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Introduction

Unintended Intrauterine Death and Preterm Delivery: What Does Philosophy Have to Offer?

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This special issue of the Journal of Medicine and Philosophy focuses on unintended intrauterine death (UID) and preterm delivery (both phenomena that are commonly—and unhelpfully—referred to as "miscarriage," "spontaneous abortion," and "early pregnancy loss"). In this essay, I do two things. First, I outline contributors' arguments. Most contributors directly respond to "inconsistency arguments," which purport to show that abortion opponents are unjustified in their comparative treatment of abortion and UID. Contributors to this issue show that such arguments often rely on a grossly oversimplified picture of abortion opponents' views. Furthermore, contributions in this issue weigh in on issues regarding UID with theoretical import and therapeutic implication beyond the inconsistency argument debate. These papers can be mined for principles that better inform us about anembryonic pregnancies (i.e., nonviable pregnancies in which a gestational sac exists but no embryonic pole can be seen via transvaginal ultrasound), UID-prevention research, the law concerning UID (especially post-Dobbs), policies for handling embryonic remains, and moral psychology as it relates to UID, emotion, and empathy. In each case, conceptual philosophical analysis might bring about therapeutic benefits for those affected by UID. Philosophers, therefore, are in position not only to provide clarity—careful analysis and discussion of UID and related phenomena—but are also in position to genuinely help people affected by UID.

KEYWORDS: *early pregnancy loss, miscarriage, preterm delivery, spontaneous abortion, unintended intrauterine death*

I. INTRODUCTION

It is widely accepted that human organisms begin to exist at the completion of conception.[1] Tragically, 40%–60% of them die within weeks of being conceived (Blackshaw and Rodger, 2019, 107). If so, then 100–200 million very young human organisms die each year (Miller, 2023). I will use the phrase, "unintended intrauterine death" (UID) to refer to these deaths.[2] How might philosophers (and other academics) respond to facts about UID, if at all? Some might think that UID is largely irrelevant. Philosophers do not have the tools to prevent UID—doing so is not their job—and so, they might have nothing to say about it.[3] In this essay, I take a different view. Philosophers, I argue, have much to contribute to discussions of UID. To illustrate, consider an analogy from the philosophy of religion. Discussions of "the problem of evil" are sometimes divided into two categories: theoretical problems and existential or "pastoral" problems (van Inwagen, 2006, 10–11; Hasker, 2008, 21). Discussions about UID can adopt a similar framework.[4] The former category—theoretical engagement—might provide clarity concerning the nature of UID, its causes, the moral, and metaphysical status of human beings that die in utero, obligations to prevent UID, moral questions surrounding research into

UID-prevention, and so on. The latter category—therapeutic engagement—provides support, benefit, or care for those who are bereaved by UID, whether in the form of enacting social change, adjustments to clinical practices, providing the bereaved with resources (directly), etc.[5] In short, as I will argue here, philosophers have tremendous potential to engage in productive discussions of UID on both theoretical and therapeutic grounds.[6]

To elaborate, in Section II, I outline recent (theoretical) discussions of UID which focus upon "inconsistency arguments." In Sections III–VII, I outline five ways in which philosophical discussions can—and *should*—reach further. Topics worth exploring include: anembryonic pregnancies, UID-prevention research, the law concerning UID (especially post-*Dobbs*), policies for handling embryonic remains, and moral psychology as it relates to UID, emotion, and empathy. In each case, theoretical issues are underexplored, and theoretical inquiry has substantial therapeutic value. By sketching this territory, I hope others will follow this issue's contributors in seeking answers to more questions about UID than have been discussed thus far.

II. INCONSISTENCY ARGUMENTS (AND THEIR SHORTCOMINGS)

Many recent discussions of UID have centered around "inconsistency arguments" which purport to show that opponents of abortion are inconsistent in their treatment of abortion and UID.[7] With help from Shaw (2022), Blackshaw, Colgrove, and Rodger (2022c) outline the general structure of inconsistency arguments as follows:

1. If abortion opponents who oppose abortion for reason A should Z and they do not Z, then they are inconsistent.
2. Abortion opponents who oppose abortion for reason A should Z.
3. Abortion opponents who oppose abortion for reason A do not Z.
4. Hence, abortion opponents who oppose abortion for reason A are inconsistent.

Suppose, for instance, someone opposes abortion given their belief that personhood begins at conception. If so, then (the argument goes) they should take extreme measures to combat UID. They fail to do so (it seems). Since these people *should* take extreme measures to combat UID (but fail to do so), they are inconsistent.[8]

Articles in this issue offer novel insights into the failures of inconsistency arguments. Anderson (2023) attacks the second premise of the inconsistency argument when the premise takes the following form: *abortion opponents who oppose abortion because fetuses have full moral status should make preventing UID a higher priority than preventing abortion*. Against this, Anderson defends "the asymmetry between the badness of spontaneous abortion and induced abortions in order to better explain why anti-abortionists prioritize stopping induced abortions over preventing spontaneous abortions." Put simply, inconsistency arguments often rely on an oversimplified account of action and morality. Critics' "focus on the moral status of embryos and its implications for the relative badness of spontaneous and induced abortions is too narrow to properly capture why anti-abortionists treat the two phenomena asymmetrically." The (justifiable) asymmetry in play "depends on a variety of factors." First, intention differs. Unlike abortion, UID involves no intent that death occurs. Second, parents' "ability to prevent such deaths from occurring" differs. Couples cannot typically prevent UID. Hence, UID typically involves neither killing nor letting die, while abortion involves killing. Third, the "default" differs. With abortion, the default—what would happen were an abortion not performed—is usually the embryo's "growth and development." In contrast, when UID is imminent the default is the death of the embryo. We need, therefore, a richer "pluralist account of moral assessment"—which considers control, the default, etc.—when discussing inconsistency arguments. By failing to do this, standard inconsistency arguments rest on an oversimplified understanding of abortion opponents' perspectives.

Like Anderson (2023), Miller argues that abortion opponents have sufficiently good "reason to seek the prevention of abortion more urgently than the prevention of miscarriage" (2023, 225). Whereas, Anderson (2023) focuses on an action theory that undergirds many abortion opponents' views, Miller (2023) focuses on ways in which abortion is far worse—or "more degrading"—than UID. First, abortion procedures commonly "involve dismembering the live fetus" in ways that will appear to most

observers "as straightforward murder" (Miller, 2023, 230).[9] Second, "abortion involves the systematic and state-sponsored violence against a particular class of people," and so, "involves the systematic *dehumanization* of a class of people" (Miller, 2023, 230–231). Prioritizing opposition to state-sponsored violence, discrimination, and dehumanization over the combating of naturally occurring death is, Miller (2023) argues, perfectly justifiable.[10] Third, Miller claims abortion is "extremely harmful to those participating" in it (in ways that UID is not) (2023, 231). There is, for example, "evidence linking abortion with increased suicide rates and increased mortality" (Miller, 2023, 231).[11] If abortion is more harmful to pregnant women than UID, that is another reason to oppose abortion more forcefully than UID. Put simply, "bad features of abortion" and the badness of UID are asymmetrical. So—contra inconsistency arguments—many reasons justify opposing abortion more strongly than UID.

Next, Waters (2023) responds to two formulations of the inconsistency argument, both advanced by Berg (2017).[12] These are "the abortion argument" and "the cancer argument," respectively. In each case, inconsistency arguments hinge on there being "a basic similarity between preventing deaths from [UID] and preventing deaths from abortion or cancer." These deaths, however, are not relevantly similar. First, consider the abortion argument. All else being equal, we have stronger reasons to prevent killing than naturally occurring deaths. Murder involves "a rights violation and thus is unjust, whereas it is 'merely' bad when someone dies of a disease."[13] If abortion involves unjust killing—as abortion opponents often claim—then obligations to prevent abortion are "stronger than any duty to reduce" UID. Unlike abortion, UID "does not violate rights and is not an issue of justice."[14] Opposing abortion over UID, therefore, is justifiable. Regarding "the cancer argument," Waters argues that "the badness of deaths of born human beings is considerably greater than the badness of deaths of fetuses" due to asymmetries in "time-relative interests" (2023, 247, Cf. Blackshaw, 2019). Waters remarks, "most born humans have very strong psychological connections to their future selves" which embryos will lack. Deaths of born humans, therefore, are "a considerably greater bad than deaths from [UID] (for the individuals in question)" (2023, 248) Objectors may argue that "if the deaths of embryos are not so bad because they have very limited time relative interests, then perhaps it would not be seriously wrong to kill them." Waters (2023) responds that even if there is an asymmetry in the badness of death between embryos and adults, the wrongness of killing is a separate matter. That a human being lacks time relative interests may explain why their death is relatively less bad, but that does not make it permissible to kill them.

Delaney (2023) targets a different inconsistency argument altogether. It goes like this. Some people claim that "human embryos have the same moral status as infants, children, and adults" (Delaney, 2023, 252). This is the "embryos have high moral status" or "EHMS" view. EHMS proponents who are aware of the prevalence of UID "and nevertheless attempt to conceive children through natural procreation are willingly sacrificing the embryos lost in pregnancy for the healthy children that they later have" (Delaney, 2023, 253). If someone "genuinely believed" EHMS, however, then they would *refrain* from sacrificing these embryos. Since EHMS advocates do not refrain from "sacrificing" embryos, however, they are "morally inconsistent" (perhaps, do not *really* believe EHMS after all).[15] In response, Delaney argues that "embryos lost in pregnancy are not properly regarded as a 'sacrifice' since they are not made worse off" (2023, 253). He explains: "to be worse off in the relevant sense," it must be that "coming into existence" and dying in utero "is worse than never coming into existence at all" (Delaney, 2023, 256).[16] That is not so, however. Prior to existence, an individual either has "no well-being level at all" or they have a well-being level of zero. If the former is correct, then existence does not—and indeed, *cannot*—reduce one's well-being. If the latter is correct, then to make someone "worse off," coming into existence must drop the individual's well-being level from zero to some negative value. This is implausible. On any account of well-being, embryos who die very young have lives that either include "*no* elements of positive or negative well-being" or some positive level of well-being (Delaney, 2023, 257). Hence, EHMS advocates who procreate do not "sacrifice" embryos (i.e., they do not make embryos "worse off" at all).

If these arguments are sound, then inconsistency arguments are fraught with problems. At best, they raise philosophically interesting questions for abortion opponents. Responses to such questions make substantial philosophical progress on a plurality of issues (e.g., action theory, the comparative badness of different deaths, etc.). Philosophers, however, have much more to offer beyond advancing inconsistency arguments, as demonstrated by Bohn (2023).[17] Bohn shows that imprecise language surrounding UID

"causes psychological harm" (2023, 266). Terms like "miscarriage," "spontaneous abortion," and "early pregnancy loss" all tend to obscure either "the object of the bereaved's grief" (i.e., the baby that has died) or "the physically difficult and often traumatic experience women have when they deliver their dead children" (Bohn, 2023, 266). The term, "pregnancy loss," for instance, obscures the fact that bereaved parents mourn "the loss of their babies, not their pregnancies" (Bohn, 2023, 268). The death of one's child applies to each parent equally as well, but terms like "pregnancy loss" and "miscarriage" do not. Hence, these terms harm "non-gestational parents" who are left with "no words to describe their specific, individual experiences" (Bohn, 2023, 271). Imprecise language also "leaves women and their partners unprepared" for "the physical impact [delivery] can have even early in pregnancy" (Bohn, 2023, 274). The healthcare community harms patients, therefore, when they "downplay the physical impact of preterm delivery," say, by "comparing it to a 'heavy period'" (Bohn, 2023, 274).[18] Put simply, social expectations are built upon a failure to understand that "miscarriage" involves death *and delivery*. When the medical community fails to make the reality of death and delivery clear, therefore, they harm patients.

Philosophical analyses of terms and concepts surrounding UID enable us to reshape our language in ways that reduce harm in significant ways. As Bohn remarks, "none of the many, significant efforts currently made to address the psychological harm the bereaved incur can mitigate these harms *without* changing language to discuss intrauterine death and premature delivery clearly" (2023, 277). Here, I follow Bohn's (2023) lead by seeking ways in which philosophers can speak about UID in theoretically rigorous and therapeutically beneficial ways. Topics that I explore include: (Section III) anembryonic pregnancies, (Section IV) UID-prevention research, (Section V) the law concerning UID, (Section VI) handling of embryonic remains, and (Section VII) moral psychology and UID.

III. UNDERSTANDING ANEMBRYONIC PREGNANCY

"Anembryonic pregnancy" (or "blighted ovum") accounts for UID in "about 50% of first trimester miscarriages" (American Pregnancy Association, 2021; Chaudhry, Tafti, and Siccardi, 2022, 4). What occurs in such cases is underdiscussed—and sometimes misunderstood—in philosophical circles. Misunderstanding, in general, generates dubious clinical practices. Specifically, anembryonic pregnancy involves "a nonviable pregnancy with a gestational sac that does not contain a yolk sac or embryo" (Prager, Micks, and Dalton, 2022) How should EHMS advocates think about these cases? Blackshaw and Rodger write that these entities "may never have been human organisms" (2019, 107).[19] Waters (2023) also suggests omitting cases of anembryonic pregnancy when assessing the prevalence of UID. Anderson notes that failure to subtract cases of "incompletely formed embryonic material" makes UID seem more prevalent than it is (2023, 221). Miller adds that "if the embryo never forms, then according to the standard pro-life view, there is no organism and hence, no life lost" (2023, 226). Critics of EHMS—like Fleck (1979) and Harris (2003)—think differently. Fleck argues that EHMS implies "the personhood of all fetuses, whether deformed or not" (1979, 274). Harris adds that "those who accept the moral importance of the embryo" are not justified "in discounting the lives of unhealthy embryos" (2003, 353). Miller ultimately rejects the "standard pro-life view" as well, since "the events in early pregnancy are too poorly understood … to know how many anembryonic pregnancies involve embryos that formed and then were destroyed, which would presumably still count as deaths" (2023, 226).[20]

Miller's (2023) view seems correct, but incomplete. Even in cases of anembryonic pregnancy where an embryo never forms, that does not imply that a human organism did not exist. This is because the term, "embryo," is ambiguous. It may refer to the entire organism or to *part* of the organism, where the latter part eventually "develops into a fetus, then an infant" (Cleveland Clinic, 2022). As Sadler explains, "approximately 3 days after fertilization, cells of the compacted embryo divide again to form a 16-cell morula (mulberry). Inner cells of the morula constitute the inner cell mass" (ICM) which "gives rise to tissues of the embryo proper" (2019, 42–43). Here, an "embryo" (i.e., post-conception organism) differs from an "embryo proper" (i.e., *part* of the organism, which forms days after conception). In cases of anembryonic pregnancy, the cells and structures that would normally give rise to the "embryo proper" are sometimes called the "embryonic pole" (or "fetal pole") (Prager, Micks, and Dalton, 2022). Importantly, the term "anembryonic pregnancy" refers to cases where *the latter* is absent.

Absence of an embryonic pole occurs in two kinds of cases. First, when the embryonic pole forms and is destroyed. Second, when the embryonic pole never forms. The first kind of anembryonic pregnancy involves the death of an organism (Cf. Miller, 2023). The second involves an organism's death as well, though less straightforwardly. In such cases, some parts of the organism—the gestational sac and/or yolk sac—form even though the embryonic pole does not. To count as an organism, Condic (2022) notes, entities must exhibit a certain kind of integration. Even "human embryos from the one-cell (zygote) stage" exhibit the relevant kind of integration (Condic, 2022, 22). The presence of a gestational sac and/or yolk sac is good evidence that—post-conception—integration was occurring, at least for a time. That is, the remaining tissues (embryonic parts) imply there was integration and coordination of cells post-conception, even if the organism's development was arrested very soon after conception. Cases of anembryonic pregnancy where an embryonic pole never forms, therefore, seem comparable to extreme cases of anencephaly. Critical parts of the organism fail to develop, but that does not imply the organism never existed.

Questions about anembryonic pregnancy and identity are worth exploring, especially when anembryonic pregnancy is caused by genetic abnormalities (e.g., when genetic abnormalities prevent the embryonic pole from developing properly). Miller mentions this issue, asking whether interventions to "save" lives from causes of UID are "identity-preserving" (2023, 228). Specifically, "if substantial genetic changes are not identity-preserving, then many genetic anomalies are not treatable" (Miller, 2023, 228). In such cases, death is "unpreventable in a way that cannot be solved by research" (Miller, 2023, 228). If Miller is correct, then interventions would merely "bring into existence" a different child than the one that is (otherwise) dying (2023, 228). There is no moral imperative to bring individuals into existence. Calls for abortion opponents to support research into these matters, therefore, are unwarranted. Either way, philosophers should examine the metaphysics and moral implications associated with anembryonic pregnancies. Generally, producing a fine-grained taxonomy of all causes of UID coupled with an explanation of whether (and why) each involves the death of a human organism would be useful.

There is therapeutic value here. "Embryo," we saw, may mean "the entire human organism post-conception" or "embryonic pole" (i.e., part of the organism). How clinicians talk about anembryonic pregnancy, therefore, may be confusing (if not psychologically harmful) to patients. Given the ambiguity, when anembryonic pregnancies are discovered, saying things like "there is no embryo"—indeed, the very word "anembryonic"—is misleading. Patients will interpret this to mean there is currently no embryo and *never was one* (which is false) or that there is currently no embryo even though there used to be one (which is true). Following Bohn's (2023) lead, this is another way in which clinical practice obscures the object of what is lost. To use Bohn's (2023) language, the patient may think that they never carried a "baby" (read, "human organism"). If so, then they have no appropriate object for their—now disenfranchised—grief. By disambiguating and clarifying the nature of what happens in anembryonic pregnancies, therefore, we improve patient understanding of what happened. This, Bohn (2023) argues, is an important step for many in the healing process: understanding what happened and identifying the object of their grief.

Relatedly, medical professionals draw a distinction between anembryonic pregnancy and cases of "'embryonic or fetal demise' in which an embryo or fetus is visualized but cardiac activity is not present" (Prager, Micks, and Dalton, 2022) This language carries the implicature that in cases of anembryonic pregnancy, embryonic demise (the death of an embryo) does not occur. As argued above, this is false. In cases of "embryonic demise" *so described*, the developing human likely lived *longer* than those in cases of anembryonic pregnancy.[21] But embryonic demise—the death of an embryo—occurs in both cases, even when an embryonic pole never forms. Limiting the phrase, "embryonic demise" only to cases where a dead embryo is *visualized* misleads patients regarding what happened and what was lost.[22] As such, careful analysis and description of what happens during anembryonic pregnancy (and UID) improves clinical practice and patients' understanding.

IV. UID-PREVENTION RESEARCH

Next, consider UID-prevention research. Critics of abortion opponents sometimes insist not enough is being done. Ord says EHMS advocates must "make an immediate push for large-scale research programs" to prevent UID (2008, 17). Simkulet expresses "exasperation" that in the face of UID, EHMS

advocates "simply *give up!*" (2022, 462). In contrast, Colgrove (2021) outlines some of what is being done to prevent UID (directly and indirectly). Bohn (2021) and Miller (2023) do as well. Miller (2023) notes that UID may be unpreventable for *metaphysical* reasons.[23] Assessing causes of UID provides insight into what can (or could, hypothetically) be done to prevent it. Specifically, it would be worth:

(a) Developing a detailed overview of what is currently being done for *each cause* of UID,
(b) Exploring what *might* be done for causes of UID that currently lack a treatment,
(c) Assessing the moral implications of actual and hypothetical UID research programs,
(d) Explaining whether each preventative measure is identity-preserving or not,
(e) Debating whether these research initiatives might garner bipartisan support, and
(f) Identifying any moral obligations to pursue UID-prevention research, whether one endorses EHMS or not.

Category (a) fills in details to which Bohn (2021), Colgrove (2021), and Miller (2023) allude. Category (b) looks at gene editing or research involving embryoids (or iBlastoids) as ways of developing UID-prevention techniques. Category (c) involves considering whether such research raises moral problems. If embryoids (or iBlastoids) count as human organisms, for instance, then EHMS advocates would oppose research that involves their destruction (just as they oppose current research programs that destroy embryos). This remains so *even if* such research would reduce UID.[24] Category (d) requires understanding the (many) causes of UID and explaining the link between identity and proposed treatments or interventions.

Regarding category (e), Berg claims that UID-prevention "is relatively more politically tractable" than abortion prevention, since "working to end miscarriage … does not face organized political opposition" (2017, 1220).[25] Can abortion opponents and proponents cooperate (substantially) to prevent UID? Like Waters (2023), I am skeptical, albeit for different reasons.[26] For abortion opponents, UID-prevention is driven by concern for the humanity of unborn children. Abortion proponents, in contrast, aim primarily to promote reproductive autonomy. Anti-abortion (or pro-EHMS) guardrails on UID-prevention research, therefore, will be rejected by pro-abortion (or anti-EHMS) groups. This is happening now, in fact, with recent calls to extend the 14-day rule (McCully, 2021). From an anti-EHMS perspective, why *should* protections for embryos limit progress on UID-prevention (or other initiatives)? Research that is morally "in bounds," therefore, will vary between anti- and pro-abortion camps. Perceived *value* of UID-prevention research varies too. From an anti-EHMS perspective, embryo selection is usually sufficient for accomplishing the goals of reproductive autonomy.[27] Hence, funding UID-prevention—to the exclusion of other healthcare issues—is wasteful. EHMS advocates, in contrast, greatly value identify-preserving UID-prevention techniques. That UID-prevention research is valued differently presents another obstacle to collaboration.

Category (f) examines connections between moral obligations to prevent UID and beliefs about moral status. Delaney (2023) claims commitment to EHMS (or rejection of it) has "significant implications" for issues surrounding UID. Two questions arise. First, if EHMS is correct, then what are our obligations to prevent UID? How would the truth of EHMS bind us when it comes to UID-prevention? Second, do obligations regarding UID-prevention change based on our acceptance or rejection of EHMS? Finley, for example, gives reason to deny that similar obligations "apply in a specific way to those who are opposed to abortion" (2022, 150). If so, then obligations regarding UID do not change based on our beliefs about EHMS. There is room for debate here.

There is therapeutic value to these theoretical discussions of UID-prevention. As Bohn observes, "47% of women feel guilty and 41% feel that they did something wrong" following UID (2023, 272).[28] If Miller (2023) is right, then in some cases of UID, *literally nothing* could save one's child. Those struggling with guilt can find comfort in this. One cannot be held morally responsible for something that was impossible to prevent. We could ask, what *led* to relevant genetic abnormalities and whether someone could be responsible for causing them. But if events leading to UID cannot be prevented, then following Anderson (2023), condemnation (or guilt) are inappropriate. We are not responsible for things "over which we have no control."[29] In sum, by discussing genetics, causation, control, and responsibility philosophers position people to overcome misplaced guilt. Finally,

sometimes interventions prevent UID (e.g., cervical cerclage in cases of incompetent cervix) (Mayo Clinic, 2021). There will also be cases where intervention *might* prevent UID (e.g., by using NaPro Technology or progesterone) (Hilgers, 2011; Bohn, 2021, and Wise, 2021). There is room to explore clinicians' moral and professional obligations regarding disclosure of this information, both in general and when UID is directly threatened. Ultimately, when asking what could prevent UID in a given case, we will often come up empty. Other times we will not. Regardless, philosophical analysis of causation, control, and responsibility is warranted.

V. UID AND THE LAW, POST-DOBBS

Following *Dobbs*, numerous authors have raised concern over the effect of abortion restrictions on treatment for UID. Iffath Hoskins (the president of ACOG) for instance, said *Dobbs* is "going to have a devastating effect on every aspect of a woman's health care including if she is miscarrying" (Rubin, 2022, 318). Kulczycki argues that providers may "refuse care in cases of spontaneous miscarriages and ectopic pregnancies for fear of wrongful denunciations and possible legal suits" (2022, 926). Davis adds that "providers who are concerned about criminal prosecution might feel pressure to wait to treat an ectopic pregnancy until the point that the pregnant person's life is in danger as a result of a ruptured fallopian tube" (2022, 327). Given such risks, Wynia says "professional civil disobedience may be what is required to repair … the integrity of [the medical] profession" (2022, 961).

Are such concerns warranted? Philosophical analysis, in response, has clear theoretical, and therapeutic (practical) implications. Allow me to illustrate. Wynia relies on Arey et al. (2022) when asserting that "abortion bans are already pushing physicians in some states to wait until patients become critically ill before intervening in cases of ectopic pregnancy or septic miscarriage" (2022, 960). Arey et al. (2022), in turn, focus on Texas Senate Bill 8 (SB8). Curiously, they do not cite SB8. Rather, Arey et al. interview "25 clinicians … about how SB8 has affected their practice" (2022, 388).[30] Obviously, how the law is interpreted by clinicians may differ from what the law says. Philosophers (and legal scholars) must clarify matters by articulating what documents like SB8 say/mean, in the service of resolving clinicians' misconceptions of the law, *especially* when such misconceptions expose patients to unnecessary harms.[31]

Here is a sketch of how to do this. SB8 is an amendment to Texas's "Health and Safety Code" concerning abortion. "Abortion" is defined as "an act of using or prescribing" some means "*with the intent* to cause the death of an unborn child."[32] The full code states that "an act is not an abortion if the act is done with the intent to … remove an ectopic pregnancy."[33] So, why do we find authors like Wynia asserting—in the *New England Journal of Medicine*, no less—that *the law* is pressuring physicians to "wait until patients become critically ill before intervening in cases of ectopic pregnancy" (2022, 960)? Are these authors looking at SB8 (2021) alone, since it states that abortions may only be performed in cases where "a medical emergency exists"? If so, that is a grave mistake. In context, these limitations do not apply to ectopic pregnancy at all. Explicitly, treatment for ectopic pregnancy is not regarded as an abortion. Any "pressure" to "wait to treat an ectopic pregnancy," therefore, stems from a misunderstanding of the law, not a limitation set forth by the law.[34] Philosophers (and other academics) must provide clarity here. Serious ethical questions arise about *their own* research when they purposefully (or carelessly) perpetuate misunderstandings of the law in ways that risk serious harm (or death) to patients who experience ectopic pregnancies.

What about complications such as "septic miscarriage" associated with UID? As Bohn (2023) notes, "miscarriage" is ambiguous. In each case, we need to know whether embryonic death has occurred. If it has, then there are no barriers to treatment.[35] What about cases where UID is imminent; must physicians wait to intervene until those patients become "critically ill?" On SB8, no. Texas law defines a medical emergency as "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that … places the woman in danger of death or a serious risk of substantial impairment … unless an abortion is performed."[36] Septic miscarriage includes cases of UID that are "complicated by uterine infection" which "can progress rapidly and be lethal" (Prager, Micks, and Dalton, 2022). Hence, it seems "septic miscarriage" involves a medical emergency and should be treated promptly.[37] Waiting to act, in other words, seems neither medically warranted nor legally required under SB8.

Finally, Nambiar et al. discuss 28 cases in Texas that allegedly involved "a medical indication for delivery" prior to the occurrence of "complications that qualified as an immediate threat to maternal life" (2022, 648–9). Expectant treatment "resulted in 57% of patients having a serious maternal morbidity compared with 33% who elected immediate pregnancy interruption under similar clinical circumstances reported in states without such legislation" (Nabiar et al., 2022, 649). If the law *requires* clinicians to withhold intervention until there is "an immediate threat to maternal life," therefore, this puts women at risk. Does the law require such delays? No.

Of cases, Nambiar et al. (2022) discussed, 26 involved "preterm premature rupture of membranes" (PPROM). Abortion, *as defined by Texas law* is not required here. As Saad explains, "killing the fetus prior to or as a means of ending pregnancy is medically unnecessary, as premature delivery without deliberate feticide is a practical alternative. Yes, the fetus may well die as a result, but … its death is outside intention" (2022, 250–1). If so, then Texas law does not forbid intervention in cases described by Nambiar et al. (2022). Legally, abortion is performed "with the intent to cause the death of an unborn child."[38] Even *if* abortion is illegal prior to some "immediate threat to maternal life," abortion *so defined* is not the only available intervention. Preterm delivery, coupled with every reasonable attempt to save the unborn individual's life, remains an option. Experts who insist that waiting is required, therefore, are morally responsible for putting patients at risk unnecessarily. In sum, given such high stakes, philosophers should provide clarity for the writing, revising, understanding, and applying of the law as it pertains to UID.[39]

VI. POLICIES FOR HANDLING EMBRYONIC AND FETAL REMAINS

Philosophers might also examine ethical issues surrounding the handling of embryonic remains following UID. Levang, Limbo, and Ziegler observe that there is a "lack of uniformity in how hospitals, clinics, and other healthcare institutions … handle fetal remains" (2018, 21).[40] Nahidi et al. add that "disposal of fetal remains as a biohazard material after spontaneous abortion has been the standard practice in many states across the United States of America," and so, "when a patient requests the fetal remains, it raises a controversy" (2021, 83). Lack of clear protocol harms bereaved parents. Snyder (2022a), for example, describes numerous hurdles that bereaved parents face when seeking to obtain and bury embryonic remains.[41] She observes that providers may be confused over whether remains *can* be released to parents, whether remains can be tested for genetic abnormalities and subsequently released, whether parents must file paperwork with a local funeral home before receiving their child's remains, etc. (Snyder, 2022a). In her own experience, Snyder notes that "although the healthcare providers were not resistant, they didn't seem to know how to fulfill our requests" (2022a, 196). There is room (and need), therefore, for clarity regarding the handling of embryonic remains.[42]

Implementing such policies may be difficult given public debates over the value of unborn human life.[43] When discussing public policies for fetal burial or cremation, for example, "Rep. Wendy Ullman bashed" the policies "calling an early miscarriage 'just some mess on a napkin'" (Pennsylvania Family Council, 2019)—a statement for which she later apologized (Calicchio, 2019). When a prevalent view within society is that the entity lost in UID is inconsequential—or that it is valuable in a *purely* subjective way—any attempt to humanize that entity (at the level of public policy) will be met with resistance. This is especially so if such policies are perceived to "stigmatize abortion care patients" (Crockett, 2017). Burial or cremation of embryonic remains could also be regarded as wasteful. Savulescu and Schuklenk argue that "failing to donate organs" is "tantamount to killing innocent people" and they make the same point against those who refuse to donate "excess embryos" (2017, 166). Some utilitarian-minded thinkers, therefore, will advance the same claim against people who bury or cremate remains following UID.[44] In sum, policies involving embryonic remains should be explored and developed. These policies cannot be developed in a vacuum, however, and so the task is not straightforward.

VII. MORAL PSYCHOLOGY, EMOTION, AND EMPATHY

Finally, in this issue, Bohn explains why "emotional granularity (or emotion differentiation) promotes psychological well-being" (2023, 267). Jettisoning imprecise language from discussions of UID is a starting point for helping people process grief. Philosophers have the resources to go further, drawing

from rich discussions of belief, emotion, and perception in moral psychology to help individuals process their experiences following UID. This is not to say that philosophers—especially *qua philosophers*—are always (or ever) in a good position to engage in therapeutic exercises with bereaved individuals directly. That work may be better left to other specialists. Rather, philosophers (even qua philosophers) may draw on and apply resources from moral psychology in the service of providing concepts and language that will better enable therapeutic work. Philosophical inquiry, in other words, may be of great instrumental (and indirect) value when helping individuals process their experiences.[45]

Here is one sketch of how this might work, using Roberts's (2013) work on emotion as an example. For Roberts emotions are "concern-based construal's" or "perceptual experiences of values possessed by situations" (2013, 38–43). Consider guilt. Feelings of guilt, Roberts claims, are grounded in (a) construing (perceiving) oneself to be "a bad person" or "blameworthy" while (b) being concerned to "be free from this stain of blameworthiness" (2003, 225).[46] Beliefs and construal's are distinct here. It is possible to "see" oneself as blameworthy while believing oneself to be innocent. By comparison, someone may believe that air travel is safe (given available data) despite "seeing" (or perceiving) air travel as dangerous, which leads them to fear flying (Roberts, 2010, 36). They can try to change their perception—to overcome their fear—by appealing to data, but this will not always work. We cannot always "argue away" our perceptions. Discussions of emotion aid discussions of UID for four reasons.

First, one's beliefs about EHMS can detach from one's construal of what is lost in UID. Those who believe EHMS sometimes fail to see (perceive) UID as involving the death of persons. Those who reject EHMS sometimes see (perceive) UID as involving the death of a person. In either case, we should not make inferences about agents' beliefs (based on their perceptions and resulting emotions). If emotions are concern-based construal's, then there is nothing unusual about believing that one's embryo was merely a potential child while construing UID as involving the loss of an actual child (and vice versa). Critically, when one's conceptual perception (i.e., emotion) and belief come apart, this leaves agents with real emotions, even if those emotions conflict with their beliefs. Anti-EHMS individuals who experience UID can genuinely feel that their child has been lost without believing this.[47] Pro-EHMS individuals can be emotionally unmoved moved by the death of an embryo, despite believing EHMS. Beliefs and emotions are importantly distinct.

Second, following UID parents often believe they are morally blameworthy, perceive themselves as such, or both. Colgrove (2019) argues that addressing belief and addressing perception require different approaches. When someone's beliefs are incorrect, providing them with data, correcting errors in reasoning, etc., is an effective remedy. Presenting data and arguments is sometimes *ineffective*, however, when addressing individuals' perceptions of blameworthiness. Showing information (e.g., that UID is unpreventable) will not automatically assuage feelings of guilt. People sometimes feel guilt despite *knowing* that information. If construal's cannot be changed, then there is nothing philosophers can do to help parents who perceive themselves as responsible for UID (despite believing this not to be so). Fortunately, construal's *can* be changed (Cf. Evans, 2004, 195–6; Roberts, 2013, 41). In the context of UID, of course, whether and how to approach this remains a delicate matter, but it can be done well.

Third, discussions in moral psychology individuate construal's (and emotions they generate) in informative ways. Common emotions after UID include guilt, grief, anger, sadness, depression, despair, shock, confusion, numbness, jealousy, emptiness, loneliness, panic, and powerlessness (loss of control) (Brier, 1999; Miscarriage Association, 2022). Each emotion has a different characteristic construal and concern. For example:

Guilt involves

a. Construing oneself to be "blameworthy" while,
b. Being concerned to "be free from this stain of blameworthiness."(Roberts, 2003, 225).

Grief involves

a. Construing some person or thing, *X*, "to whom (which) I was (am) deeply attached and who (which) is irreplaceable" as having "been irrevocably taken from me" while,
b. Being concerned to have *X* "restored to me." (Roberts, 2003, 236).

Anger involves

a. Construing oneself as being in "the moral position to condemn" some entity, *S*, as "bad" for *S*'s having "culpably offended in the important matter of *X* (action or omission)" while,
b. Being concerned that *"S* be hurt for *X*." (Roberts, 2003, 207).

There are clear differences between common emotions following UID. If Bohn is correct—that "emotion differentiation … promotes psychological well-being"—then philosophers are equipped to help those affected by UID better understand the emotion(s) they (or others) experience (2023, 267). Being able to identify—and articulate the details of—the emotion that one (or another) is experiencing is valuable. If someone feels guilt, we can explore whether available evidence supports the proposition that one is blameworthy for what occurred. In most cases of UID, one has no control over what happened (and so, should not be blamed). By learning that one's construal is out of sync with the evidence, one may take an important step towards healing.[48] This analysis can help motivate people to change their construal's as well. If someone is angry at *S*, for instance, but discovers that their construal of *S* as "offender" is unjustified—*S* has done nothing wrong—then they have good reason to work at changing their construal of *S*. This takes effort. Either way, identifying the emotion in play, understanding its content, and testing it against the evidence are all ways in which philosophers can improve discussions of UID.

Fourth, these analyses have great interpersonal value. They reveal why certain responses to UID are inappropriate. Harrison (2020) observes that many well-meaning expressions—like "you can try again soon"—are poor attempts to console "those who are grieving." If Roberts (2003) is correct, then grief involves seeing something precious as "irrevocably taken." There is *no way* to "try again." What was loved is lost. By identifying the structures of the emotion in play (grief), we see in advance which responses will fall flat. Philosophical analyses of emotion (sketched here) are also conducive to developing empathy. By understanding the complexities of (and differences between) emotions, philosophers will help others better understand, imagine, and experience the emotions felt by others. Beyond merely "feeling" what others feel, the above analysis lends itself to a better understanding of how others *perceive* the world. To use Read's language, one is better positioned to engage in "affect sharing" and "cognitive" understanding of others' emotions (which are both important dimensions of empathy) (2019, 3–4). Multi-faceted empathy, Read argues, conveys "validation or acknowledgement of the target's experience" and "concern for her welfare, in turn promoting intimacy, mutual trust, and attachment" (2019, 4). For people that experience UID—who commonly experience loneliness, isolation, and emptiness—such empathy is deeply beneficial.

VIII. CONCLUSION

By advancing and undermining inconsistency arguments, philosophers have already engaged in conversations about UID at some length. This issue presents several responses to inconsistency arguments, each of which advances the literature on UID, causation, responsibility, morality, and abortion. I encourage the reader to examine contributors' arguments in detail. Furthermore, I have sketched other ways in which philosophers might engage in discussions of UID. With inconsistency arguments in shambles (or so it seems to me), I am hopeful that philosophers will turn greater attention towards work on UID that has both theoretical and therapeutic value.

NOTES

1 See, Condic (2013) and (2022), as well as Jacobs (2018). Brown (2019) and Lee (2022) deny this claim. Blackshaw and Rodger (2020) and Hershenov and Hershenov (2020) offer counterarguments (whether directly or in effect).

2 Given Bohn's (2023) argument that there are excellent reasons to avoid referring to the death of young human organisms as "miscarriage," "spontaneous abortion," or "early pregnancy loss," I use her terminology to describe the relevant phenomena precisely: "intrauterine death" and "preterm delivery." I add "unintended" to contrast UID with deaths caused via abortion (which involves *intentional* killing).

3 I am thankful to an anonymous reviewer for raising this point.

4 These two categories are not mutually exclusive. van Inwagen (2006, 10) notes of evil that "anything of value that is said in response to any of these problems is very likely to have implications … for what can be said in response to the others." Bohn (2023) provides an excellent illustration of this: by carefully disambiguating language surrounding UID, there are direct therapeutic benefits.

5 Work with a therapeutic aim also extends to post-abortive care in beneficial ways, though UID is my focus here.
6 In doing so, I aim to show two things. First, that there are numerous issues related to UID that philosophers *qua philosophers* are equipped to address. Second, that philosophers have unique resources to support others (e.g., clinicians, bereaved individuals, etc.), even though providing this kind of support may be interdisciplinary (i.e., not uniquely philosophical) in nature.
7 For standard inconsistency arguments, see Ord (2008); Berg (2017), and Simkulet (2017).
8 What is meant by "inconsistent" varies by author. Colgrove, Blackshaw, and Rodger (2021) note it may mean abortion opponents are "hypocritical, 'fair-weather' [defenders of life], morally blameworthy, deluded, self-deceived and/or disingenuous." See Blackshaw, Colgrove, and Rodger (2022a) for a lengthier overview.
9 Elsewhere, Miller shows that literature on "abortion providers' attitudes toward surgical abortion is replete with similar sentiments" since the "basic reality" of abortion involves "killing human life" (2022, 275–8).
10 Setting aside the question of justifiability—which Miller (2023) addresses directly—this kind of prioritization is also common. Miller (2023) and Colgrove (2021) both note, for example, that social movements like *Black Lives Matter* rely on the claim that it is justifiable for a movement to oppose state-sponsored (or "state-sanctioned") violence even if that movement does not aim to maximize the number of lives saved overall.
11 Miller defends this claim at length, relying on the best available empirical data while "entirely excluding research authored by pro-life researchers" (2022, 268).
12 Since Berg's (2017) arguments are not substantially different from Ord's (2008), Waters' (2023) responses to Berg (2017) apply to Ord (2008) as well.
13 Here, Waters (2023) builds on work by Friberg-Fernros (2019).
14 Thomson (1971) famously argues that even if embryos are persons, abortion is not murder because it does not involve the *unjust* killing of persons. See also Boonin (1997, 2003, 2019). Thomson's (1971) argument and its progeny have been subject to considerable criticism, however. See Beckwith (2007, 2022), Kaczor (2015), Bernstein and Manata (2019), and Hendricks (2022).
15 Relatedly, Delaney (2023) addresses an argument by Harris (2003) where "Harris thinks that one is inconsistent if she opposes embryonic stem cell research because it involves the deaths of embryos, but does not oppose natural procreation because for the same reason (as well as IVF and abortion). So, one must either oppose both or oppose neither." Like Waters (2023), therefore, Delaney (2023) attacks multiple types of inconsistency argument.
16 For an argument that nonexistence *is* better, see Benatar (2015, 21–22). For responses to Benatar, see DeGrazia (2010, 321–3) and Liao (Forthcoming).
17 Aside from Bohn's (2023) work—and this issue—two other special issues on UID explore this kind of territory. One issue is at the *Journal of Social Philosophy*—see Cahill, Norlock, and Stoyles (2015)—and the other is at *Narrative Inquiry in Bioethics*, which is forthcoming.
18 Obscuring delivery has negative downstream effects. Angela, for example, recalls having "had a former employer ask—in all real and true sincerity—why I needed more than a day off to recover from my almost seven months along pregnancy loss" (Bohn, 2023, 276).
19 Similarly, Beckwith argues that "not everything that results from a sperm-egg union is a conception (e.g., 'blighted ovum')" (2007, 75).
20 Cf. Prager, Micks, and Dalton (2022) who observe that "anembryonic pregnancy" also "includes pregnancies in which an embryo may have been present but has since been resorbed."
21 There are therapeutic implications for cases of anembryonic pregnancy in which parts of the organism (e.g., the yolk sac) continue to develop, even though the embryonic pole has not developed. In these cases, it could be that the organism has died [in that it is no longer sufficiently integrated per Condic's (2022) criteria]. Alternatively, it could be argued that the entity *is* sufficiently integrated to count as an organism, similar to cases of anencephalic infants. Whether intervention—for example, a D&C to remove the entity—counts as an act of killing, therefore, will vary depending on one's view. The former view is more plausible to me, but I will not attempt to settle the matter here.
22 Recall that "anembryonic pregnancy" even refers to cases where there *was* an embryonic pole that existed and was destroyed prior to being visualized. As Miller (2023) notes, these cases obviously involve the death of an embryo. But, given present terms, "embryonic demise" does not include such cases, which is problematic.
23 Similarly, Rulli argues that using gene editing techniques on embryos (like CRISPR-Cas9) would not "treat or save lives that would otherwise have a genetic disease" (2019, 1072). See Schaefer (2020) for a response, however.
24 Category (c) would also require thinking about the moral costs of UID-prevention. As Waters notes, "the medical feasibility of reducing" UID "may be low … partly because many miscarriages occur before a woman is aware that she is pregnant" (2023, 244). Realistically, what would UID-prevention require in these cases and what would be the ethical implications of proposed interventions? Anderson (2023) has made it clear that oversimplified answers—for example, that EHMS advocates should take *all* measures to prevent UID whatsoever—are untenable.
25 Simkulet also claims that "legislation restricting the creation of surplus IVF embryos is relatively morally innocuous and would face little opposition" (2022, 462). Blackshaw, Colgrove, and Rodger (2022b) explain why Simkulet's (2022) claim here is detached from reality.
26 Waters notes, "it may be politically difficult to redirect funding and political capital away from [things like] cancer research" (2023, 244).
27 This is Rulli's (2019) view.
28 Bohn (2023) cites Bardos et al. (2015).
29 Harris (2003) will respond that someone *can* prevent UID by avoiding all sexual activity. Delaney (2023) addresses this argument, however.
30 I will set aside worries about sample size and other methodological concerns, for the sake of argument.
31 Ethical questions also arise when scholars themselves perpetuate misconceptions, as we will see below.
32 From Texas Health and Safety Code, Section 245.002(1).
33 See Texas Health and Safety Code, Section 245.002(1)(A)–(C). The same section states that an act is *not* an abortion when it aims "to remove a dead, unborn child whose death was caused by spontaneous abortion." See Snyder (2022b) who highlights the same language.
34 Relatedly, in some cases, ectopic pregnancy "will end naturally and there will be no need for an operation or a drug to treat the condition." See Ectopic Pregnancy Trust (2022). If so, then it is misleading to suggest that laws like SB8 require "waiting" as though absent such laws, waiting ("expectant management") would not occur.
35 See footnote 31.
36 From Texas Health and Safety Code, Section 171.002(3).
37 Additionally, recall that interventions with no *intent* to cause the death of an unborn child are not considered abortions. So, interventions such as preterm delivery are available in non-emergency cases. The law, therefore, permits intervention in cases of septic miscarriage on multiple grounds. See Omelianchuck (2022) for a discussion.
38 Texas Health and Safety Code, Section 245.002(1).
39 I only focused on Texas's law since my interlocutors did so first. Other jurisdictions may have laws that *do* support my interlocutors' worries. If so, then by focusing on Texas's law, my interlocutors chose a bad example. For a more comprehensive discussion, see Snyder (2022b).
40 For one such proposal, however, see National Perinatal Association (2017), which is based on Catlin (2018).

41 Snyder's (2022a) essay is part of a special issue at *Narratives in Bioethics* devoted to UID. See also Terzo (2021).
42 See Levang, Limbo, and Ziegler for some concrete suggestions, though even they note that "respectful fetal disposition" must be "tailored to the individual healthcare setting owing to the many variations in institutions, the factors that guide their core mission, and state law" (2018, 22–3).
43 See, for instance, heated debates surrounding fetal burial laws, as discussed by Berry (2016), Joseph et al. (2016), and Crockett (2017).
44 For more on the entanglement of "fetal tissue research" with the abortion debate, see Boonstra (2016).
45 My points here parallel van Inwagen's (2006) observations about the problem of evil. As van Inwagen notes of evil, "anything of value that is said in response to [theoretical] problems is very likely to have implications, and by no means trivial ones, for what can be said in response to the others" (2006, 10). At the same time, perhaps "it is asking too much, it is asking the wrong thing entirely, of a philosopher's or theologian's response to the argument from evil, to ask that it be suitable reading for a mother who has lost a child" (van Inwagen, 2006, 10). Applied to UID, theoretical and philosophically rich discussions of UID may not be directly helpful to bereaved individuals. That does not mean that such discussions are unhelpful altogether, however, or so I will argue in the remainder of this section.
46 Both components are essential to guilt. Merely seeing oneself as blameworthy will not give rise to guilt's "negative" or "unpleasant" affect (Roberts, 2003, 224). A contented thief, for example, might perceive himself to be a bad person, while not caring about his character. Experiencing guilt, therefore, requires that one be concerned not to be blameworthy.
47 Parsons' seeks to resolve this tension by redefining "personhood [as] a relational concept" (2010, 14). Parsons claims that "my losses could be understood more holistically, not merely as the death of developing beings, but also as the loss of my hopes and expectations" (2010, 14). Different solutions will appeal to different people. An advantage of the Roberts-based approach is that it does not require redefinition of central moral concepts to resolve the tension.
48 Recall, learning relevant information will not, by itself, change one's construal (e.g., as being blameworthy). This is why I call this process an "important *step* towards healing" rather than healing *per se*.

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