

“The Event That Was Nothing”: Miscarriage as a Liminal Event

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I remembered,
then, the miscarriage, and before that
the months of waiting: like baskets filled
with bright shapes, the imagination
run wild. And then what arrived:
the event that was nothing, a mistaken idea,
a scrap of charred cloth, the enormous
present folding over the future,
like a wave overtaking
a grain of sand.

—Excerpt from “A Language,” by Susan Stewart¹

How is it possible that an event is, and is not? How can any event, properly called, be nothing? And yet Susan Stewart’s fine words capture something important about the nature of miscarriage in American society. It both is and is not. It is both a source of acknowledged pain and suffering, and one swept easily away with “you can always try again” or “it could be worse.”

I argue here that miscarriage is a liminal event. It is perhaps for this reason that it has been both poorly addressed in our society—it occurs in about 25 percent of pregnancies and yet 55 percent of Americans believe it is rare²—and enrolled in larger debates over women’s reproduction. We see laws governing the behavior of pregnant women used to minimize maternal autonomy, justified by preventing fetal harm, including miscarriage. We see laws that require women to prove pregnancy loss is a miscarriage rather than an abortion. Were miscarriage better theorized, perhaps it would not so easily be enrolled in these other debates. Its very liminality and the fact that it is enrolled in these debates sheds light on the complicated network of concepts within which miscarriage lies, an event that is nothing, that is neither abortion nor pregnancy.

I shall begin by discussing relevant features of miscarriage and our poor understanding thereof. This poor understanding is, itself, to be expected from a liminal event. I then clarify what I mean by “liminal” even as I establish the liminality of miscarriage. We shall see that miscarriage is liminal along four distinct but related, and perhaps inextricable, dimensions: parenthood, procreation, death, and abortion. Finally, I show how miscarriage is thus enrolled in social and moral debates which are not really about miscarriage at all but rather about

the dimensions of liminality on which miscarriage lies. The interrelatedness of these dimensions makes me gravely concerned about how and whether we can improve the lives of those who experience miscarriage.

To truly understand why miscarriage is so taboo and to fully grasp the identity disruption that miscarriage poses, as well as to later understand how it becomes enrolled in social debates which are not really about miscarriage, we must first understand miscarriage as a liminal event.

Liminality, and Miscarriage as a Liminal Event

The notion of the liminal was coined by Arnold van Gennep, a French ethnographer practicing in the early 20th century. Van Gennep focused on ceremonies of rites of passage which he divided into three phases: preliminary, *liminaire*, and *post-liminaire*. The phase of *liminaire*, or liminality, is one in which a member of society is transitioning from one social role into another. Van Gennep took the term from the Latin word *limen*: a threshold.³

Study of the liminal phase was expanded by British cultural anthropologist Victor Turner. As Willett and Deegan note, in Turner's work rites of separation symbolically detach the individual from an existing point in the social structure; the former social status no longer applies but neither does the new one yet apply.⁴ Turner himself found this to be the most interesting phase of a rite of passage and, tellingly for our purposes, used embryos as a metaphor for the "neophyte" which passes through social rituals.⁵ The neophyte's lack of formal status is, Turner notes, "often expressed in symbols modeled on processes of gestation or parturition."⁶ However, Turner need not have hinted quite so close to home for this to be useful. As Ronald Carson observed in describing the doctor-patient relationship as liminal, this notion can refer to

...the ritual 'space' in which one is suspended, straddling or wavering between two worlds, neither here nor there, betwixt and between settled states of self, as in rites of passage or, by extension, *when experiencing illness, especially life-threatening or self-threatening illness.*

Liminal space is a place of ambiguity and anxiety, of no-longer and not-yet.⁷

This betwixt-and-between-ness uncannily captures the sense conveyed by Susan Stewart in her poem "A Language" when she describes a miscarriage as "the event that was nothing... the enormous/ present folding over the future."⁸ This is complicated by the intense issues of personal identity and social role raised by miscarriage.

For women who miscarry while gestating a wanted pregnancy, miscarriage goes far beyond a mere medical condition or event. This should come as no surprise. As John Robertson argued, procreation is morally important because "control over whether one reproduces or not is central to personal identity, to

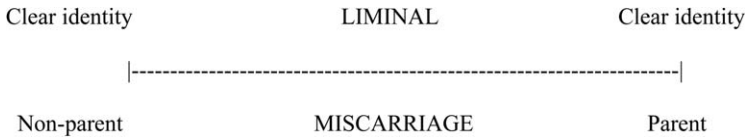


Figure 1. The parenthood dimension of the liminality of miscarriage

dignity, and to the meaning of one's life... being deprived of the ability to reproduce [whether through infertility or governmental restriction] prevents one from an experience that is central to individual identity and meaning in life."⁹ This sweeping scope for the potential effect of miscarriage is borne out by research on pregnancy loss which has found that "women who do experience fetal loss are not always grieving for the loss of the fetus for its own sake, but sometimes are grieving the loss of a relationship the pregnancy facilitated."¹⁰ Procreation is not only identity-constituting, but sometimes relationship-constituting. Pregnancy loss, then, can deal profound damage to both personal identity and to interpersonal relationships. When miscarriage is treated as a medical event instead of an event with a well-understood social place, miscarriage and those who experience it are set off from society, sequestered, and occupy unclear social roles and personal identities. This, too, is a clue to its liminal nature.

If a wanted pregnancy is a state in between being a nonparent and being a parent then a miscarriage halts the transition as much or more than it reverses the transition. The person who has miscarried is in the archetypal situation of "no-longer" and "not-yet," for she will never parent the child who might have been; neither will any partner she may have. Fathers whose longed-for child never arrives due to a miscarriage also grieve, both for the loss of the child and the loss of their own identity as a father to that child.¹¹ Again, given Robertson's explanation of the importance of procreation to personal identity and meaning in life, this should surprise us not at all. Thus, we see that miscarriage is liminal in at least one sense: it places the once-pregnant woman, and any would-be coparent, in a *space between not being a parent and being a parent* with respect to that particular child who might have been. This parenthood dimension of the liminality of miscarriage is a far different experience from infertility, in which one's might-have-been children are formless. Here, there is a might-have-been child to which one stood in relation. Now, that relation can never fully manifest.¹² It is a state of becoming which never becomes (see Figure 1).

Some individuals may wish not only to parent—or even not to parent—but specifically to procreate. Here, too, the issue becomes particularly complicated for women. As Robertson argues, both genetic contribution to a future person and gestation may constitute procreation. How is the woman who has miscarried to feel? She procreated in one sense: her genetic material, and/or her gestational capacity, have begun the process of procreation. But what happens when that

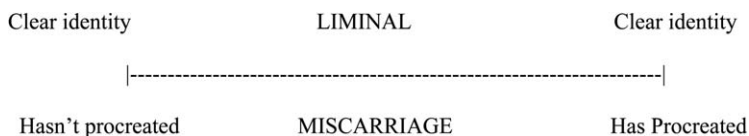


Figure 2. The procreation dimension of the liminality of miscarriage

process is disrupted, when it cannot be completed? What happens in the case of a miscarriage? One's genetic material, one's gestational capacity, is involved, but only incompletely. Has one procreated? Or has one not? Here, I contend, there is not only a space between not being a parent and being a parent, but also *a space between not having procreated and having procreated*. This has interesting implications for gestational surrogates and for genetic donors who are following the process of a pregnancy that is the result of assisted reproductive technology (ART). In the brave new world of ARTs, many persons may be betwixt and between with respect to the procreation dimension of the liminality of miscarriage (see Figure 2).

The fit of the notion of liminality for miscarriage is further extended—and applies to any conceivable dimension of the liminality of miscarriage—when we consider Turner's studies of the Ndembu people. In Ndembu culture, neophytes have a physical but not social reality, and are often hidden away or disguised.¹³ Though less formal, the isolation of women who have miscarried, and its taboo nature for public discussion, is common. Consider the following.

Julia Frost and colleagues examined early pregnancy loss and found that it is "clouded by secrecy" and is a "paradigmatic example of the sequestration of death, both in the sense that most women . . . know little about it until they experience it themselves, and in the sense that its occurrence is surrounded by secrecy and is hidden from public view."¹⁴ These features are common to modern Anglo-heritage cultures' responses to death. When an illness or event has "death salience," as cancer and miscarriage both do, those who survive the experience have had a much closer experience with death than our culture normally encourages. Survivors may "turn inward to their deep selves in order to establish an understanding of what their life projects might become. Observers, on the other hand, find death salience hard to live with, and may turn away from the distressed survivor."¹⁵ I suspect this is no small feature of the liminality of miscarriage, and no small cause of its sequestration and the sequestration of those who have experienced miscarriage.

Despite the frequency and commonality of miscarriage, it tends to be taboo, off limits for public discussion in a way that the ins-and-outs of pregnancy are not quite off limits. Death salience helps to explain why this is so, and is differently so from pregnancy. Helping women through pregnancy involves a great deal of social support: magazines, baby showers, unsolicited advice—however welcome or unwelcome—on how to behave while pregnant. The mere sight of a pregnant belly can elicit intimate revelations from total strangers about

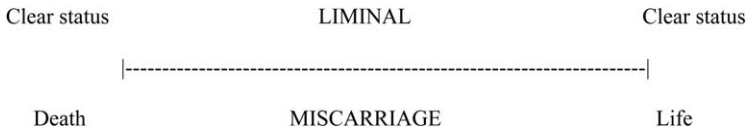


Figure 3. The death dimension of the liminality of miscarriage

pregnancy, labor, and delivery. Indeed, pregnancy and motherhood are socially constructed as well as biologically constructed, and this begins as soon as those around pregnant women know they are pregnant; discursive interactions shape attachment and, even absent one's social circle knowing one is pregnant, can prepare one to become attached to the fetus, contributing to deep grief after pregnancy loss.¹⁶ We have clear cultural scripts for pregnancy, which is not liminal, but entails well-established social roles and interactions. Not so for miscarriage. Instead, there is a great separation between a woman who miscarries and society as a whole: "silence, isolation and uncertainty combine to augment the suffering of miscarrying women."¹⁷

Miscarriage can raise not only the specter of death and thus become shrouded in secrecy, but also cause deep confusion for the survivor. Did someone die? Was there a loss of potential life or a loss of life? For many people, this is not clear. For others, it is. But the lack of social agreement puts miscarriage in *a space betwixt and between death and life*. All this raises a third dimension of the liminality of miscarriage related to its death salience (see Figure 3).

A similar sense of liminality and resultant confusion occurs with respect to cancer, the death salience of which is strong. In discussing liminality as a major category of the experience of cancer illness, Miles Little and Emma-Jane Sayers note that an initial phase of liminality is "marked by disorientation, a sense of loss and of loss of control, and a sense of uncertainty" (1485). The liminar—a term for the person in the liminal space more general than "neophyte"—is set off from others and left, in the case of miscarriage, largely to her own devices to seek clarity and meaning. Whereas cancer survivors at least can seek the comfort of their fellow survivors through support groups, women who have miscarried often lack even this level of support. Given how little men discuss infertility,¹⁸ the same is true for men whose female partner or gestational surrogate miscarries a pregnancy.¹⁹ The once-pregnant woman is caught between being a parent and not being a parent. If she has a would-be coparent, whether male or female, the social status of miscarriage reinforces isolation and then both liminars are caught betwixt and between. This isolation is typical of liminal states or events, and a typical experience for a liminar.

This brings us to another key aspect of liminality, a temporal one identified in discussions of disability as a liminal state. Kristi Kirschner raises this in considering new-onset disability, as illustrated by the case of a 17-year old boy whose spinal cord injury while playing in a pool resulted in quadriplegia: "the past is irrevocably gone, the future hard to imagine. 'Old normal' can't be regained, 'new normal' hasn't yet arrived."²⁰ Such disabilities not only present

issues at onset, but can result in persons who occupy a liminal state not just temporarily but permanently. Jeffrey Willet and Mary Jo Deegan argue that chronic disability may well trap disabled persons in a liminal state. The liminal stage is supposed to be a transition between two socially viable positions; for the chronically disabled in a society constructed around the able, there is no socially viable position. There is only “a confusion of all the customary categories.”²¹ For women who have miscarried, movement out of the liminal can also be problematic since the states between which they found themselves were related to procreation and parenting, and specifically creating or parenting that particular child, as well as to death and life. As I have indicated, we have well-practiced scripts for clear social events such as birth (“Congratulations!”; “Welcome, baby X!”; “Sleep whenever you can!”). These incorporate people into society and shared experience. But we have no such incorporating scripts for miscarriage. Insofar as we have scripts, they tend to be dismissive or to reinforce the sequestration and isolation of both miscarriage and the liminars. The colloquial response which urges women who have miscarried to “try again” or seeks to console by saying “you can always have another” is, I think, not necessarily a lack of compassion even though it is often interpreted that way. Through the liminal framework, we can come to see it as a hamhanded way of attempting to usher the liminar toward a stable state. In this case, that of a parent after all. But, alas, a parent of a different child. The unfulfilled relation remains unfulfilled. The loss remains unaddressed, somewhere between death and life. The liminar remains liminal.

Being trapped in liminality is often excruciating for liminars, especially because of the isolation it entails. For Willet and Deegan, the solution to the permanent liminality of chronic disability is for liminars to engage in what Turner called “*communitas*,” in which liminars treat each other as equals regardless of any status differences before the transition. Willet and Deegan provide the example of a blind woman who looks forward to going to national conventions for the blind or disabled not just because it allows her to act on her political convictions but because she feels a strong relationship to strangers who share with her the experience of disability. From this follows mutual aid and support and the ability to build self-concepts of normality. Willet and Deegan argue that these help group members to actively discover and construct identities different from those given them by society. Alas, persons who miscarry suffer an attenuated ability to build *communitas*. Many women say that it was only after they miscarried that they discovered how many people they knew had, themselves, miscarried. However, even this does not enable effective *communitas*. The taboo nature of miscarriage and the inability to easily identify others who have miscarried outside of one’s immediate social circle hinder the ability to form connections, to mobilize, to “actively discover and construct identities.” The lack of cultural scripts to draw upon in order to deal with miscarriage further hinders the ability to form *communitas*, or even to access public and community support from beyond the shared-experience group of women who have miscarried, assuming that one even has access to

that. Because of the sequestration of miscarriage, some never do: Dr. Zev Williams tells of once caring for two sisters, both of whom had miscarried and neither of whom knew it of the other.²²

We have seen the case for miscarriage as a liminal event along three dimensions, parenthood and procreation and death, discussion of which is taboo. We have seen the case for conceiving of women who have miscarried, and sometimes their partners, as liminars struggling in isolation to make meaning out of miscarriage. This positions us to now see how “the event that was nothing,” and the women who experience it, become focal points for social discourse on reproduction. This will also lead us to the fourth dimension of miscarriage as a liminal event.

Miscarriage as a Liminal Event, Abortion, and Control Over Pregnancy

Miscarriage’s liminal nature and its corollary sequestration make it all too easy to enroll women who have miscarried, and their families, in related political and moral debates. These include debates over abortion, and over how much control society should be able to exert over the behavior of women with wanted pregnancies who wish to carry to term.

A clinical term for miscarriage, “spontaneous abortion,” reveals some of this liminality. Specific clinical descriptors for types of miscarriage include “complete abortion,” “incomplete abortion,” “inevitable abortion,” “infected (septic) abortion,” and “missed abortion.”²³ Treatment guidelines are almost entirely clinical; whether women receive bereavement counseling is not standardized. Interviews with women who had miscarried indicate such terms are deeply alienating and consider medical use of them to be “insensitive,” particularly when hospital staff attempt to use them as a clinical euphemism while discussing a miscarriage with the woman who has just experienced one, given the “stigma and moral confusion” surrounding abortion.²⁴

Colloquially, miscarriage may be described as a “lost pregnancy” or a “failed pregnancy.” This is only slightly better than clinical use of the term “abortion,” for while it also entails a degree of agency on the part of the pregnant woman, here it is an issue of omission rather than of commission. A lost pregnancy must have been lost by someone; someone must have failed for there to be a failed pregnancy. Such attempts to comfort are all too easily converted into a devastating subject-verb-object: “I lost the pregnancy” or “I lost the baby.”

Thus we see that miscarriage stands in a fourth liminal space between the fraught social categories of induced abortion and pregnancy (see Figure 4).

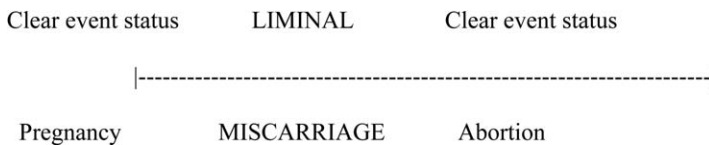


Figure 4. The abortion dimension of the liminality of miscarriage

A thing such as miscarriage is poorly understood because it is so little spoken of and because it is sequestered due to the dimensions on which it is liminal. A thing poorly understood but too-like states or events which we believe we understand is quite likely to be drawn into debates over those other states or events. And so we see how the liminality of miscarriage leads to a *paradox*: that we speak of it little and yet that we can speak of it to such disastrous effect. Miscarriage, if better theorized, might not be so easily brought into these larger debates over women's reproduction and responsibility for reproduction. We should be able to see that, while it is liminal with respect to these four dimensions, it is nonetheless distinct from the poles of each. Even though it is likely by its nature to remain ontologically a liminal event, it—like long-term disability—can gain much from further theorizing.

We see this inability to separate miscarriage from the poles of its dimensions of liminality in several distinct, but related, sets of laws—whether proposed or enacted—that bear on miscarriage. These include:

1. Laws which seek to control abortion by requiring women to prove that pregnancy loss is due to miscarriage rather than induced abortion or infanticide.
2. Laws which allow health care providers to opt out of treating miscarriage because it uses similar techniques to abortion.
3. Laws whose effect is to hold women criminally responsible for miscarriages where their actions had any plausible causal role in the pregnancy loss.

They are thus *laws which enroll miscarriage in the abortion debate* (1 and 2) and *laws which enroll miscarriage in debates over the control of pregnancy* (3). We have already seen that miscarriage is a liminal event between the well-defined social categories of abortion and pregnancy. That it would thus play into laws pertaining to both is nearly a foregone conclusion; that it would do so without careful reflection by the law's framers is a result of its undertheorized and sequestered state.

We must examine these laws in some detail to see not only *that* miscarriage's liminality is in play, but also the damage it can do when deployed unreflectively. Let us begin with laws which enroll miscarriage in the abortion debate.

Laws Which Enroll Miscarriage in the Abortion Debate

The first set of these involves laws which require women to prove that a pregnancy which does not go to term is not due to an abortion.

In 2009, Virginia state Senator Mark Obenshain—who ran for Virginia Attorney General in 2013—authored a bill that, on one reading, would have required Virginia women to “report miscarriages to police or risk legal penalties,

including as much as a year in jail.”²⁵ This reading requires one to believe that persons might misinterpret a clause requiring the woman who miscarried, or someone acting on her behalf, to report her name and the location of fetal remains to police within 24 hours of a “fetal death” occurring without “medical attendance.” In fact, this may seem *prima facie* reasonable. According to Obenshain’s campaign manager, Obenshain had in mind not targeting women who miscarried, but rather ensuring that fetal deaths were not due to infanticide or illegal abortion and instead due to stillbirth or miscarriage. To his credit, the bill was “stricken at the request of patron,” meaning that Obenshain himself pulled it after the unintended consequences for women who miscarried had become clear.²⁶ This law, though part of an attempt to regulate fetal death, was judged by its own author to be too sweeping in scope. So why bring it up? The proposed law *and its downfall*, exemplify how difficult it is to separate the liminal event of miscarriage, or its close cousin stillbirth, from debates over abortion.

The United States is not the only nation in which the liminal status of miscarriage comes up against the brick wall of the abortion debate. In El Salvador, women who suffer miscarriages or stillbirths are sometimes suspected of inducing an abortion and can be jailed for murder. Take Glenda Cruze, a 19-year-old El Salvadoran suffering severe abdominal pain and heavy bleeding in 2012. Doctors said she had lost the pregnancy; she had been unaware she was pregnant given that a pregnancy test had been negative, her weight had not changed, and she had continued to menstruate. Four days later, she was charged with aggravated murder: the hospital had reported her to the police for a suspected late-term abortion. She was convicted and sentenced to 10 years in jail. In the judge’s ruling, he said she should have saved the baby’s life.²⁷ El Salvador has a total ban on abortion; between 2000 and 2011, more than 200 women were reported to the police for suspected abortions, 49 of whom were convicted with 7 more convicted since 2012.²⁸ A lawyer who has worked with 29 of the incarcerated women, Dennis Munoz Estanley, says that only one intentionally induced an abortion whereas the other 28 were all jailed for murder without any evidence beyond suffering from obstetrical complications. One advocate says many El Salvadoran women who suffer miscarriages or complications during pregnancy are “too afraid to seek medical help.”²⁹ The implications for the liminality of miscarriage in a zero-tolerance-for-abortion setting are predictable, and the ethical fallout is distressing.

In addition to these sorts of laws which would require women to prove that a miscarriage was a “spontaneous abortion” rather than induced abortion or face harsh consequences, we should consider an entirely different sort of law which enrolls miscarriage in the abortion debate due in large part to its liminal status with respect to pregnancy and abortion. These are laws or informal policies which allow health care providers to opt out of, or constrain them from participating in, treatment for miscarriages because of its resemblance to abortions.

Let us first consider policies—supported by conscientious objection laws—which allow providers to opt out of training in techniques that are used to treat

incomplete miscarriages because these same techniques are also used in abortions. Within months of *Roe v. Wade* (1973), states began considering laws that would allow health care providers to exert a “right of conscience.” Such a right extends now to the federal level, where federal funding can be withheld from hospitals that punish providers for refusing to participate in medical procedures such as abortion which the provider finds morally objectionable, on grounds of personal conscience. In part because of such laws, some medical schools have seen fit to allow students to “opt out” of training dilation and curettage (D&C), a common technique for a surgical abortion, and indeed to opt out of all abortion training.³⁰ D&C is also used after “incomplete abortions,” not induced abortions at all but rather miscarriages in which material from the pregnancy remains trapped inside the uterus of the woman who suffered a miscarriage. In addition, 44 percent of medical schools offer no formal preclinical elective abortion education at all and 25 percent of OB-gyn clerkships report no formal education about abortion training.³¹ American Medical Association policy “encourages education on termination of pregnancy issues” but goes on to state that “any direct or indirect participation in an abortion should not be required.”³² Such sentiments can be used to opt out of D&C training; even though obstetricians or family practice students who take obstetrics training typically learn to perform D&C for miscarriage,³³ not all medical schools obligate their nonobstetrical students to learn such procedures. The liminal status of miscarriage as too-like abortion in the public conception leads to issues about one affecting training about the other.

Another legal and policy issue which reveals how miscarriage is enrolled in abortion debates is less about health care providers’ ability to opt, than about constraints on their ability to opt in. As Freedman and Stulberg document, physicians working in Catholic hospitals can come into conflict with the hospital’s policies on abortion when attempting to treat miscarriage. The ability of Catholic hospitals to refuse to perform abortions is rooted in the same rights of conscience, as well as of religious liberty, which underpin the issue of conscientious objection to abortion. In this case, the entire hospital is legally entitled to set policy in accord with the Ethical and Religious Directives for Catholic Health Care Services, written by the U.S. Conference of Catholic bishops and enforced by local bishops and in some cases the Vatican.³⁴ These directives prohibit abortion on the grounds that conception creates a new human being, created in the image of God. On this view, “The pregnant woman and her embryo (and later fetus) are two people, both with equal claims and independent moral status . . . any act that intentionally harms or kills the fetus is thus prohibited.”³⁵ It will come as no surprise to the reader who follows reproductive ethics that Catholic morality prohibits abortion.

This bears on miscarriage, however, in some ways I found quite surprising. One of these is the effect of such policies on what are sometimes called “inevitable miscarriages,” or miscarriages which have already begun and cannot be stopped. In some portion of these miscarriages, the pregnant woman’s

chances for morbidity and mortality greatly increase without early intervention. That intervention sometimes takes the form of surgical procedures which also hasten the end of the pregnancy, including a procedure called “dilation and evacuation” in which all the contents of the uterus, including potentially a relatively developed fetus, are removed. Even health care providers whose own personal conscience generally lines up with the directives found they could come into conflict with the directives because they generally made “significant distinctions between emergency obstetric care and abortion.”³⁶ This becomes especially significant because “those applying the Directives can construe medical treatment as abortion even when the fetus has no chance of life and the woman is miscarrying anyway.”³⁷

Freedman and Stulberg recount the case of a woman with a 19-week fetus and ruptured membranes who showed up at a Catholic health care facility which was the only one within two hours’ travel which could handle such a situation. The fetus had a severe heart defect, and the earliest known survivor of the operation required to repair the heart defect had been operated on at 32-weeks gestation. In the process of miscarrying and 3 months shy of that date, it was clear the fetus had no chance of survival and that prolonging the miscarriage could damage the pregnant woman’s health. The team proceeded to precipitate the end of the pregnancy using medical means in a situation they viewed as an obstetrical emergency. After the fact, however, two members of the hospital ethics committee accused the physicians of violating the directives by carrying out an elective, induced abortion. Other such cases came to light in Freedman and Stulberg’s interviews with physicians at Catholic hospitals: “For them, such treatment would not have been equated with abortion and instead was thought of as miscarriage management.”³⁸ The degree of constraint involved is even more profound when Freedman and Stulberg discuss absolute prohibitions under Catholic hospital policy to perform dilation and evacuations, prohibitions which often result in patient transfers from sometimes-isolated religious hospitals to care settings which will perform such procedures.³⁹

Thus we see numerous ways in which the liminality of miscarriage makes it all too easy once again to unreflectively enroll it in debates over abortion in ways which negatively impact the women who miscarry, and their families.

Laws Which Enroll Miscarriage in Debates Over the Control of Pregnancy

We have seen laws which enroll miscarriage in the abortion debate and laws or policies which put health care providers in a sticky position when miscarriage is taken to too-closely resemble abortion. I have suggested that with better reflection by law-makers (and also, by extension, institutional policy-makers) on the liminal nature of miscarriage, and the ability to separate it from the poles of the dimensions of liminality, the outcomes might be quite different. It is the abortion dimension of miscarriage’s liminality which is particularly in play

in these laws so far, and it shows up again in a third set of laws which pertains to the other end of this dimension: pregnancy, and control over pregnancy.

Like Virginia, Mississippi also fell afoul of unreflectively encountering the liminality of miscarriage, in this case not with respect to reporting laws but with respect to a far more serious criminal offense: manslaughter. Twenty-nine-year-old Nina Buckhalter was 31 weeks into her pregnancy when she miscarried and gave birth to a stillborn baby girl whom she named Hayley Jade. Not two months later, she was indicted for manslaughter. The grand jury claimed that she “did willfully, unlawfully, feloniously, kill Hayley Jade Buckhalter, a human being, by culpable negligence.”⁴⁰ An attorney with National Advocates for Pregnant Women said the state would be setting a “dangerous precedent” that “unintentional pregnancy loss can be treated as a form of homicide.”⁴¹ Though Mississippi lawmakers had actually rejected proposals that would have set specific penalties for damaging a fetus by using illegal drugs during pregnancy, prosecutors drew on two other state laws to charge Buckhalter, one of which defines manslaughter as the “killing of a human being, by the act, procurement, or culpable negligence of another” and a second which defines human beings as “an unborn child at every stage of gestation from conception until live birth.” Since the precise cause of any particular instance of miscarriage is so hard to identify, Buckhalter’s lawyers argued that any number of potential causes of miscarriage and stillbirth could be prosecuted on the same rationale including “smoking, drinking alcohol, using drugs, exercising against doctor’s orders, or failing to follow advice regarding conditions such as obesity or hypertension.”

This case came in the context of a 2013 Alabama Supreme Court decision that upheld convictions of two women for “chemical endangerment of a child” based on their behavior during pregnancy, namely taking illegal drugs. In one case, a premature birth resulted in the death of the newborn and, in another, a normal birth of a healthy boy resulted in charges after the newborn was found to have illegal drugs in his system. As Howard Minkoff and Anne Drapkin Lyerly note, these and other cases like them “indicate a worrisome lack of progress with respect to the personhood and rights of women when pregnant.”⁴² Minkoff and Lyerly note that this is despite the famous 1990 legal case of *In re A.C.* “A.C.” was Angela Carder, who was pregnant and dying of cancer when, in 1987, she was ordered by a court to undergo a C-section despite her and her family’s wishes. She and her family wished to preserve her life as long as possible and knew the C-section might diminish it. The physicians involved focused on the life of the fetus and not only sought but were able to obtain a court order overriding Carder’s medical autonomy. A rash of cases, only some of which have ended up in the courts, show similar violations of pregnant women’s medical autonomy. They include Samantha Burton, who was ordered onto bed rest but declined to be admitted to the hospital on grounds that she had no one to care for her other children and could not afford to lose either of her two jobs by being away from work for so long,⁴³ and Alicia Beltran, whose right to refuse

unnecessary medical treatment was violated when she was ordered into an inpatient drug treatment facility for 78 days because her obstetrician found out that she had a history of pill addiction even though tests had showed was not using and had not recently used.⁴⁴

In the United States, thirty-eight states have fetal homicide laws, many of which could bear on miscarriage if the woman who miscarries cannot adequately prove that she did not cause the death of her fetus outside of a legal medical procedure. According to the National Conference of State Legislatures, twenty-three of these states have fetal homicide laws that apply to the earliest stages of pregnancy by including language such as “any state of gestation,” “conception,” “fertilization,” or “post-fertilization.”⁴⁵ Many of these state laws contain explicit language, like Tennessee’s, which exempts a woman from prosecution for the death of an embryo or fetus which she is gestating. Others, such as Arizona’s, include a provision for “negligent homicide” that could easily be applied to a miscarriage which can plausibly be seen as due to a woman’s own actions or omissions. Even Tennessee’s formal protection from charges of fetal homicide did not protect then-4-months-pregnant Maria Guerra of Memphis, who was charged under other statutes in October of 2013 with child endangerment: she was found driving with a blood alcohol level well within the legal limit.⁴⁶

This raises the prospect of what Joan Wolf called an ideology of “total motherhood” in which mothers are held responsible for any harm that may befall their children.⁴⁷ In the case of miscarriage, pregnant women are seen as mothers whose entire range of behaviors must be sacrificed to maximize the good of the fetus, which is being conceptualized as already her child. A 2013 peer-reviewed study found that between 1973 and 2005, over 413 cases occurred in which a woman’s pregnancy was a necessary factor leading to attempted and actual deprivations of a woman’s physical liberty, through arrests or forced medical interventions, generally on grounds that the state had an overriding interest in the welfare of the fetus.⁴⁸ For a pregnant woman to retain her liberty, especially with the rise of laws which attempt to control the behavior of the gestator, it seems she must increasingly subject her well-being to the fetus’s by refraining from any behavior that might cause a pregnancy loss, up to and including refusing medical treatment which would otherwise be within her rights to refuse.

Relation of Laws to Liminality

Laws which constrict the ability of health care providers to perform miscarriage treatments because of concerns about abortion, or allow them to refuse to learn miscarriage treatments because of concerns about abortion, remain firmly classified as laws related to the abortion debate. However, I expect it is by now apparent that many of the laws that I have classified as pertaining to control over pregnancy are, in practice, also perilously close to membership in the category of laws I have classified as related to the abortion debate. It is only the

justification and origins, and some small points of language, which separate many of them.

These laws also raise more than just the obvious abortion dimension of the liminality of miscarriage. By conceiving of the fetus within a pregnant woman as already her child, we involve the parenthood dimension of the liminality of miscarriage. We might see the push toward “total motherhood” that results from these laws controlling pregnancy as part of an attempt to clarify pregnancy. But it is also an attempt to establish whether a pregnant woman is a parent, thus invoking the parenthood dimension of the liminality of miscarriage. We might see the push toward manslaughter laws as related to the death dimension: is miscarriage a death? Was there any “man” alive to be slaughtered?

Making laws and policies about miscarriage, all the while not quite aware of the fact and nature of the liminality of miscarriage, is part and parcel of the harm done by assuming we understand it when in fact we do not. As a result, it seems politicians, institutions, and individuals push their decision making to fit the mold of either end of these four dimensions of the liminality of miscarriage, casting miscarriage as abortion, as a failure of parenting, as a culpable death. Without a clear notion of what miscarriage is, one that does not merely derive from the pairs that nail down each dimension at the poles, I fear we will repeat again and again the negative ethical fallout of failure to understand miscarriage’s liminality. The result? Women who miscarry will again and again be isolated, their troubles sequestered, their experiences and fates enrolled in debates which hardly bear on miscarriage at all.

Conclusions

I have argued that to make sense of miscarriage means, in part, to conceive of it as a liminal event, and of women—and others—who experience it as liminars. It is this liminal state which makes it all too easy to look away from miscarriage and to isolate women who miscarry from social supports. The two tightly related dimensions of parenthood and procreation combine with the fact that miscarriage’s death salience complicates its placement with respect to the otherwise relatively clear states of death and life. Complicating the picture further is the fact that miscarriage is particularly liminal with respect to abortion and pregnancy. The result? These four dimensions of the liminality of miscarriage make it all too easy for miscarriage to be enrolled in debates about abortion and control over pregnancy. Women who miscarry and their families suffer from their isolation and from this enrollment, compounding any suffering they feel as a result of the pregnancy loss,⁴⁹ itself. We either hide miscarriage away, or discuss it badly and unreflectively, because of its liminality.

Perhaps with better theorization about miscarriage, some of the isolation experienced by women and their families will diminish. At the very least, we can turn away less from those who have experienced miscarriage and provide a space for them to seek *communitas* as other liminars have done.

Perhaps with better theorization about miscarriage, it will not be so easily enrolled in debates over abortion. One area in which we can expect real improvement due to better understanding of miscarriage as a liminal state should be the refusal of health care providers to learn techniques that are used to treat both miscarriage and abortion. Further awareness of the nature of miscarriage and its treatment ought to forestall the tight association of D&C training with abortion alone. We may not be able to avoid the binds in which providers find themselves when working for employers that forbid abortion and treating patients in the process of miscarrying. Though the line between completing or accelerating a miscarriage and performing an induced abortion seems clear to me, miscarriage's liminality with respect to abortion clearly complicates providing care in these particular antiabortion contexts. Perhaps a more open discussion of both states could lead to more clarity for hospital ethics committees at antiabortion institutions.

I strongly suspect that miscarriage will retain much of its liminal character—it may be ontological as much as social on at least some of these dimensions—and that it will continue to be enrolled in debates about control over pregnancy. After all, those debates focus intensely on whether pregnant women are “good mothers” even before their children are born; in those debates, the ultimate negative outcome for a “bad mother” is to avoidably miscarry. These four dimensions of miscarriage—betwixt and between parent or not-parent, procreator or not-procreator, death and life, pregnancy or abortion—are in theory extricable. In practice, and in the context of this society and its cultural imperatives about reproduction and motherhood, I struggle to reach even a cautious optimism that we can separate them one from another and avoid entirely the way that women are enrolled in these debates to their detriment. However, by becoming aware of the liminality of miscarriage and the role that this plays, by improving our ability to distinguish miscarriage properly from the poles that ground its liminality along these four dimensions, perhaps we can at least mitigate the impact on those women who are made vulnerable both by miscarriage and by our treatment of it. A more reflective and aware process of policy- and law-making might go a long way.

There may be no way completely out of the ethically troubling fallout of miscarriage's liminality, though I have hinted at areas where some resolution may be reached. If there is a way to entirely resolve miscarriage's liminality, it will require a better characterization of miscarriage and one which accounts for the liminality I have argued for here. I strongly advise against attempting to resolve miscarriage's liminality by pushing it toward any end of any dimension, and in favor of characterizing miscarriage in its own right. It is clearly distinct from these other states and events, and without knowledge of what it is we can only characterize it as “nothing.” A clear characterization of miscarriage may be necessary to eliminate the ethical fallout of miscarriage's liminality. Or perhaps this can be done without a more accurate description of miscarriage simply by addressing a more normative stance which clarifies how we ought to treat the liminars of miscarriage.

My hope is that this analysis will be useful as a foundation for real change. We can learn much about miscarriage and our society's reactions to it, and to those who experience it, by realizing that "the event that was nothing" is a liminal one.

Notes

- ¹ Susan Stewart, "A Language," *Poetry* (2011). Retrieved from <http://www.poetryfoundation.org/poetrymagazine/poem/242268>
- ² Larry Hand, "Misconceptions About Cause, Frequency of Miscarriage Common," *Medscape* (2013). Retrieved from <http://www.medscape.com/viewarticle/813084>
- ³ Arnold van Gennep, *The Rites of Passage* (Chicago: University of Chicago Press, 1961 Reprint Edition).
- ⁴ Jeffrey Willett and Mary Jo Deegan, "Liminality and Disability: Rites of Passage and Community in Hypermodern Society," *Disability Studies Quarterly* 21, no.3 (2001): 137–52.
- ⁵ Victor Turner, "Betwixt and Between: The Liminal Period in Rites of Passage." In *Betwixt and Between: Patterns of Masculine and Feminine Initiation*, ed. Lousie Carus Mahdi, Steven Foster, and Meredith Little (Peru, IL: Open Court Publishing Company, 1987), 3–22, 7.
- ⁶ *Ibid.*, 7.
- ⁷ Ronald A. Carson, "The Hyphenated Space: Liminality in the Doctor-Patient Relationship." In *Stories Matter: The Role of Narrative in Medical Ethics*, ed. Rita Charon and Martha Montello (New York: Routledge, 2002), 171–82. 180, my emphasis.
- ⁸ Stewart, "A Language."
- ⁹ John A. Robertson, *Children of Choice: Freedom and the New Reproductive Technologies* (Princeton, NJ: Princeton University Press, 1994), 24.
- ¹⁰ Katrina Kimport, "(Mis)understanding Abortion Regret," *Symbolic Interaction* 35, no. 2 (2012): 105–122. 107.
- ¹¹ Julia Frost, Harriet Bradley, Ruth Levitas, Lindsay Smith, and Jo Garcia, "The Loss of Possibility: Scientisation of Death and the Special Case of Early Miscarriage," *Sociology of Health and Illness* 29, no. 7 (2007): 1003–22.
- ¹² Because this is about becoming a parent, it is possible that this sense of liminality may also apply in cases of gestational surrogacy to the individual or couple that intends to parent the resulting child. In a normal gestational surrogacy, a child is born and the intentional parent(s) will indeed become parents. However, if the surrogate miscarries, both she and the intentional parent(s) will have had a relation to the child that might have been, without the possibility of a full parenting relation. All will be liminars; all are potentially trapped in this liminal state of becoming that never becomes.
- ¹³ Turner, "Betwixt and Between," 8.
- ¹⁴ Frost et al., "Loss of Possibility," 1004.
- ¹⁵ Miles Little and Emma-Jane Sayers, "While There's Life... Hope and the Experience of Cancer," *Social Science and Medicine* 59 (2004): 1329–1337. 1329.
- ¹⁶ Kimport, "(Mis)understanding," 106–07.
- ¹⁷ Frost et al., "Loss of Possibility," 1003.
- ¹⁸ Liberty Barnes, *Conceiving Masculinity: Male Infertility, Medicine, and Identity* (Philadelphia, PA: Temple University Press, 2014).
- ¹⁹ By emphasizing women as the liminars with respect to miscarriage and merely gesturing toward coparents/progenitors, I do not mean to minimize the damage that miscarriage does to men who have begun to form father-identities in relation to a fetus, or to any coparent or coprogenitor identities with a spouse or partner regardless of gender. They, too, can be liminars with respect to miscarriage. I note that this can occur with heterosexual couples, married or unmarried, as well as with same-sex couples who contract with a gestational surrogate who experiences a

- pregnancy loss. For a moving description of this from the male side of the equation I recommend Amit Majmudar's fine poem, "The Miscarriage," an excerpt from which runs as follows: "Forgive me. . . I was wondering. . . whether to console you/ if I consoled you it would make the loss/ your loss." Amit Majmudar (2005), "The Miscarriage," *Poetry*. Retrieved from <http://www.poetryfoundation.org/poetrymagazine/poem/175619>
- ²⁰ Kristi Kirschner, "Liminal States: The Challenge of New-Onset Disability," *Atrium: The Report of the Northwestern Medical Humanities and Bioethics Program 2* (2006): 1–3, 6.
- ²¹ Turner quoted in Willet and Deegan, "Liminality and Disability."
- ²² Hand, "Misconceptions."
- ²³ Susan Storck, "Miscarriage," *Medline Plus*. National Institutes of Health (2012). Retrieved from <http://www.nlm.nih.gov/medlineplus/ency/article/001488.htm>
- ²⁴ Frost et al., "Loss of Possibility," 1005.
- ²⁵ Susan Perry, "Failed Virginia Bill on Miscarriages Reveals Ignorance about Women's Health," *MINNPOST* (2013). Retrieved from <http://www.minnpost.com/second-opinion/2013/05/failed-virginia-bill-miscarriages-reveals-ignorance-about-womens-health>
- ²⁶ Errin Whack, "In Race for Virginia Attorney General, Abortion Debate Takes on Greater Intensity," *The Washington Post* (June 25, 2013). Retrieved from http://www.washingtonpost.com/local/va-politics/in-race-for-virginia-attorney-general-abortion-takes-on-greater-intensity/2013/06/25/4b122118-d9bf-11e2-9df4-895344c13c30_story.html
- ²⁷ Nina Lakhani, "El Salvador: Where Women May Be Jailed for Miscarrying," *BBC News* (October 17, 2013). Retrieved from <http://www.bbc.com/news/magazine-24532694>
- ²⁸ *Ibid.*
- ²⁹ *Ibid.*
- ³⁰ Beth Rogers, "Secret Practice: The Struggle to Integrate Abortion Training Into the Medical School Curriculum," *The New Physician* 58, no. 8 (2009). Retrieved from <http://www.amsa.org/AMSA/Homepage/Publications/TheNewPhysician/2009/1109FeatureAbortion.aspx>
- ³¹ *Ibid.*
- ³² Myrle Croasdale, "Abortion Training: Hard to Get?" *American Medical News* (2005). Retrieved from <http://www.amednews.com/article/20051024/profession/310249958/4/>
- ³³ *Ibid.*
- ³⁴ Lori R. Freedman and Debra B. Stulberg, "Conflicts in Care for Obstetric Complications in Catholic Hospitals," *AJOB Primary Research* 4, no. 4 (2013): 1–10, 1.
- ³⁵ *Ibid.*, 2.
- ³⁶ *Ibid.*, 4
- ³⁷ *Ibid.*, 5
- ³⁸ *Ibid.*, 6
- ³⁹ *Ibid.*, 4–5.
- ⁴⁰ Kate Sheppard, "Mississippi Could Soon Jail Women for Stillbirths, Miscarriages," *Mother Jones* (2013). Retrieved from <http://www.motherjones.com/politics/2013/05/buckhalter-mississippi-stillbirth-manslaughter>
- ⁴¹ *Ibid.*
- ⁴² Howard Minkoff and Anne Drapkin Lyerly, "Samantha Burton and the Rights of Pregnant Women Twenty Years After *In re A.C.*," *Hastings Center Report* 40, no. 6 (2010): 13–15, 13.
- ⁴³ *Ibid.*
- ⁴⁴ Erik Eckholm, "Case Explores Rights of Fetus Versus Mother," *The New York Times* (October 23, 2013). Retrieved from http://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html?pagewanted=all&_r=0
- ⁴⁵ National Conference of State Legislatures, "Fetal Homicide Laws" (2013). Retrieved from <http://www.ncsl.org/research/health/fetal-homicide-state-laws.aspx>
- ⁴⁶ Kontji Anthony, "Police: Woman Earns DUI for Endangering Fetus," *WMC-TV* (January 7, 2013). Retrieved from <http://www.14news.com/story/20525700/police-pregnant-woman-earns-dui-for-endangering-fetus>

⁴⁷ Joan Wolf, "Is Breast Really Best? Risk and Total Motherhood in the National Breastfeeding Awareness Campaign," *Journal of Health Politics, Policy and Law* 32, no. 4 (2007): 595–636.

⁴⁸ Lynn M. Paltrow and Jeanne Flavin, "Arrests of and Forced Interventions on Pregnant Women in the United States 1973–2005: Implications for Women's Legal Status and Public Health," *Journal of Health Politics, Policy and Law* 38, no. 2 (2013): 299–343.

⁴⁹ Kimport draws our attention to the fact that attachment happens differently during pregnancy, not at all for some women, partially for others, and intensely for still others. This is discursively produced and/or primed and thus highly variable depending on social interactions, meaning of pregnancy and personal identity regarding procreation, and whether pregnant women were aware they were pregnant at the time they miscarry. Carrie Pitzulo recounts her own example of how she did not feel the sorrow over the pregnancy loss that everyone thought she should, even though the pregnancy was wanted, but rather simply relief that the horror of the miscarriage itself was over.