled substances include benzodiazepines (Xanax, Valium, Ativan) and many sleeping aids.

What about legal substances? Some laws criminalizing use of [controlled substances](#) (<https://www.deadiversion.usdoj.gov/schedules/>) in pregnancy do not distinguish between prescribed medications and those obtained illicitly. This makes [women prescribed opioids](#) (<https://www.propublica.org/article/when-the-womb-is-a-crime-scene>) for chronic pain or medication-assisted treatment ([MAT](#) (<https://www.samhsa.gov/medication-assisted-treatment>)) for opioid use disorder particularly vulnerable. For example, a woman in Alabama faced 20 years in prison and lost custody of her child after taking prescribed methadone during pregnancy.⁷ (<https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/view/footnotes/#footnote-441084-7>) Meanwhile, a woman in Louisiana miscarried after receiving the contraceptive

Depo-Provera (<https://blog.everymothercounts.org/a-new-study-details-how-roe-v-wade-and-proposed-personhood-laws-affect-every-woman-b6450825d48>) from her doctor while unknowingly pregnant; she served over a year in jail for second degree murder before charges were dropped. In 2016, Alabama (<https://rewire.news/legislative-tracker/law/alabama-bill-regarding-pregnancy-controlled-substances-sb-372/>) signed into law an exemption for women legally prescribed drugs from their chemical endangerment law. Despite this, gray area still remains as to how the use of legal, but not prescribed substances— like cigarettes, alcohol, herbal remedies and supplements—could be criminalized during pregnancy.

What does substance use research say? While multiple court cases (<https://read.dukeupress.edu/jhpl/article/38/2/299-343/13533>) have concluded substance use *caused* the woman's pregnancy loss, the medical reality of these cases is typically less straightforward. Several confounders pose barriers to studying the impact of substance use on pregnancy loss. Poor nutrition, medical comorbidities and lack of prenatal care can all influence a healthy pregnancy, and are prevalent among people with substance use disorders. Effects of substance use (<https://www.uptodate.com/contents/substance-use-by-pregnant-women>) in pregnancy also vary based on when in pregnancy the drug was taken, how often and at what dose. While decades of research on substance use and pregnancy have yielded mixed results, review of the literature suggests active cigarette (<https://www.ncbi.nlm.nih.gov/pubmed/24518810>) smoking and methamphetamine (<https://www.ncbi.nlm.nih.gov/pubmed/24905417>) use confer higher risks of pregnancy loss than in non-users. The relationship between pregnancy loss and alcohol⁸ (<https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/view/footnotes/#footnote-441084-8>), marijuana (<https://www.ncbi.nlm.nih.gov/pubmed/27607879>), cocaine (<https://www.ncbi.nlm.nih.gov/pubmed/8214673>)⁹ (<https://www.kff.org/womens-health-policy/issue-brief/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws/view/footnotes/#footnote-441084-9>), opiates (<https://anesthesiology.pubs.asahq.org/article.aspx?articleid=1936522>) and caffeine (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3121964/>) remains less clear. It should be emphasized that substance use is considered a risk factor for pregnancy loss, but has rarely been identified as the direct cause (<https://www.ncbi.nlm.nih.gov/pubmed/31240077>) of pregnancy loss.

What does the medical community say? ACOG (https://www.acog.org/Clinical-Guidance-and-Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Substance_Abuse_Reporting_and_Pregnancy_The_Role_of-the-Obstetrician-Gynecologist) has urged state legislators to retract laws punishing women for substance use in pregnancy, stating that punitive legal efforts are inappropriate and ineffective to address substance use disorders. Similarly, the American Medical Association (AMA (<https://jamanetwork.com/journals/jama/article-abstract/384076>)), the American Nurses Association (ANA

(<https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/nonpunitivetreatment-pregnantbreastfeedingwomen-sud.pdf>), the American Public Health Association ([APHA \(https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/03/10/56/illicit-drug-use-by-pregnant-women\)](https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/03/10/56/illicit-drug-use-by-pregnant-women)), the American Society of Addiction Medicine ([ASAM \(https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2017/01/19/substance-use-misuse-and-use-disorders-during-and-following-pregnancy-with-an-emphasis-on-opioids\)](https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2017/01/19/substance-use-misuse-and-use-disorders-during-and-following-pregnancy-with-an-emphasis-on-opioids)) and multiple other [medical organizations](#) (<http://advocatesforpregnantwomen.org/Health%20Statements%20re.%20Punitive%20Policies%20NAPW%202015.pdf>) oppose the criminalization of substance use disorder in pregnancy, as these policies [deter women](#) (<https://www.ncbi.nlm.nih.gov/pubmed/20407979>) from prenatal care, confiding in medical providers and seeking substance use disorder treatment.

Conclusions

Pregnancy loss is extremely common, and is sometimes conflated with abortion. Growing efforts to restrict abortion may create a medical and legal environment in which some pregnant people are discouraged from seeking medical care and are vulnerable criminalization if they experience pregnancy loss.

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[APPENDICES \(HTTPS://WWW.KFF.ORG/REPORT-SECTION/UNDERSTANDING-PREGNANCY-LOSS-IN-THE-CONTEXT-OF-ABORTION-RESTRICTIONS-AND-FETAL-HARM-LAWS-APPENDICES/\)](https://www.kff.org/report-section/understanding-pregnancy-loss-in-the-context-of-abortion-restrictions-and-fetal-harm-laws-appendices/) >

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