No. 2010-M-819-SCT

IN THE SUPREME COURT
OF THE STATE OF MISSISSIPPI

RENNIE T. GIBBS,

Appellant,

v.

STATE OF MISSISSIPPI,

Appellee.

On Grant of Interlocutory Appeal from the Circuit Court of Lowndes County

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BRIEF OF *AMICUS CURIAE* OF LEGAL VOICE AND PREGNANCY LOSS SUPPORT ORGANIZATIONS AND EXPERTS IN SUPPORT OF APPELLANT RENNIE GIBBS

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons have an interest in the outcome of this case. These representations are made in order that the justices of the Supreme Court and/or the judges of the Court of Appeals may evaluate possible disqualification or recusal.

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The Birth Attendants
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See Appendix A

Open Arms Perinatal Services
Seattle, WA
See Appendix A

The MISS Foundation
Tucson, AZ
See Appendix A

The Hygeia Foundation, Inc.
Institute for Perinatal Loss and Bereavement
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See Appendix A

Our Hope Place
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I. STATEMENT OF THE ISSUES AND STATEMENT OF THE CASE

Amici adopt the statements of issues and the case set forth in the Brief of Appellant.

II. STATEMENTS OF INTEREST OF AMICI CURIAE

Amici Curiae are leading non-profit organizations that provide support to women and families going through a pregnancy, childbirth, and/or pregnancy loss. They are also nationally-known academic experts and authors, each with expertise in how women and their families cope with pregnancy loss. *Amici* respectfully submit this brief to provide the court information about stillbirth, stillbirth prevention, and the profound grief associated with such losses. Individual statements of interest of *Amici* are attached to this brief as **Appendix A**.

III. SUMMARY OF ARGUMENT

Pregnancy loss remains a common outcome of pregnancies in the United States. The causes of stillbirth, in particular, are hard to identify, which adds both to the difficulty of prevention and to the emotional hardship experienced by bereaved women. Indeed, even when one identifiable factor associated with elevated risk of stillbirth is present, the interaction with other complex factors makes it extremely difficult to discern how and why the incident occurred. What anthropologists, social scientists, and, most importantly, women themselves know, however, is that pregnant women experience stillbirth as a profound loss. Prosecuting a woman—in this case, a teenage girl—enduring this experience is inordinately cruel. Treating as a murderer a girl who has experienced a stillbirth serves only to increase her suffering. Moreover, it reinforces the pervasive societal failure to acknowledge the grief that accompanies a stillbirth, and fails utterly to address the root causes of pregnancy loss.

IV. ARGUMENT

A. Thousands of Women in the United States Experience Stillbirth Each Year, Yet Its Causes Are Not Well Understood

Pregnancy loss is an unexpected and often shocking pregnancy outcome. American culture is rife with rituals reinforcing the expectation that a pregnancy will result in the birth of a child. The due date for the baby is routinely given at a woman's first prenatal visit, as if the simple fact that one is pregnant means a baby will be born on or around a particular date.[1] This practice masks the fact that approximately 15 to 20 percent of all pregnancies result in unintentional early pregnancy loss.[2] Naming the baby while in utero, baby showers prior to birth, and the preparation of a nursery reinforce the assumption that if a pregnant woman has reached the second or third trimester, she can count on bringing a baby home.[3] Yet an additional one percent of pregnancies—approximately 26,000 per year—end in stillbirth; another 19,000 per year end in neonatal death.[4] These statistics belie the notion that the birth of a living child is a guaranteed outcome of a pregnancy even if one "does everything right."

Stillbirth[5] is one of the most common adverse pregnancy outcomes.[6] Despite its relative frequency, its causes are not well understood.[7] Indeed, physicians cannot determine the cause of

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[1] Linda L. Layne, *A Women's Health Model for Pregnancy Loss: A Call for a New Standard of Care*, 32 FEMINIST STUDIES 573, 586 (2006).

[2] Raj Rai & Lesley Regan, *Recurrent Miscarriage*, 368 LANCET 601, 601 (2006).

[3] Linda L. Layne, MOTHERHOOD LOST: A FEMINIST ACCOUNT OF PREGNANCY LOSS IN AMERICA 17 (2003); *see also* Linda L. Layne, *"Your Child Deserves a Name:" Possessive Individualism and the Politics of Memory in Pregnancy Loss* in TROPES OF ENTANGLEMENT: TOWARDS AN ANTHROPOLOGY OF NAMES AND NAMING 31 (Gabriele vom Bruck & Barbara Bodenhorn eds., 2006).

[4] Ruth C. Fretts, *Etiology and Prevention of Stillbirth*, 193 AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY 1923, 1924 (March 2005).

[5] A stillbirth is the death of a fetus prior to delivery. Generally, the term "miscarriage" describes spontaneous abortion early in pregnancy, while the term "stillbirth" describes antenatal death later in pregnancy. Centers for Disease Control and Prevention, *Stillbirth* (October 28, 2009), http://www.cdc.gov/ncbddd/bd/stillbirths.htm. There is no universally accepted understanding of at what point fetal demise prior to birth is considered a stillbirth as opposed to a miscarriage. *Id.* American medical researchers commonly draw the line at 20 weeks gestation or a birth weight greater than 350 grams. R.L. Goldenberg et al., *Stillbirth: A Review*, 16 JOURNAL OF MATERNAL-FETAL & NEONATAL MEDICINE 79, 80 (2004).

[6] Goldenberg et al., *supra* note 5, at 79.

between 25 and 65 percent of all stillbirths.[8] Later pregnancy losses (after 28 weeks gestation) are even more likely to defy explanation,[9] partly because of limited research into the causes of stillbirth, which itself may be explained by a public perception that adverse pregnancy outcomes are rare. The lack of uniform definitions and the inaccurate collection of data further muddy the waters.[10] Identifying a single cause of a stillbirth is extremely difficult, as fetal demise can be very complex, and often results from the cumulative effect of several risk factors.[11]

B. Many of the Risk Factors for Stillbirth Are Beyond the Pregnant Woman's Control

If prosecutions for behavior during childbirth are any indication, pregnant women are the vector for blame for stillbirths. Some maternal factors—particularly cigarette smoking –have been strongly associated with stillbirth.[12] But association, and even a *likelihood* of causation, does not prove *actual* causation. Indeed, numerous other factors can increase a woman's likelihood of stillbirth. These include genetic predisposition, environmental hazards, intimate partner violence, paternal factors, lack of access to health care, and the fact that many health care providers have not adopted simple monitoring methods shown to help reduce the incidence of stillbirth.[13] Medical science has great difficulty separating these various factors and determining one particular cause of stillbirth.[14] Thus, prosecuting the pregnant woman because she experienced a stillbirth is not only wrong as a matter of social policy, it is highly likely to be wrong as a matter of fact.

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[7] *Id.* at 90; Fretts, *supra* note 4, at 1923.

[8] Fretts, *supra* note 4, at 1925; *see also* Melissa A. Sims & Kim A. Collins, *Fetal Death: A 10-Year Retrospective Study*, 22 AMERICAN JOURNAL OF FORENSIC MEDICINE & PATHOLOGY 261 (2005).

[9] Fretts, *supra* note 4, at 1925.

[10] *See, e.g.,* Goldenberg et al., *supra* note 5, at 79, 89-90.

[11] Donald J. Dudley et al., *A New System for Determining the Causes of Stillbirth*, 116 OBSTETRICS & GYNECOLOGY 254, 258 (August 2010).

[12] Goldenberg et al., *supra* note 5, at 82.

[13] *Id.* at 80-88.

[14] Dudley et al., *supra* note 11, at 258.

1. A pregnant woman's health history, age, and other factors contribute to her risk of stillbirth.

Stillbirths happen more frequently to women at both ends of the spectrum of childbearing years: older pregnant women are more likely to experience a stillbirth, as are teenage girls.[15] Women carrying multiples also bear a heightened risk of stillbirth.[16] An elevated risk for intrauterine fetal death is also associated with maternal health conditions such as obesity, hypertension, and diabetes.[17] Similarly, inherited conditions, such as lupus, increase the risk of stillbirth.[18] Indeed, these losses "tend to cluster in families," indicating that genes contribute to an increased risk of stillbirth.[19]

2. Conditions outside the pregnant woman's body also contribute to the risk of stillbirth.

a. Lack of Access to Health Care

Another obvious risk factor for stillbirth is lack of prenatal care, and indeed, good medical care throughout a woman's lifespan. Access to decent medical care is a key determinant of health outcomes.[20] Inability to pay for health care is a strong predictor of fetal death, especially near-term fetal death.[21] Both a lack of prenatal care early in pregnancy and poor quality of prenatal care are associated with an increased risk of stillbirth.[22]

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[15] Brian T. Bateman & L. L. Simpson, *Higher Rate of Stillbirth at the Extremes of Reproductive Age: A Large Nationwide Sample of Deliveries in the United States*, 194 AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY 840 (2006); *see also* Sims & Collins, *supra* note 8, at 263.

[16] Goldenberg et al., *supra* note 5, at 82.

[17] Fretts, *supra* note 4, at 1928; Sims & Collins, *supra* note 8, at 264; Goldenberg et al., *supra* note 5, 87.

[18] Goldenberg et al., *supra* note 5, at 87.

[19] Cande v. Ananth et al., *Stillbirths in the United States, 1981-2000: An Age, Period, and Cohort Analysis*, 95 AMERICAN JOURNAL OF PUBLIC HEALTH 2213, 2216 (2005).

[20] AGENCY FOR HEALTH CARE RESEARCH AND QUALITY, HEALTH CARE FOR MINORITY WOMEN: RECENT FINDINGS 2 (April 2009), http://www.ahrq.gov/research/minority.pdf.

[21] Goldenberg et al., *supra* note 5, at 81.

[22] Sims & Collins, *supra* note 8, 265.

b. Exposure to Environmental Toxins

Numerous toxins routinely present in the workplace,[23] in homes, and in communities[24] pose reproductive health hazards. Exposure to high levels of lead, mercury, and certain pesticides can each affect fetal development and increase the incidence of stillbirth.[25] These risks are not merely speculative. In one infamous example, people living in Woburn, Massachusetts in the 1970s suffered high rates of childhood leukemia and an elevated incidence of stillbirth, eventually linked to water contamination.[26] While not every worker or community suffers such toxins exposures, communities of color, low-income neighborhoods, and workers without the option to avoid hazardous chemicals are more likely to be subject to such exposures.[27]

c. Paternal Factors

Furthermore, when fetal protection is at issue, employers, policy-makers, and here, prosecutors, focus exclusively on maternal factors that may increase the risk of fetal death, without considering paternal factors, including age, alcohol and caffeine consumption, cigarette smoking, drug use, genetic conditions, and exposure to workplace and wartime environmental toxins.[28] This is not to suggest that men should be prosecuted for cigarette smoking or drug use

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[23] *See, e.g.,* Cynthia R. Daniels, *The Science and Politics of Male-Mediated Fetal Harm* in EXPOSING MEN: THE SCIENCE AND POLITICS OF MALE REPRODUCTION 109, 127 (2006) ("OSHA estimates that workers are regularly exposed to more than 1,000 chemicals that have been identified as reproductive hazards").

[24] There is a vast literature on environmental injustice beyond the scope of this brief. For an overview by one of the founders of the movement for environmental justice, *see* Robert D. Bullard, *Mississippi River Symposium: Building Just, Safe, and Healthy Communities*, 12 TUL. ENVTL. L.J. 373 (1999).

[25] *See, e.g.,* Linda C. Fentiman, *New Scholarship on Reproductive Rights: In the Name of Fetal Protection: Why American Prosecutors Pursue Pregnant Drug Users (And Other Countries Don't)*, 18 COLUM. J. GENDER &L. 647, 653-654 (2009) (listing the numerous risks of such exposures).

[26] Linda L. Layne, *In Search of Community: Tales of Pregnancy Loss in Three Toxically-Assaulted Communities in the U.S.*, 29 WOMEN'S STUDIES QUARTERLY 25 (2001).

[27] Bullard, *supra* note 24, at 382-387.

[28] *See* Daniels, *supra* note 23, at 138 (discussing, among other paternal factors that may influence adverse pregnancy outcomes, the federal Government Accountability's office findings that soldiers serving in Iraq and Kuwait have been potentially exposed to 22 different toxins that endanger reproductive health); *see also Int'l Union v. Johnson Controls*, 499 U.S. 187, 198-199 (1991) (holding that employer violated Title

when they are the parent of a stillborn baby. But prosecuting a woman for a stillbirth ignores the contribution of sperm and paternal acts, and assumes that all aspects of fetal development rest entirely with the pregnant woman and her behavior during pregnancy. This is scientifically unsound, and grounded in long-rejected notions of women's roles in the family and society.[29]

d. Intimate Partner Violence

Pregnant women are particularly vulnerable to domestic violence.[30] Intimate partner violence against pregnant women can cause the death of the pregnant woman, physical injury, miscarriage, stillbirth, and can lead to low fetal birth weight.[31] While the physical trauma of a violent assault can cause fetal death, adverse pregnancy outcomes may also be related to additional factors short of traumatic injury, including the chronic stress of living with domestic abuse, the association of domestic abuse with maternal coping mechanisms such as cigarette smoking and substance use, and a lack of access to prenatal care.[32]

VII of the Civil Rights Act by discriminating against women employees on the basis of sex when it excluded women—but not men—from lead-exposed jobs.); Dep't Of Health & Human Services, Pub. No. 96-132, *The Effects Of Workplace Hazards On Male Reproductive Health* 2, tbl.1 (1997), http://www.cdc.gov/niosh/malrepro.html.

[29] *See, e.g., Johnson Controls*, 499 U.S. at 211(acknowledging that views of women as potential reproducers was used historically to deny them equal employment opportunities); *see also Planned Parenthood v. Casey*, 505 U.S. 833, 896-897 (1992) (affirming a woman's constitutional right to terminate her pregnancy, and, in striking down a provision of Pennsylvania law requiring a married woman to notify her husband prior to abortion, noting the history of legal constraints placed on women based on their reproductive capacity.)

[30] *See* Julie A. Gazmararian et al., *Prevalence of Violence Against Pregnant Women*, 275 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1915, 1918 (1996).

[31] *See* Patricia A. Janssen et al., *Intimate Partner Violence and Adverse Pregnancy Outcomes: A Population-Based Study*, 188 AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY 1341, 1346-47 (2003) (finding an association between abuse of pregnant women and perinatal death); *see also* Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 88 IND. L.J. 667, 672 (2006) (in the context of a thorough overview of research into intimate partner violence during pregnancy, *citing* Thomas M. Goodwin & Michael T. Breen, *Pregnancy Outcome and Fetomaternal Hemorrhage After Noncatastrophic Trauma*, 162 AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY 665 (1990).)

[32] Loraine Bacchus et al., *Domestic Violence: Prevalence in Pregnant Women and Associations with Physical and Psychological Health*, 113 EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY 6 (2004) (*citing* American and Scottish studies).

e. Health Disparities

Structural inequalities also contribute to the incidence of stillbirth. As the federal Agency for Healthcare Research and Quality explains, "race, education, income, and social status all interact to affect the health of pregnant women."[33] Lower-income women have higher rates of stillbirth.[34] Shockingly, African-American women suffer stillbirths at twice the rate of their white counterparts.[35] In fact, African American women suffer disproportionate rates of many adverse pregnancy consequences, including ectopic pregnancies, infant mortality, premature labor, and low birth-weight babies.[36]

While these disparities have increasingly been studied, researchers have yet to identify a clear, single determinant.[37] However, what is *not* determinative of these disparities is the use of illegal drugs, as rates of drug use are similar across race and class lines.[38] Rather, lifelong lack of access to health care and poverty increase disparate outcomes.[39] At the same time, these determinants do not entirely explain the higher rate of disparate pregnancy outcomes for African American women. African American women are more likely to experience premature labor and have low birth weight babies even when controlling for socioeconomic status, access to early and

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[33] AGENCY FOR HEALTH CARE RESEARCH AND QUALITY, HEALTH CARE FOR MINORITY WOMEN: RECENT FINDINGS 6 (April 2009), http://www.ahrq.gov/research/minority.pdf.

[34] Fretts, *supra* note 4, 1926.

[35] *Id.*, Marian Willinger et al., *Racial Disparities in Stillbirth Risk Across Gestation in the United States*, 201 AM. J. OF OBSTETRICS & GYNECOLOGY 469.e1 (2009) (African American women had higher rates of stillbirth than white women, and higher educational status widened, rather than reduced, these disparities).

[36] *See* Michael C. Lu et al. Closing the Black-White Gap in Birth Outcomes: A Life-course Approach, 20 ETHNICITY & DISEASE S2-62 (2010).

[37] *Id.*

[38] *See* Substance Abuse and Mental Health Services Administration, *Results from the 2006 National Survey on Drug Use and Heath: National Findings*, OFFICE OF APPLIED STUDIES, NSDUH SERIES H-32, DHHS PUBLICATION NO. SMA 07-4293, Appendix G (2006).

[39] Lu et al., *supra* note 38, at S2-62; *see also* Allison Kempe et al., *Clinical Determinants of the Racial Disparity in Very Low Birth Weight*, 32 NEW ENGLAND JOURNAL OF MEDICINE 969, 973 (1992) (noting that "racial disparities in the frequency of very low birth weight are rooted in profound social inequities and calling for additional research to help address the "complex cascade" of factors that cause such disparities).

regular prenatal care, and other variables.[40] Research increasingly indicates that chronic stress from racial discrimination plays a role in health disparities.[41] Indeed, many factors, including experiences of racism, and lack of consistent access to health care, may contribute to the higher incidence of pregnancy loss for African American women.[42]

Prosecutions of women who experience stillbirths necessarily fall more heavily on the populations most at risk, including African American women and low-income women.[43] Research indicates that the majority of such prosecutions—virtually all ultimately found to be without legal basis—have been directed at women of color and/or low-income women.[44] As noted above, the etiology of stillbirth is rarely easily understood. Selecting *some* women for prosecution based on one factor that a prosecutor believes to cause stillbirths is illogical and unjust; prosecuting *any* woman after she suffers a stillbirth is cruel and shortsighted.

f. Health Care Providers' Lack of Implementation of Prevention Tools

In contrast to the seemingly intractable social problems of poverty, domestic violence, environmental degradation, and discrimination, health care providers can implement inexpensive measures when caring for pregnant women that may help reduce stillbirth. Studies have shown

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[40] Lu et al., *supra* note 38, at S2-62.

[41] *Id.* at S2-71 ("Increasing evidence suggests racism may be the 'cause of the cause' of health disparities in the United States.").

[42] *Id.* at S2-62-73 (proposing a "life-course" model for recognizing and addressing the many factors that lead to disparate birth outcomes).

[43] *See* Dorothy Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1432-1436 (1991) (explaining that African American women are much more likely to be the targets of the punitive response to drug use during pregnancy, for a variety of reasons, including the fact that health care professionals are more likely to report the drug use of an African American patient than a white patient, even though rates of substance use during pregnancy are similar across race and economic status.)

[44] *Id.* at 1421; *see also* Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* 172 (1997); Jeanne Flavin, *Our Bodies, Our Crimes: The Policing of Women's Reproduction in America* 109 (2009).

that charting fetal movement significantly reduces fetal mortality rates.[45] Yet, Mississippi does not appear to have either a unified public health campaign or a standardized practice among physicians and midwives to implement the regular charting of fetal movement.

The numerous risk factors—genetic, environmental, societal—that could cause stillbirths, along with the myriad possibilities for prevention, counsel interventions aimed at improving research, reducing environmental toxins, educating all people about prevention, providing support when needed to overcome addiction to cigarettes and other substances, and ensuring lifelong access to health care, including prenatal care. Such a strategy has the additional effect of honoring, rather than discounting, the loss that the pregnant woman has suffered.

C. Regardless of the causes of pregnancy loss, pregnant women experience stillbirth as a profound loss.

1. Pregnant women and their families grieve after a stillbirth.

American society has historically granted little public acknowledgment of the grief and feelings of loss associated with pregnancy loss.[46] The experiences of such loss are therefore hidden and tend to be suffered in private.[47] Yet, despite (or perhaps in part because of) society's failure to honor these losses, pregnant women suffer profound grief after a stillbirth.[48]

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[45] *See* Fretts, *supra* note 4, at 1930 (*citing* J. Frederik Frøen, et al., *A Kick From Within –Fetal Movement Counting and the Cancelled Progress in Antenatal Care*, 32 J. OF PERINATAL MED. 13-24 (2004)).

[46] *See e.g.*, Layne, *supra* note 2, at 59-79, 247 (numerous cultural factors, including discomfort with confronting death and expectations of linear progress, combine to create a strong social taboo against openly grieving a pregnancy loss); *see also* Rosanne Cecil, *Introduction: An Insignificant Event? Literary and Anthropological Perspectives on Pregnancy Loss*, in THE ANTHROPOLOGY OF PREGNANCY LOSS: COMPARATIVE STUDIES IN MISCARRIAGE, STILLBIRTH, AND NEONATAL DEATH 2 (Rosanne Cecil ed., 1996); Irving G. Leon, *Perinatal Loss*, in PSYCHOLOGICAL ASPECTS OF WOMEN'S HEALTH CARE, SECOND EDITION 141, 143 (Nada L. Stotland & Donna E. Stewart eds., 2001).

[47] Linda L. Layne, *Breaking the Silence: An Agenda for a Feminist Discourse of Pregnancy Loss*, 23 FEMINIST STUDIES 289 (1997); *see also* Rosanne Cecil, *Memories of Pregnancy Loss: Recollections of Elderly Women in Northern Ireland* in Cecil, ed., *supra* note 46, at 179,181,186.

[48] Leon, *supra* note 46, at 147-148; *see also* Joanne Cacciatore & Suzanne Bushfield, *Stillbirth: A Sociopolitical Issue,* 23 AFFILIA: JOURNAL OF WOMEN AND SOCIAL WORK 378 (2008) ("Giving birth to a dead baby is one of the most profound losses that a woman can suffer and has a wide variety of emotional, cognitive, psychological, spiritual, and physiological consequences") (citations omitted).

Those who have not experienced a pregnancy loss sometimes have difficulty understanding why pregnant women and their families suffer so intensely.[49] For this and other cultural reasons, friends, families and communities often fail to recognize the event.[50] Family, friends, and others typically tell women who have just suffered a stillbirth "don't worry, you can try again," or other platitudes that fail to acknowledge the magnitude of the woman's experience.[51] Yet, contrary to what one may imagine, the pregnancy did not just disappear. The pregnant woman experiences labor and childbirth, giving birth to a baby who, in most instances, friends and family members never see. In effect, she suffered a loss invisible to others.[52]

The role that childbirth plays in the trauma of pregnancy loss is significant. Giving birth is hard; giving birth to a baby who has died in utero is harder still. One reason is psychological: if the demise has been discovered before birth, as it often is, women must face the challenges of labor without the "prize" at the end.[53] In addition, some women report that they so desperately did not want the pregnancy loss to happen, they fought their bodies, trying to hang onto the pregnancy.[54]

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[49] Leon, *supra* note 46, at 158-159.

[50] *Id.*; *see also* Layne, *supra* note 2, at 64-65; Cacciatore & Bushfield, *supra* note 48, at 380.

[51] *See* BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *Our Bodies, Ourselves*, 2nd ed. 502-503 (2005) ("Child-bearing loss evokes many emotions. You . . . may feel buffeted and torn by confusion, relief, shame, anger, sorrow, fear, powerlessness, or despair. You may need to withdraw at first and not confront a reality that may be too much to bear. You may feel entirely numb. You may want those around you to comfort you physically and listen empathetically. Platitudes such as "You'll have another baby before you know it'" or "Think of your wonderful children at home" are usually not comforting. Thoughtful compassion from family, friends, and health care practitioners is crucial.").

[52] Leon, *supra* note 46, at 143, 147-148.

[53] Linda Layne, *Designing a Woman-Centered Health Care Approach to Pregnancy Loss: Lessons from Feminist Models of Childbirth* in REPRODUCTIVE DISRUPTIONS: GENDER, TECHNOLOGY 89 (Marcia Inhorn ed., 2007).

[54] *Id.* at 100.

Common experiences of grief in pregnancy loss include feelings of shame, self-blame, anxiety, and the intense desire to have another pregnancy.[55] It may be extremely difficult for the person who has suffered stillbirth to be near other families with babies or young children.[56] While every individual will experience a pregnancy loss in a unique way, research supports the proposition that women (and to a slightly lesser extent, their partners) suffer psychological harm, extreme feelings of grief and loss, and even trauma after a stillbirth.[57] For some women, intense feelings of depression, anxiety, and despair will linger for years.[58] Others may recover and integrate the loss into their lives more readily, but still feel a deep sense of alienation from their communities "because their mourning experiences are generally devalued."[59]

Grief after pregnancy loss, while suffered differently from person to person, is not unique to any particular group or class of women. One cannot assume that a teenager, for example, would not experience a stillbirth as a grievous loss. Indeed, a large study of mothers of stillborn babies conducted jointly by the MISS Foundation and the International Stillbirth Alliance indicates that young women have a higher incidence of anxiety and depression associated with pregnancy loss.[60] A woman who has been targeted for prosecution after a stillbirth shares these same feelings of despair. Although the voices of women in these circumstances are obscured by societal reprobation, anecdotal reports confirm what is obvious: a woman, regardless of circumstances, also and just as poignantly grieves her loss.[61]

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[55] Leon, *supra* note 46, at 148-150.

[56] *Id.* at 151.

[57] *Id.* at 148-150; *see also* Cacciatore & Bushfield, *supra* note 48, at 378.

[58] Leon, *supra* note 46, at 141.

[59] *Id.*; *see also* Cacciatore & Bushfield, *supra* note 48, at 378 (citations omitted).

[60] E-mail from Joanne Cacciatore, researcher, to Linda L. Layne, anthropologist (Nov. 10, 2010, 09:00:11 EST) (on file with author).

[61] *See, e.g.*, Patrick Reardon, *'I Loved Her,' Mother Says 'Shocked' Over Arrest in Baby's Drug Death*, CHI. TRIB., May 11, 1989, at News 1, http://articles.chicagotribune.com/1989-05-11/news/8904110840_1_bianca-cocaine-apartment-building (reporting the arrest of Melanie Green, the

2. After pregnancy loss, women often unduly blame themselves for what they could not have prevented.

Women typically cast about for an explanation for such a loss and hold themselves responsible, even absent evidence that their behavior led to the stillbirth.[62] Women blame themselves even when they have substantial evidence that factors beyond their control led to pregnancy losses, as in the cases of extreme exposure to environmental toxins in Love Canal, New York, Woburn, Massachusetts, and Alsea, Oregon.[63] Medical anthropologist Gail Landsman found a similar trend with mothers whose babies were born with disabilities.[64] None of the mothers interviewed for her study had children whose disabilities were attributed by medical professions to maternal behavior. Yet, with few exceptions, they initially assumed "that they personally must have done something wrong to account for the disability.[65]

While women may blame themselves for adverse pregnancy outcomes, society must not reinforce that message. First, it is particularly cruel for the state to assert, as in this case, that cocaine toxicity caused the stillbirth when scientific research has in fact been unable to find a causal connection between cocaine use and stillbirths.[66] Second, blaming women for stillbirth disregards the numerous risk factors for fetal death that the pregnant woman cannot possibly

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mother of a six-year old boy and a baby who died two days after her birth. As Ms. Green explained in the interview, losing her daughter "was the worst time in my life." She told the reporter that she tried to get help for substance addiction during her pregnancy, but was offered none. Green's pastor told the reporter that her baby's death was "very traumatic" for Green. Ms. Green told the reporter, "I loved her, I did.") A grand jury refused to indict Ms. Green and she was not prosecuted. Patrick Reardon, *Grand Jury Won't Indict Mother in Baby's Drug Death*, CHI. TRIB., May 27, 1989, at News 1.

[62] Layne, *supra* note 2, at 146-152.

[63] Layne, *supra* note 26.

[64] Gail H. Landsman, RECONSTRUCTING MOTHERHOOD AND DISABILITY IN THE AGE OF "PERFECT" BABIES 15-47 (2009).

[65] *Id.* at 18.

[66] *See, e.g.*, Teresa A. Campbell & Kim A. Collins, *Pediatric Toxicologic Deaths: A 10 Year Retrospective Study*, 22 AM. J. FORENSIC MED. & PATHOLOGY 184, 187 (2001) (in a retroactive study of pediatric deaths, including stillbirths and neonatal deaths, maternal cocaine use was considered "contributory," not causal, in five of eight cases, but even in those cases "the direct cause and effect is still under much investigation.").

control, including significant societal conditions that lead to disparate birth outcomes. Moreover, prosecution diverts both attention and resources from research and education that could prevent stillbirth. Finally, it discourages those women who need prenatal care but fear prosecution from seeking the care, treatment, and support necessary for healthy pregnancies.[67]

3. Recognition of the importance of acknowledging and honoring perinatal loss has grown in recent decades.

Until the United States improves its birth outcomes—and likely even after—pregnancy loss will remain a reality. It is important, therefore, that women who have suffered pregnancy loss and their families receive compassionate care from the medical profession, their families, and communities.[68] The pregnancy loss support group movement,[69] established in the mid-1970s, has done significant work toward providing and advocating for such support. In addition to giving bereaved parents a place to discuss their losses with a sense of normalcy, the self-help groups' efforts influenced an improved medical response to stillbirth and neonatal death.[70]

As recently as thirty years ago, perinatal death was treated as an insignificant event by the medical profession.[71] Today's medical standard of care requires recognition and support.[72] Share, Pregnancy & Infant Loss Support, Inc., the largest pregnancy loss support organization in

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[67] Roberts, *supra* note 43, at 1449; *see also* American Med. Ass'n Bd. Of Trustees, *Legal Intervention During Pregnancy*, 264 JOURNAL OF THE AMERICAN MEDICAL ASS'N 2663, 2667 (1990); March of Dimes, *Statement on Maternal Drug Abuse* 1 (Dec. 1990) ("[F]ear of punishment may cause women most in need of prenatal services to avoid health care professionals"); *see also Ferguson v. City of Charleston*, 532 U.S. 67, 84 n.23 (2001) (holding unconstitutional a program in which health care providers informed law enforcement of pregnant women's drug test results, and noting that *amici* in that case"[claim] a near consensus in the medical community that programs of the sort at issue, by discouraging women who use drugs from seeking prenatal care, harm, rather than advance, the cause of prenatal health.")

[68] *See* Leon, *supra* note 46, at 153 ("Perhaps more than any other single variable, the availability or absence of social support may influence both the process and the outcome of pregnancy loss.")

[69] Layne, *supra* note 2, 41-57.

[70] *Id.* at 44-46.

[71] Leon, *supra* note 46, at 141.

[72] *Id.*

the United States, endorses a set of "Rights of Parents When a Baby Dies."[73] These rights now constitute the accepted standard of care for women whose babies are stillborn or die shortly after birth.[74] These rights include the right of the woman "to be given the opportunity to see, hold, touch, and bathe her baby", "to name her baby", and "to be cared for by an empathetic staff."[75]

Studies show that offering bereaved women these opportunities are important for their mental health following a loss.[76] Social support following a loss is likewise correlated with better mental health outcomes.[77] One hopes Ms. Gibbs was provided compassionate care immediately after suffering a stillbirth; she should have been provided the social support she needed to recover in the aftermath. Prosecuting her is the inverse of "social support" and can reasonably be expected to damage her emotional and mental health.

4. Prosecuting women for stillbirth does not address underlying causes.

As the Appellant argues in her opening brief, the plain language of the homicide statutes, alongside the legislative rejection of laws penalizing pregnant women who seek to continue their pregnancies despite of a drug problem, make clear that the Mississippi Legislature has chosen not to address these issues through the criminal law. *Amici* contend that the Legislature has taken the correct approach. Resources would be better directed at research to understand and prevent stillbirth, and on improving the appalling rates of health disparities in the United States. It was not until 2003 that United States researchers began working to obtain a geographic population-based determination of the incidence of stillbirth, and such research remains seriously

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[73] Share, Pregnancy & Infant Loss Support, Inc., Your Rights, http://www.nationalshare.org/rights.html (last visited Nov. 17, 2010).

[74] *Id.*

[75] *Id.*

[76] Joanne Cacciatore et al., *Effects of Contact with Stillborn Babies on Maternal Anxiety and Depression*, 35 BIRTH 313 (2008).

[77] Leon, *supra* note 46, at 153; *see also* Joanne Cacciatore et al., *The Effects of Social Support on Maternal Anxiety and Depression After Stillbirth*, 17 HEALTH AND SOCIAL CARE IN THE COMMUNITY 167-176 (2009).

underfunded.[78] Prosecutions like this do nothing to address stillbirth, and may have the perverse effect of discouraging women who want to carry their pregnancies to term, but who need treatment for addiction, from seeking prenatal and other medical care.

V. CONCLUSION

Prosecuting a woman for a stillbirth is cruel, inhumane, ignores the root causes of poor pregnancy outcomes and perinatal loss and discourages those who most need prenatal care from seeking it. Treating a woman (in this case, a teenage girl) who suffers this loss as if she were a murderer sends a public message that women are to blame for stillbirth, when in fact the causes of stillbirth are often unknown and are difficult to link with maternal or paternal conditions. A society with compassion for women's experiences of pregnancy loss would direct resources at researching ways to prevent stillbirth and improving disparate pregnancy outcomes, rather than prosecuting the grieving woman.

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[78] *See* First Candle, Research http://www.firstcandle.org/grieving-families/stillbirth/about-stillbirth/research/ (last visited Nov. 17, 2010) (noting that "research specific to stillbirth has been slow in coming" and lauding a three million dollar federal funding commitment for such research.) *Amici* are also pleased with any funding infusion but posit that significant additional funding is needed to fully document and identify the causes of and prevention tools for stillbirth.

IN THE SUPREME COURT OF MISSISSIPPI

RENNIE T. GIBBS,	)	
	)	
APPELLANT	)	
	)	**CASE #: 2010-IA-00819-SCT**
	)	
v.	)	
	)	
STATE OF MISSISSIPPI,	)	
	)	
APPELLEE.	)	

CERTIFICATE OF SERVICE

Undersigned counsel for *Amicus Curiae* Legal Voice certifies that he has this day served the Brief of *Amicus Curiae* upon:

James T. Kitchens, Jr.
Lowndes County Circuit Judge
Post Office Box 1387
Columbus, Mississippi 39703

by placing a copy of the same in the U.S. Mail First Class, postage prepaid.

This 31st day of January 2011.

James M. Priest, Jr., MSB [redacted]
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CERTIFICATE OF SERVICE

I hereby certify that I have this date served a copy of the above and foregoing on all counsel of record for the parties by placing a copy of the same in the United States mail, postage prepaid and addressed to their regular mailing address, or by hand delivery, as follows:

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Lynn Paltrow
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This the 19th day of November, 2010.

James M. Priest, Jr.

APPENDIX A

STATEMENTS OF INTEREST OF *AMICI CURIAE*

Organizations

The Birth Attendants is a grass roots collective providing informational, physical and emotional resources to incarcerated women and mothers. Since 2002, the Birth Attendants have provided one-on-one support for people incarcerated at the Washington Corrections Center for Women, including labor and birth support by experienced doulas, postpartum depression support, and help adjusting to parenting from behind bars. The Birth Attendants also provide reproductive health classes, emotional support, and support post-release. Because pregnancy loss is a part of the spectrum of birth experience, the Birth Attendants have provided support and care for women who have lost their pregnancies, and recognize firsthand that the trauma resulting from the loss of a child necessitates mental and physical support.

The Hygeia Foundation, Inc. is a national non-profit organization dedicated to providing comfort to those who grieve the loss of a pregnancy or newborn child, and to raising awareness of the impact of perinatal and neonatal death. The Hygeia Foundation provides this support through online community support groups, local in-person support groups, and the provision of education and information to both families and health care providers. More than 30,000 bereaved families participate in its programs. The Hygeia Foundation supports the premise that perinatal and infant morbidity and mortality can be affected by providing all women and their families perinatal bereavement counseling, pre- and inter-conception counseling, and access to comprehensive women's healthcare services.

Legal Voice, formerly known as the Northwest Women's Law Center, is a regional non-profit public interest organization that works to advance the legal rights of all women through public impact litigation, legislation and legal rights education. Since its founding in 1978, Legal

Voice has been dedicated to protecting and expanding women's reproductive rights. Toward that end, Legal Voice has participated as counsel and as *amicus curiae* in cases throughout the Northwest and the country. Legal Voice opposes, and has successfully challenged in the northwest states, prosecutions of pregnant women for their pregnancy outcomes, and works to end punitive measures that undermine the humanity and legal rights of all pregnant women.

The MISS Foundation is an international non-profit organization with more than 77 chapters around the world, dedicated to helping and healing families during and after the death of a child from any cause, at any age. More than half the organization's members have experienced stillbirth. The MISS Foundation provides culturally competent counseling, an array of support services, and mental health care to parents and their families following a stillbirth. Part of the organization's mission is to conduct culturally sensitive empirical research to improve psychosocial care to and policies for the traumatically bereaved. In the United States alone, about 100,000 people per year utilize these services. Recognizing the trauma and long term negative consequences of stillbirth, the MISS Foundation works toward more compassionate policies and laws for bereaved families and to facilitate a healing and healthy societal response to traumatic bereavement from stillbirth.

Open Arms Perinatal Services (Open Arms) is a non-profit organization in Seattle, Washington, providing birth doula services to women and their families in the Puget Sound area. Since 1997, Open Arms has offered services to pregnant women who would otherwise find themselves alone or with little support. Open Arms provides prenatal support and parenting education, continuous emotional and physical support throughout labor and delivery, and assistance in the first six weeks after delivery. The organization is committed to providing services that are culturally and linguistically appropriate, providing bilingual and bicultural doulas when possible. Open Arms embraces a world that cherishes birthing women, their babies,

families and communities. Prosecuting a woman for a pregnancy loss is a wrongheaded response to a tragic loss, and does nothing to promote healing or address disparate health outcomes affecting low-income communities and communities of color in the United States.

Our Hope Place, (www.OurHopePlace.com), is a web resource and blog created by Laura Racanelli and Sharon Stenger, two long time friends who have each experienced miscarriage. They decided to share their friendship, a special bracelet and its inspiring story to help other women who have also experienced this type of loss. The mission of Our Hope Place is to demystify miscarriage and offer advice to individual sufferers of miscarriage, as well as to friends, spouses and partners, on how to best comfort and help in this time of need. Our Hope Place joins this brief because pregnancy loss is one of the most devastating experiences that can happen to a woman. Even if you follow all the "right" advice from your doctor, you are not guaranteed to give birth to a healthy baby. There are many factors that come into play. Instead of spending time and money on convicting mothers who have had a stillbirth, efforts would be better spent on education, health care, and support for the women who suffer these losses.

Individual *Amici Curiae*

Joanne Cacciatore, Ph.D. is Asst Professor and Director, Graduate Certificate in Trauma and Bereavement, at Arizona State University School of Social Work. She suffered the death of her fourth daughter Cheyenne in 1994. Cheyenne died during birth on her due date from unknown causes. Dr. Cacciatore has since devoted herself to advocacy, research, and direct practice with bereaved parents. She is the author of numerous articles and publications on the grief associated with stillbirth and pregnancy loss. Ms. Cacciatore joins the brief to help illuminate the profound grief a woman suffers after a stillbirth, a grief that remains too often shrouded in silence.

Denise Coté-Arsenault, Ph.D. is Associate and Brody Professor at the University of Rochester School of Nursing. Dr. Cote-Arsenault is a nurse researcher who specializes in research on pregnancy loss. She is most recently the co-author of *Emotional Cushioning in Pregnancy After Perinatal Loss*, published in the Journal of Reproductive and Infant Psychology in October 2010. She suffered a pregnancy loss at 20 weeks gestation. In her experience, women who have suffered a stillbirth are subject to significant emotional trauma, making prosecution and incarceration extremely misguided and inappropriate.

Cynthia R. Daniels, Ph.D. is Professor of Political Science at Rutgers University. She has published widely on questions of gender equality, racial and class politics, fetal rights and reproductive politics, violence against women, and the law. Her most recent book is Exposing Men: The Science and Politics of Male Reproduction . She is also the author or editor of four other books and dozens of articles and book chapters including *At Women's Expense: State Power and the Politics of Fetal Rights* (winner of the American Political Science Association's Victoria Schuck Award), and Lost Fathers: The Politics of Fatherlessness in America. Dr. Daniels' work points up the lack of attention to men's reproductive health and the impact of paternal factors on pregnancy outcomes.

Ina May Gaskin, MA, CPM, is founder and director of the Farm Midwifery Center, located near Summertown, Tennessee. Between 1971 and 1996, the Farm handled more than 2,600 births. The Farm has remarkably low rates of intervention, morbidity and mortality. However, inevitably, some of their pregnancies end in heartbreaking loss, including Ms. Gaskin's own loss of her son who was born two months early and lived for twelve hours. She is author of Spiritual Midwifery, now in its fourth edition. In 1997, she received the ASPO/Lamaze Irwin Chabon Award and the Tennessee Perinatal Association Recognition Award. Ms. Gaskin latest book, Birth Matters, scheduled for publication in March of 2011,

includes discussion of the grief and trauma associated with pregnancy loss. Ms. Gaskin herself has attended more than 1,200 births. Her experience teaches that grief is the normal, typical reaction to stillbirth and neonatal death.

Anne Hohenstein, J.D., is an attorney and a mother of two surviving children. Her first child, Sarah, died two days after she was born, unexpectedly and after an uneventful and normal term pregnancy. Ms. Hohenstein is co-editor of Unseen Voices/Voces No Vistas, a forthcoming collection, in English and Spanish, of art and writing on pregnancy and child loss. Her book seeks to honor and support families who have suffered such irretrievable losses. Ms. Hohenstein joins this brief out of a strong conviction that to exacerbate these sorrows with vindictive and misguided criminal prosecution misses their point, not only for the mother, but for all.

Gail Landsman is Professor Emerita in the Department of Anthropology, University at Albany, State University of New York. She is author of the book Reconstructing Motherhood and Disability in the Age of "Perfect" Babies, and was a member of the panel that prepared the New York State Department of Health Early Intervention Program's Clinical Guidelines for Children with Motor Disabilities. Among the findings of her research on mothers of disabled infants and toddlers is that in many cultures throughout the world, including the United States, there is a tradition of blaming mothers for adverse pregnancy outcomes regardless of actual causation; as a consequence, women whose pregnancies do not result in healthy children are made to feel guilty and experience stigma and isolation.

Linda Layne, Ph.D. is Hale Professor of Humanities and Social Sciences and Professor of Anthropology at Rensselaer. She is author of Motherhood Lost, a study based on long-term ethnographic research with members of pregnancy loss support organizations, and co-producer of Motherhood Lost: Conversations, an award-winning, eleven-episode educational television series. She is a contributor to the Childbearing Loss chapter of Our Bodies, Ourselves and co-

editor of Understanding Reproductive Loss (forthcoming). Since experiencing the first of seven miscarriages in 1986, Dr. Layne has used her training as a medical anthropologist to work toward better public understanding and social support for these those who suffer these heartbreaking events. She also works to support efforts to lower the incidence of pregnancy loss by educating the public and health-care providers about paternal factors, fighting intimate partner violence, protecting the environment, and making sure all pregnant women have access to quality prenatal care, including substance abuse treatment if needed, and urging health care providers to use systematic kick counting to reduce the number of stillbirths.

Joanne Leonard is the Diane M. Kirkpatrick and Griselda Pollock Distinguished University Professor of the School of Art and Design and Women's Studies Program at the University of Michigan. Professor Leonard suffered a pregnancy loss as a single woman in 1973. Following this loss, Leonard produced a pioneering work, Journal of a Miscarriage, which has been exhibited and published in several places including Being in Pictures: An Intimate Photo Memoir. Pregnancy loss is largely an invisible tragedy for the approximately one million American women a year who suffer miscarriage or stillbirth. Professor Leonard uses her artwork to make such losses visible, and to break the taboos that keep these losses hidden in shrouds of shame. Professor Leonard joins this brief because a woman who has suffered a stillbirth needs support, not condemnation from her community and the law.

Laury Oaks is Associate Professor of Feminist Studies, Sociology, and Anthropology at the University of California, Santa Barbara. Ms. Oaks is the author of Smoking and Pregnancy: The Politics of Fetal Protection based on research in the Baltimore, Maryland area. She argues that social forces shape public and medical experts' attitudes about what is "safe" during pregnancy and documents changes in medical, social, and, therefore, legal perceptions of "risks" during pregnancy.

Sarah Kye Price, PhD, MSW is Assistant Professor, Virginia Commonwealth University School of Social Work. Dr. Kye Price is a National Institute of Health-funded researcher and scholar focused on understanding the interrelationships among disparities in fetal and infant mortality and the mental health and psychosocial well-being of low income women and families. While medical research has not uncovered the precise causal mechanisms of fetal and infant mortality, including stillbirth, epidemiological studies confirm their heightened prevalence in communities where health and mental health resources are the most scarce. This creates not only greater risk for adverse pregnancy outcomes, but a higher likelihood of mental health and psychological sequalae created by exposure to multiple losses. Dr. Kye Price asserts that structural systems of change will have more systemic impact on improving pregnancy and birth outcomes than the prosecution of individuals whose lives are interwoven with the structural inequalities created by racism, poverty and other social determinants of health.

Barbara Katz Rothman is Professor of Sociology at the City University of New York, and holds Visiting Professorships at the Charite Medical School in Berlin, the University of Plymouth in the United Kingdom, and with the International Midwifery Preparation Program of Ryerson University in Toronto, Canada. She has written, cowritten, or edited nine books on childbearing, medical sociology and bioethics including In Labor, updated and rewritten as Laboring On with co-author Wendy Simonds, The Tentative Pregnancy, Recreating Motherhood, The Encyclopedia of Childbearing, and Bioethical Issues, Sociological Perspectives. Of special relevance to this case is her book Centuries of Solace: Expressions of Maternal Grief in Popular Literature, co-authored with Wendy Simonds. Since the late 1970s, the grief of women who experience miscarriage, stillbirth, or the death of an infant has been an increasingly visible topic in mainstream American publications. Dr. Katz Rothman joins this brief because stillbirth is

experienced as a tragedy, and women should not be punished for their vulnerability to the numerous risk factors that increase the likelihood of stillbirth.

Janet Stein, M.D., is a board certified OGBYN practicing in high risk obstetrics in a major teaching hospital in New York City. Dr. Stein has been in practice for over twenty years, working specifically with pregnant women who have current and past substance addiction. Dr. Stein's goal is treatment of the pregnant woman, connection to care and treatment, and access to resources and support. Involving law enforcement and the judicial system in no way enhances medical care and it does nothing to improve birth outcomes.

Heather Swain, novelist, suffered two pregnancy losses, one of which she describes in a nonfiction piece published in 2003 as "My Flesh and Blood", www.Salon.com, and on which she drew in writing her novel, Luscious Lemon, which centers on the devastating experience of a pregnancy loss. Ms. Swain joins this brief because pregnancy loss, whether early or late-term, is not a crime, but a sad reality of pregnancy for some women, regardless of whether they "do everything right." Prosecuting women for the loss of a pregnancy devalues and harms women, and reinforces an incorrect perception that women are to blame for pregnancy loss.

Susannah Thompson, PhD is an Honorary Fellow in the School of Humanities, University of Western Australia. Dr. Thompson is a social historian whose award-winning research focuses on the changing attitudes towards perinatal loss in Australia and other western societies. As a historian working primarily with oral history testimony, Dr. Thompson's work demonstrates that many women – and indeed, their families – are profoundly affected by perinatal loss, often for many years after the event and even after the birth of subsequently healthy children. Grief after perinatal loss cuts across age and cultural boundaries. Dr. Thompson supports this brief both as a scholar and the mother of a stillborn baby.