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RACIAL DISPARITIES IN MATERNAL MORTALITY

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Racial disparities in maternal mortality have recently become a popular topic, with a host of media outlets devoting time and space to covering the appalling state of black maternal health in the country. Congress responded to this increased societal awareness by passing the Preventing Maternal Deaths Act at the tail end of 2018. The law provides states twelve million dollars annually, for five years, to fund maternal mortality review commissions—interdisciplinary collections of experts that evaluate and investigate the causes of every maternal death in a jurisdiction. Fascinatingly, although activists, journalists, politicians, scholars, and other commentators understand that the maternal health tragedy in the United States is a racial tragedy, the Preventing Maternal Deaths Act completely ignores race. Indeed, the term “race” does not appear anywhere in the text of the statute. The irony is striking: An effort to address a phenomenon that has become salient because of its racial nature ignores race entirely.

The racial irony embodied by the Preventing Maternal Deaths Act serves as an invitation to investigate not only the Act itself, but the national conversation that is currently taking place about racial disparities in maternal deaths. Indeed, in important respects, if the general discourse that surrounds racial disparities in maternal mortality is impoverished, then we should expect that the solutions that observers propose will be impoverished as well. This is precisely what this Article discovers. The analysis proceeds in four Parts.

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Part I provides an overview of racial disparities in maternal mortality, identifying the various elements that have made pregnancy, childbirth, and the postpartum period much more dangerous for black women than their white counterparts in the United States. Part II then offers critiques of the national conversation around racial disparities in maternal mortality and warns of both the marginalizing effects it may have on black women and the possibility that it will lead to blaming black women for dying on the path to motherhood.

Part III describes the Preventing Maternal Deaths Act in some detail. Part IV follows with a critique of the Act, identifying three deficiencies. First, it notes the racial erasure contained in the Act—the fact that the Act nowhere mentions the racial dimensions of the nation’s maternal health debacle. It then observes the predicament created by the fact that erasing race likely was essential to the very passage of the Act. Second, it notes that because the Act does not direct the state maternal mortality review commissions to investigate the structural and institutional forces that produce excess maternal deaths in the United States, it leaves space for maternal mortality review commissions to simply blame the dead for dying. Third, it notes that the Act does no more than fund the gathering of more data about pregnancy-related deaths. However, it observes that there is a strong argument to be made that we do not need more data. We already know why women are dying, and we already know how to save them. In this way, the tragedy of maternal mortality in the United States is not a problem of information; it is a problem of political will. To the extent that Congress chose to intervene in the maternal health debacle not with policy changes, but rather with an attestation that we need more information, the Preventing Maternal Deaths Act demonstrates that we still lack the political will to make the concrete changes that will make pregnancy and childbirth safe.

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INTRODUCTION

Racial disparities in maternal mortality have become a popular topic, although the problem is not at all new. Black women¹ in the United States have *always* died during pregnancy, childbirth, or shortly thereafter at higher rates than white women. Statistics compiled in the early 1900s—when epidemiologists first began to document the frequency of pregnancy-related deaths—reveal that pregnancy and childbirth were much deadlier for black women than for their white counterparts.² What was true at the dawn of the twentieth century remains true today.³ However, only recently have racial

¹ While cisgender women are not the only people who can become pregnant, I use the term “woman” and “women” in this article to refer to those who can experience pregnancy. I do this solely because the data collected around maternal mortality employs the category of “woman” and “women.”

² Population Council, *CDC on Infant and Maternal Mortality in the United States: 1900-99*, 25 POPULATION & DEV. REV. 821, 824 (1999) (“The gap in maternal mortality between black and white women has increased since the early 1900s. During the first decades of the 20th century, black women were twice as likely to die of pregnancy-related complications as white women.”); see also Andreea A. Creanga, *Maternal Mortality in the United States: A Review of Contemporary Data and Their Limitations*, 61 CLINICAL OBSTETRICS & GYNECOLOGY 296, 298 (2018) [hereinafter Creanga, *Maternal Mortality*] (discussing trends in maternal mortality in the United States and critiquing available data).

³ Population Council, *supra* note 2, at 824 (“Today, black women are more than three times as likely to die as white women.”).

disparities in maternal mortality become the subject of national attention.⁴

Media outlets like *The New York Times*,⁵ *USA Today*,⁶ *ProPublica*,⁷ and *NPR*⁸ have all published stories in the last few years about racial disparities in maternal mortality—each endeavoring to put names and faces on the fact that three to four times as many black women as white women die annually from pregnancy-related causes.⁹ Further, two of the most famous black women in the United States—if not the world—came forward with stories of having narrowly avoided death during their pregnancies. Tennis phenomenon Serena Williams published an account of developing a pulmonary embolism after the birth of her daughter.¹⁰ She stated that her healthcare providers ignored her when she reported her symptoms. Had she not been adamant in advocating for herself, the blood clot that had formed in her lung might have killed her.¹¹ Further, pop star and cultural icon

⁴ The question of *why* racial disparities in maternal mortality have only recently become the subject of national attention, although they have always existed, is a topic that I intend to explore in future research.

⁵ See Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. TIMES MAG. (Apr. 11, 2018) <https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html>.

⁶ See Alison Young, *Hospitals Know How to Protect Mothers. They Just Aren't Doing It*, USA TODAY, <https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002> (last updated Nov. 14, 2019) [hereinafter Young, *Hospitals Know How to Protect Mothers*].

⁷ See *Lost Mothers*, PROPUBLICA, <https://www.propublica.org/series/lost-mothers> (last visited July 4, 2020).

⁸ See *Lost Mothers: Maternal Mortality in the U.S.*, NPR, <https://www.npr.org/series/543928389/lost-mothers> (last visited July 4, 2020).

⁹ Andreea A. Creanga, Carla Syverson, Kristi Seed & William M. Callaghan, *Pregnancy-Related Mortality in the United States, 2011-2013*, 130 OBSTETRICS & GYNECOLOGY 366, 372 (2017) [hereinafter Creanga et al., *Pregnancy-Related Mortality, 2011-2013*] (finding the pregnancy-related mortality ratio from 2011–2013 to be 3.4 times as high for non-Hispanic black women as compared to non-Hispanic white women); Emily E. Petersen, Nicole L. Davis, David Goodman, Shanna Cox, Carla Syverson, Kristi Seed, Carrie Shapiro-Mendoza, William M. Callaghan & Wanda Barfield, *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007-2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762, 762–63 (2019), <https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6835a3-H.pdf> (finding that pregnancy-related mortality ratios from 2007–2016 were around four to five times as high for non-Hispanic black women as compared to non-Hispanic white women).

¹⁰ Serena Williams, *Opinion, What My Life-Threatening Experience Taught Me About Giving Birth*, CNN, <https://www.cnn.com/2018/02/20/opinions/protect-mother-pregnancy-williams-opinion/index.html> (last updated Feb. 20, 2018, 3:32PM); see also Allyson Chiu, *Beyoncé, Serena Williams Open Up About Potentially Fatal Childbirths, A Problem Especially for Black Mothers*, WASH. POST (Aug. 7, 2018, 7:22AM), <https://www.washingtonpost.com/news/morning-mix/wp/2018/08/07/beyonce-serena-williams-open-up-about-potentially-fatal-childbirths-a-problem-especially-for-black-mothers>.

¹¹ See Chiu, *supra* note 10.

Beyoncé, one of the richest black women in the world, reported that she developed preeclampsia during her pregnancy with her twins, leaving her swollen and on bed rest for a month.¹² She eventually had an emergency cesarean section (C-section) to save her life and the lives of her babies.¹³ For many, the fact that both Serena Williams and Beyoncé—wealthy black women who presumably have access to the best medical care in the world—were almost felled on their paths to motherhood dramatized just how poor the state of black maternal health is in this country. As legal scholar Derecka Purnell asked in an opinion piece in *The Guardian*, “If even Beyoncé had a rough pregnancy, what hope do other black women have?”¹⁴

With the spotlight shining brightly on poor black maternal health outcomes, politicians hoping for the Democratic Party nomination for the 2020 presidential election articulated their positions on the issue. California Senator Kamala Harris introduced a resolution that would make the week of April 11–17 Black Maternal Health Week.¹⁵ She also introduced an act that would incentivize healthcare providers to be trained on implicit biases, to which she attributed disparities in maternal mortality.¹⁶ Massachusetts Senator Elizabeth Warren introduced a plan to address racial disparities in maternal mortality that involved financially rewarding hospitals with good maternal health outcomes while financially penalizing hospitals with poor outcomes.¹⁷

Warren, Harris, Beyoncé, and Williams are simply adding their voices to a conversation about an issue around which activists for racial justice have long agitated. These activists—keenly aware of the existence and persistence of poor maternal health outcomes for black women—have clearly articulated their view that racial disparities in

¹² *Id.* Preeclampsia is a medical condition, usually appearing in the third trimester, that is characterized by hypertension and swelling. See *Preeclampsia*, WEBMD, <https://webmd.com/baby/preeclampsia-eclampsia> (last visited July 4, 2020). Preeclampsia can lead to eclampsia, which causes seizures and, possibly, brain injury and death. See *id.*

¹³ See Chiu, *supra* note 10.

¹⁴ Derecka Purnell, *If Even Beyoncé Had a Rough Pregnancy, What Hope do Other Black Women Have?*, GUARDIAN (Apr. 23, 2019), <https://www.theguardian.com/commentisfree/2019/apr/23/beyonce-pregnancy-black-women>.

¹⁵ Press Release, Kamala D. Harris, U.S. Sen. for California, Harris, 16 Senators Introduce Resolution Designating April 11-17 as Black Maternal Health Week (Apr. 11, 2019), <https://www.harris.senate.gov/news/press-releases/harris-16-senators-introduce-resolution-designating-april-11-17-as-black-maternal-health-week>.

¹⁶ See Press Release, Kamala D. Harris, U.S. Sen. for California, Sen. Harris Introduces Bill Aimed at Reducing Racial Disparities in Maternal Mortality (Aug. 22, 2018), <https://www.harris.senate.gov/news/press-releases/sen-harris-introduces-bill-aimed-at-reducing-racial-disparities-in-maternal-mortality>.

¹⁷ See Elizabeth Warren, *Sen. Elizabeth Warren on Black Women Maternal Mortality: ‘Hold Health Systems Accountable for Protecting Black Moms,’* ESSENCE (Apr. 30, 2019), <https://www.essence.com/feature/sen-elizabeth-warren-black-women-mortality-essence>.

maternal mortality are a manifestation of broader systemic racism.¹⁸ They have insisted that the relatively impoverished state of black maternal health in the United States demonstrates the general lack of care or concern for black people in the country—a fact that they argue is apparent across multiple domains of public life.¹⁹ For example, a *National Geographic* story covering racial disparities in maternal mortality quotes a healthcare provider and advocate who states, “[j]ust like state violence is allowing black folks to be shot dead in the street, and no one’s being held accountable or even having to atone for the death of black bodies, the same thing is happening in these medical institutions.”²⁰

In the maelstrom of attention that has been paid of late to racial disparities in maternal mortality, Congress has acted, passing the Preventing Maternal Deaths Act at the end of 2018.²¹ The law provides states twelve million dollars annually, for five years, to fund maternal mortality review committees—interdisciplinary collections of experts who evaluate every maternal death in a jurisdiction, seeking to understand why each death occurred and what can be done to prevent similar deaths in the future.²² Although activists, journalists, poli-

¹⁸ See Morgan Brinlee, *Racism Is Literally Killing Pregnant Black Women & These Numbers Prove It*, BUSTLE (Nov. 7, 2017), <https://www.bustle.com/p/race-maternal-mortality-are-linked-black-mothers-are-paying-the-price-3017625> (quoting Marsha Jones, the director of a reproductive justice advocacy organization called the Afiya Center, who described the higher rates of pregnancy-related deaths among black women as a “direct result of how black women are received when they enter the health care system that is riddled with bias about black women’s bodies” (internal quotations omitted) and arguing that “[h]istorically racist ideology and practices continue to dictate how black women are treated, so even when we present with resources and access we are treated no differently than if we had no access or resources because we are still black” (internal quotations omitted)); Annalisa Merelli, *What’s Killing America’s New Mothers*, QUARTZ (Oct. 29, 2017), <https://qz.com/1108193/whats-killing-americas-new-mothers> (quoting midwife Jennie Joseph, who described the elevated rates of black maternal mortality in the United States as an effect of “racism,” “classism,” and “sexism”).

¹⁹ See, e.g., Rachel Jones, *American Women Are Still Dying at Alarming Rates While Giving Birth*, NAT’L GEOGRAPHIC (Dec. 13, 2018), <https://www.nationalgeographic.com/culture/2018/12/maternal-mortality-usa-health-motherhood>.

²⁰ *Id.*

²¹ See Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, 132 Stat. 5047 (2018).

²² *Id.* § 2(d). The Preventing Maternal Deaths Act is an amendment to the Public Health Service Act, which implements the Safe Motherhood and Infant Health Initiative of the CDC. As such, the bill includes a fifty-eight million dollar figure—a sum that refers to the money allocated annually to that initiative as a whole. The bill does not indicate how much money is specifically allocated to MMRCs through the amendment. The sponsor of the bill, Representative Jaime Herrera Beutler, announced that the bill secured twelve million dollars for states to fund MMRCs. Press Release, U.S. Congresswoman Jaime Herrera Beutler, Jaime Herrera Beutler’s Bipartisan Bill to Prevent Maternal Deaths Receives Committee Hearing (Sept. 27, 2018), <https://jhb.house.gov/news/documentsingle.aspx?DocumentID=399310>. See also Nina Martin, “Landmark” Maternal Health

ticians, scholars, and other commentators understand that the maternal health tragedy in the United States is a *racial* tragedy, the Preventing Maternal Deaths Act completely ignores race. Indeed, the term “race” does not appear anywhere in the text of the statute. The irony is striking: An effort to address a phenomenon that has become salient *because* of its racial nature ignores race entirely.

The racial irony embodied by the Preventing Maternal Deaths Act serves as an invitation to investigate not only the Act itself, but the national conversation that is currently taking place about racial disparities in maternal deaths. Indeed, in important respects, if the general discourse that surrounds racial disparities in maternal mortality is impoverished, then we should expect that the solutions that observers propose to this problem will be impoverished as well. This is precisely what this Article concludes.

The analysis proceeds in four Parts. Part I provides an overview of maternal mortality in the United States. It describes the multiple factors that have contributed to the United States attaining the status as the nation with the highest frequency of maternal deaths in the industrialized world. It then turns to an analysis of racial disparities in maternal mortality, identifying the various elements that have made pregnancy, childbirth, and the postpartum period much more dangerous for black women than their white counterparts in the United States.

After providing essential background about the issue, Part II offers three critiques of the national conversation that is currently taking place around racial disparities in maternal mortality. First, it observes the latent racism in the oft heard statement that maternal deaths should not be happening “here”—in the wealthy, resource-rich, white United States. The unstated assumption in that statement is that maternal deaths, if they are to occur, should be happening “over there”—in the (implicitly nonwhite) developing world. Second, it warns that the solutions proposed to address the problem of the excess maternal death that black women experience in the United States may have the effect of marginalizing black women even further. To be precise, black women may find themselves subjected to more surveillance and regulation in our attempts to save them. That is, in our contemporary world, *efforts to address the effects of racism carry the risk of further subordinating the victims of racism*. Third, it observes that if the general public comes to understand the problem of maternal mortality in the United States as an issue that, at bottom,

is “about” black women, we should be prepared for the development of narratives that would blame black women for dying on the path to motherhood. Essentially, the stories that we tell about black women make it easy to fault black women for finding pregnancy difficult to survive. Following this outline of the inadequacy of the general discourse around maternal mortality in the United States, Part III then describes the Preventing Maternal Deaths Act. Part IV follows with a critique of the Act, identifying three deficiencies.

First, there is the racial erasure within the text of the Act—the Act nowhere mentions the racial character of the nation’s maternal health debacle. However, attempting to depoliticize the sad state of maternal health in the nation by erasing its racial dimensions was essential to the very passage of the Act. As a point of comparison, this Part contrasts the government’s “will to know” in the context of maternal mortality with the government’s steadfast “will *not* to know” in the context of officer-involved homicides. The comparison underscores that when an issue is racialized, and therefore, politicized—as the issue of officer-involved homicides most certainly is—the State is much less likely to support gathering information about the phenomenon. The problem, however, is that the failure to acknowledge the maternal health tragedy as a tragedy of racial inequality limits the Act’s potential to be an effective means of reducing or eliminating racial disparities in maternal mortality. If the intention is not to investigate ways to make the path to motherhood safer for *black* women, then the interventions that governments make under the Act’s banner may not help black women. This is especially true because studies show that black women are dying during pregnancy, childbirth, and the postpartum period from different causes than white women.²³ The general lesson here is that *the inability to speak about racism often-times makes attempts to address the effects of racism ineffective.*

Second, the Act does not direct the state maternal mortality review commissions that are created by and supported with federal funds to investigate the structural and institutional forces that produce excess maternal deaths in the United States. This leaves space for the ideological commitments of those who staff state maternal mortality review commissions to guide these bodies. This means that commissions can just as easily identify the problem of maternal mortality to be structural in nature (i.e., due to low Medicaid reimbursement rates) as they can identify it to be individual in nature (i.e., due to a woman’s obesity). Because the Act fails to offer guidance to states about the

²³ See AMNESTY INT’L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA ONE YEAR UPDATE 7 (2011) [hereinafter AMNESTY INT’L, ONE YEAR UPDATE].

focus that their maternal mortality review commissions should have, the policy changes that these commissions ultimately recommend might be focused on finding shortcomings in the individuals who are dying on the path to motherhood. Simply put, maternal mortality review commissions may end up blaming the victim. That these commissions may fault women for finding pregnancy difficult to survive is especially likely given the overrepresentation of black women among the dead.

Finally, the intervention that the state has made to address maternal mortality, the Preventing Maternal Deaths Act, is misguidedly information-centered. The Act does no more than fund the gathering of data about pregnancy-related deaths. However, there is a strong argument to be made that we do not need more data. We *already* know why women are dying, and we already know how to save them. In this way, the disaster and embarrassment that is maternal mortality in the United States is not a problem of information; it is a problem of political will. Women are dying from pregnancy-related causes in the United States because the country lacks the political will to make the changes that will save women's lives. To the extent that Congress chose to intervene in the current maternal health debacle not with policy changes, but rather with an attestation that we need more information, the Preventing Maternal Deaths Act demonstrates that we *still* lack the political will to make the concrete changes that will make pregnancy and childbirth safe. A short conclusion follows.

A brief note before continuing: black women are not the only nonwhite women who die more frequently from pregnancy-related causes than white women. In fact, the maternal mortality ratios of indigenous women and Asian/Pacific Islander women are also higher than the maternal mortality ratios of white women.²⁴ In this way, the

²⁴ See *Pregnancy Mortality Surveillance System*, CTNS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> (last visited July 7, 2020) (noting that between 2011 and 2016, the ratios of maternal deaths for black non-Hispanic women, American Indian/Alaskan Native non-Hispanic women, Asian/Pacific Islander non-Hispanic women, and white non-Hispanic women, per 100,000 live births, were 42.4, 30.4, 14.1, and 13.0, respectively).

Interestingly, the maternal mortality ratio for "Hispanic women," 11.3 deaths per 100,000 live births, is lower than that for white women. See *id.* This figure should not be taken to suggest that Latinx women enjoy a racial privilege vis-à-vis white women. Rather, it should be taken to suggest that the racial categories we employ elide vast differences among those who comprise the group. In other words, while some groups of women who have been racialized as Latinx are doing incredibly well, other groups of women who have been racialized as Latinx are suffering. The MMR of 11.3 for "Hispanic women" erases that heterogeneity. See SUZANNE MACARTNEY, ALEMAYEHU BISHAW & KAYLA

injustice of racial disparities in maternal mortality implicates multiple categories of nonwhite women. Nevertheless, this Article focuses on *black* maternal health and *black* maternal deaths because most of the conversation around racial disparities in maternal mortality in the last few years has centered black women. Because the issue of maternal deaths has become associated with black women, maternal mortality—and racial disparities in maternal mortality—have been racialized in a particular way. This Article explores the consequences of that particular racial cast.

Further, while black, Latinx, Asian, and indigenous people are all racially unprivileged vis-à-vis white people, the forms of each group's racial unprivilege differ from the forms of other groups' racial unprivilege. That is, while all of these groups have been racialized as nonwhite, they remain *differently* racialized. This Article chooses to focus on the specific racial discourses that have attached to black women and, consequently, the specific forms that racial disadvantage takes for this group. To do otherwise and to speak about “nonwhite women” broadly might problematically elide the heterogeneity of the group when it comes to maternal health.

I

MATERNAL MORTALITY IN THE UNITED STATES

In the United States, approximately two women die from pregnancy-related²⁵ causes every day, with some seven hundred preg-

FONTENOT, CENSUS BUREAU, POVERTY RATES FOR SELECTED DETAILED RACE AND HISPANIC GROUPS BY STATE AND PLACE: 2007-2011 4 (2013) <https://www2.census.gov/library/publications/2013/acs/acsbr11-17.pdf> (showing that while the poverty rate among Cuban-Americans approximated 15%, the poverty rate among Americans with backgrounds from Puerto Rico and the Dominican Republic approximated 25%). The same, of course, is true for all other racial groups. Compare KARTHICK RAMAKRISHNAN & FARAH Z. AHMAD, CTR. FOR AM. PROGRESS, STATE OF ASIAN AMERICANS AND PACIFIC ISLANDERS SERIES 90 (2014), <http://aapidata.com/wp-content/uploads/2015/10/AAPIData-CAP-report.pdf> (explaining that the poverty rates for Hmong- and Bangladeshi-Americans (who are racialized as Asian) are 27% and 21.1%, respectively) and Bic Ngo & Stacey J. Lee, *Complicating the Image of Model Minority Success: A Review of Southeast Asian American Education*, 77 REV. EDUC. RES. 415, 419 (2007) (explaining that fewer than half of Hmong- and Cambodian-Americans have completed high school based on data from the 2000 U.S. Census), with PEW RESEARCH CTR., THE RISE OF ASIAN AMERICANS 18 (2013) (explaining that 70% and 51% of Indian-Americans (who are racialized as Asian) and Chinese-Americans, respectively, have a college degree or higher, and that the median income of their households is approximately \$88,000 and \$65,000, respectively).

²⁵ Experts define a pregnancy-related death as resulting “from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.” *Pregnancy-Related Deaths*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm> (last visited July 6, 2020). Some authorities define “pregnancy-related” as death occurring within a year after the end of the

nant women or new mothers dying every year.²⁶ These numbers are notable for many reasons. First, that seven hundred women in this country die annually while attempting new motherhood means that the likelihood that a woman will not survive pregnancy and childbirth is much greater in the United States than in the countries that the United States tends to consider its peers. Indeed, the maternal mortality ratio (MMR) in the United States—23.8 deaths per 100,000 live births²⁷—is approximately twice the MMR found in the United Kingdom and Canada.²⁸

Second, seven hundred women dying on the path to motherhood annually in the country means that the United States is currently a deadlier place to be pregnant and give birth than it was in the recent past.²⁹ That is, the MMR in the United States has been steadily increasing over the course of the last quarter century.³⁰ In fact, the

pregnancy. *See id.* Other authorities, like the World Health Organization, limit that time frame to six weeks. *See* World Health Organization, *Maternal Mortality Ratio (Per 100 000 Live Births)*, WHO, <https://www.who.int/healthinfo/statistics/indmaternalmortality> (last visited July 6, 2020). Thousands of pregnant women die annually from causes that cannot be directly attributed to their pregnancies—namely suicide and homicide. Christie Lancaster Palladino, Vijay Singh, Jacquelyn Campbell, Heather Flynn & Katherine J. Gold, *Homicide and Suicide During the Perinatal Period: Findings from the National Violent Death Reporting System*, 118 *OBSTETRICS & GYNECOLOGY* 1056, 1061 (2011) (“[P]regnancy-associated homicide and suicide each account for more deaths than many other obstetric complications . . .”). The frequency of these pregnancy-associated deaths—which are a broader category of deaths than pregnancy-related deaths—have led some researchers to call for a greater focus on psychosocial health during the perinatal period. *See* AMNESTY INT’L, ONE YEAR UPDATE, *supra* note 23, at 24.

²⁶ Emily E. Petersen, Nicole L. Davis, David Goodman, Shanna Cox, Nikki Mayes, Emily Johnston, Carly Syverson, Kristi Seed, Carrie K. Shapiro-Mendoza, William M. Callaghan & Wanda Barfield, Ctrs. for Disease Control & Prevention, *Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017*, 68 *MORBIDITY & MORTALITY WKLY. REP.* 423, 423 (2019) [hereinafter Petersen, *Vital Signs*] (“Approximately 700 women die annually in the United States from pregnancy-related complications.”).

²⁷ Maternal mortality ratios refer to the number of pregnancy-related deaths per 100,000 live births.

²⁸ John A. Ozimek & Sarah J. Kilpatrick, *Maternal Mortality in the Twenty-First Century*, 45 *OBSTETRICS & GYNECOLOGY CLINICS NORTH AM.* 175, 176–77 (2018) (noting that “the current MMR in the United States is almost 2 times greater than that of the United Kingdom and more than 2 times greater than the MMR in Canada”).

²⁹ The United States first began tracking its MMR in 1900, when eight hundred women died of pregnancy-related causes for every 100,000 live births. *See* Creanga, *Maternal Mortality*, *supra* note 2, at 298. However, the MMR dropped precipitously in 1920, after the discovery of penicillin. *See id.* (noting that a “monotonic decline in maternal mortality . . . coincides with the introduction of penicillin in 1928”). The United States’ MMR was at its lowest in 1998, when only seven women died of pregnancy-related causes for every 100,000 live births. *See id.* Since 1998, it has been generally increasing. *Id.*

³⁰ Some have observed that the apparent increase in the United States’ MMR may not be owed entirely to an increased frequency of maternal deaths, but may also be attributed to improvements in identifying maternal deaths. For one, states added a standardized

United States is one of just thirteen countries that have experienced an uptick in its MMR over the past twenty-five years.³¹ Moreover, the United States is the *only* developed country among this ignominious thirteen.³² The other 158 countries where pregnancy-related deaths have been tracked—countries hailing from both the developed and developing world—managed to reduce their MMRs in the last quarter century.³³

Third, that seven hundred women die of pregnancy-related causes in the United States annually is remarkable when one considers the large sums of money spent on healthcare every year in the country—specifically healthcare concerning pregnancy and childbirth.³⁴ As one commentator notes, the ninety-eight billion dollars spent on pregnancy-related healthcare is a “shockingly poor return on investment”³⁵ in light of the hundreds of maternal deaths annually.

Fourth, that seven hundred women die in the United States of pregnancy-related causes annually is significant because researchers

pregnancy checkbox on death certificates in 2003, decreasing the likelihood that a deceased woman’s recent pregnancy would go unrecorded. Anna E. C. Daymude, Andrea Catalano & Dave Goodman, *Checking the Pregnancy Checkbox: Evaluation of a Four-State Quality Assurance Pilot*, 46 BIRTH 648, 649 (2019). Additionally, the International Classification of Diseases was revised in 1999, improving the coding of disease and death and thereby increasing the likelihood that a death from pregnancy-related causes will be flagged as such. Nat’l Ctr. for Health Statistics, *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/nchs/icd/icd9cm.htm> (last visited July 5, 2020). Nevertheless, many observers have argued that although some of the recorded increase in MMR in the United States may be owed to improvements in tracking pregnancy-related deaths, we can still safely conclude that, at the very least, the United States has not reduced its MMR in the last twenty-five years—unlike the overwhelming majority of nations in the world. See Creanga, *Maternal Mortality*, *supra* note 2, at 299 (“Despite a level of uncertainty around actual mortality levels, without question, the risk of death during and shortly after pregnancy from pregnancy-related causes has not declined in the United States for more than 25 years.”); Ozimek & Kilpatrick, *supra* note 28, at 176 (“Of the 171 countries studied by the United Nations Maternal-Mortality Estimation Inter-Agency Group, 158 demonstrated a reduction in maternal mortality over the 25 years studied.”).

³¹ See Ozimek & Kilpatrick, *supra* note 28, at 176.

³² These thirteen nations are the “Bahamas, Georgia, Guyana, Jamaica, North Korea, St. Lucia, Serbia, South Africa, Suriname, Tonga, United States, Venezuela, and Zimbabwe.” *Id.*

³³ *Id.*

³⁴ See CTR. FOR REPROD. RIGHTS, SISTERSONG, & THE NAT’L LATINA INST. FOR REPROD. HEALTH, *REPRODUCTIVE INJUSTICE: RACIAL AND GENDER DISCRIMINATION IN U.S. HEALTH CARE 12* (2014) [hereinafter *REPRODUCTIVE INJUSTICE*] (noting that the “U.S. spends an estimated \$98 billion per year on hospitalization during pregnancy and childbirth—twice as much as any other country”).

³⁵ Debra Bingham, Nan Strauss & Francine Coeytaux, *Maternal Mortality in the United States: A Human Rights Failure*, 83 CONTRACEPTION 189, 189 (2011).

estimate that more than half of these deaths are preventable.³⁶ That is, these deaths are not “inevitable”—an unfortunate, but unavoidable, consequence of pregnancy and childbirth.³⁷ The preventability of maternal deaths is evident in the fact that there is significant variation in MMRs across states. Some states have impressively low MMRs—like California, where only seven women die from pregnancy-related causes for every 100,000 live births.³⁸ Other states have terribly high MMRs—like Louisiana, where seventy-eight women die from pregnancy-related causes for every 100,000 live births.³⁹ The significant variation in MMRs across states has led at least one group of researchers to assert that the risk of dying from pregnancy-related causes “is not a ‘natural’ distribution,” but rather the result of “state-by-state policies.”⁴⁰

What is true at the state level is true at the national level. Just as states can implement policies to reduce MMR, so too can the United

³⁶ *Pregnancy-Related Deaths*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vitalsigns/maternal-deaths> (last visited Feb. 17, 2020) (“About 3 in 5 pregnancy-related deaths could be prevented.”).

³⁷ See Rebecca J. Cook & Bernard M. Dickens, *Upholding Pregnant Women’s Right to Life*, 117 INT’L J. GYNECOLOGY & OBSTETRICS 90, 90 (2012) (stating that oftentimes, a “fatalistic” view that women simply will not “survive their pregnancies” can be found everywhere, including in those countries that are not “resource-poor”).

³⁸ *CA-PAMR (Maternal Mortality Review)*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, <https://www.cmqcc.org/research/ca-pamr-maternal-mortality-review> (last visited Feb. 17, 2020). Notably, the MMR in California used to be much higher, at 16.9 deaths per 100,000 live births in 2006. *Id.*; see Creanga, *Maternal Mortality*, *supra* note 2, at 303. In order to address the issue, a consortium of several stakeholder organizations known as the California Maternal Quality Care Collaborative developed “patient safety bundles” that help healthcare providers identify and manage the risks that their pregnant and postpartum patients face. *What We Do*, CAL. MATERNAL QUALITY CARE COLLABORATIVE, <https://www.cmqcc.org/about-cmqcc/what-we-do> (last visited Feb. 17, 2020). Observers credit the drastic reduction of the MMR in California to the Collaborative’s work. See Creanga, *Maternal Mortality*, *supra* note 2, at 303.

³⁹ In Louisiana, the MMR among black women is 72.6 per 100,000 live births, while the MMR among white women is 27.3. Casey Leins, *States with the Highest Maternal Mortality Rates*, U.S. NEWS (June 12, 2019), <https://www.usnews.com/news/best-states/articles/2019-06-12/these-states-have-the-highest-maternal-mortality-rates>.

⁴⁰ YALE GLOB. HEALTH JUSTICE P’SHIP, WHEN THE STATE FAILS: MATERNAL MORTALITY & RACIAL DISPARITY IN GEORGIA 5 (2018); see also CTR. FOR REPROD. RIGHTS, BLACK MAMAS MATTER: ADVANCING THE HUMAN RIGHT TO SAFE AND RESPECTFUL MATERNAL HEALTH CARE 10 (2018), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf [hereinafter BLACK MAMAS MATTER] (“[P]oor maternal health outcomes are not inevitable, but are instead the result of laws, policies, and institutional practices that can be changed.”). *But see* Amirhossein Moaddab, Gary A. Dildy, Haywood L. Brown, Zhoobin H. Bateni, Michael A. Belfort, Haleh Sangi-Haghpeykar & Steven L. Clark, *Health Care Disparity and Pregnancy-Related Mortality in the United States, 2005–2014*, 131 OBSTETRICS & GYNECOLOGY 707, 707 (2018) (observing that the variation in MMRs across states “may simply be a product of differences in the prevalence of medical risk factors for poor perinatal outcomes”).

States nationally. Thus, if the risk of dying during pregnancy, childbirth, or shortly thereafter is twice as high in the United States as in the nations that we tend to think of as its peers, it is due to the United States' failure to do what is necessary to make pregnancy and childbirth less deadly. This is a task that, while not at all easy, is achievable.⁴¹ As some commentators have observed, “[m]aternal mortality is not principally a medical problem; it is primarily a social problem and a problem of political will”⁴² Hundreds of women in the United States die preventable deaths every year “not because we do not know how to save them,”⁴³ but because we simply have not made the effort to do so. Legal scholars Rebecca Cook and Bernard Dickens have made this point cogently, arguing that we have not made pregnancy and childbirth safe in the United States because we live in a

political culture that perceives the need for national defense in only a military context, not in a health context. If countries and governments suffered their rates of maternal mortality due not to inadequate maternity services but to military aggression, they would consider themselves under major attack, and allocate their resources to effective defense.⁴⁴

Which is to say: if seven hundred people died annually from terrorist attacks within the borders of the United States, the efforts to prevent these deaths would far exceed what the nation is currently doing to prevent the deaths of the seven hundred women who die annually from pregnancy-related causes.

Notably, while maternal mortality is a problem in the United States, rates of maternal morbidity are even higher. Severe maternal morbidity refers to cases in which a pregnant or recently postpartum woman faces a life-threatening diagnosis or must undergo a life-saving medical procedure—like a hysterectomy, blood transfusion, or

⁴¹ This is to say that although most of the pregnancy-related deaths in the United States are preventable, the reasons for them are complicated. See BUILDING U.S. CAPACITY TO REVIEW AND PREVENT MATERNAL DEATHS: REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES 35 (2018), https://reviewtoaction.org/sites/default/files/national-portal-material/Report%20from%20Nine%20MMRCs%20final_0.pdf [hereinafter REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES] (“[C]ircumstances leading to maternal death are complex and multifactorial; no one contributing factor is likely sufficient to result in a death. On average, four contributing factors were identified for each pregnancy-related death”).

⁴² Alicia Ely Yamin, *Toward Transformative Accountability: Applying a Rights-Based Approach to Fulfill Maternal Health Obligations*, 7 SUR INT'L J. HUM. RTS. 95, 112 (2010); see also Laura Katzive, *Maternal Mortality and Human Rights*, 104 INT'L LAW TIME CHANGE 383, 383 (2010) (“The persistently high number of maternal deaths every year, despite so much knowledge about how to prevent them, requires us to look at this problem as a failure of political will—a failure that reflects women’s low status around the world.”).

⁴³ Yamin, *supra* note 42, at 112.

⁴⁴ Cook & Dickens, *supra* note 37, at 91.

mechanical ventilation—to avoid death.⁴⁵ For every maternal death in the country, there are close to one hundred cases of severe maternal morbidity.⁴⁶ As one might expect, the risk of a woman suffering from severe maternal morbidity, like the risk of a woman dying from a pregnancy-related cause, has steadily increased over the past few decades.⁴⁷

A. Causes of Maternal Mortality

One might conceptualize the causes of maternal mortality either narrowly or broadly. A narrow framing would approach the issue technically, focusing on the medical conditions that have led to maternal deaths. Meanwhile, a broad framing would focus on the social conditions that have made it difficult for women to survive pregnancy and childbirth.

1. Looking Narrowly

When researchers approach the causes of maternal mortality narrowly, they observe that a third of pregnancy-related deaths in 2006–2009 were due to a condition involving the cardiovascular system.⁴⁸ The other leading causes of maternal deaths are “other medical noncardiovascular disease,” infection, and hemorrhage.⁴⁹ While some medical conditions that have contributed to pregnancy-related deaths are exceedingly difficult to avoid and treat—amniotic fluid

⁴⁵ See Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 CLINICAL OBSTETRICS & GYNECOLOGY 387, 388 (2018) [hereinafter Howell, *Reducing Disparities*] (describing trends and disparities in maternal morbidity in the United States); *Severe Maternal Morbidity in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html> (last updated Jan. 31, 2020) (providing descriptions and trends in severe maternal morbidity).

⁴⁶ Howell, *Reducing Disparities*, *supra* note 45, at 488.

⁴⁷ See *id.* (noting that “[s]evere maternal morbidity . . . in the United States . . . has been on the rise over the last few decades”); Katherine Ellison & Nina Martin, *Nearly Dying in Childbirth: Why Preventable Complications Are Growing in U.S.*, NPR (Dec. 22, 2017, 12:17 PM), <https://www.npr.org/2017/12/22/572298802/nearly-dying-in-childbirth-why-preventable-complications-are-growing-in-u-s> (“[T]he rate at which women are suffering nearly fatal experiences in childbirth has risen faster than the rate at which they’re dying. Based on the rate per 10,000 deliveries, serious complications more than doubled from 1993 to 2014 . . .”).

⁴⁸ See Andreea A. Creanga, Cynthia J. Berg, Jean Y. Ko, Sherry L. Farr, Van T. Tong, F. Carol Bruce & William M. Callaghan, *Maternal Mortality and Morbidity in the United States: Where Are We Now?*, 23 J. WOMEN’S HEALTH 3, 5 (2014).

⁴⁹ Ozimek & Kilpatrick, *supra* note 28, at 178. This represents a departure from past eras, during which the leading causes of maternal mortality included hypertensive disorders, blood clots, and hemorrhage. See *id.* at 177.

embolism, for example⁵⁰—the deaths that result from the medical conditions that constitute the leading causes of maternal mortality are much more preventable.⁵¹ A report released by nine maternal mortality review commissions states that approximately 68.2% of deaths involving cardiovascular disease and 70% of deaths involving hemorrhage could have been avoided.⁵²

Others have argued that the relatively high MMR in the United States, and the fact that it has been increasing steadily over the course of the past several decades, is attributable to the women who are becoming pregnant. More precisely, this explanation for the United States' comparatively high MMR looks to the increased prevalence among women of reproductive age in the country of chronic conditions, like heart disease, hypertension, obesity, and diabetes.⁵³ These chronic conditions increase the risk of pregnancy complications.⁵⁴ Accordingly, if more women enter pregnancy with one or more of these chronic conditions, more women will suffer from pregnancy complications—and more women will die from them. However, this explanation does not hold up against analysis, as researchers have shown that other nations have managed to reduce their MMRs despite the increased incidence of chronic conditions among women of reproductive age in those countries.⁵⁵ Sections II.C. and IV.B. return to patient-focused explanations of maternal mortality.

⁵⁰ See REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 25 (noting that “embolism deaths are considered one of the least preventable among pregnancy-related deaths”); Nina Martin, Emma Cillekens & Alessandra Freitas, *Lost Mothers*, PROPUBLICA (July 17, 2017) [hereinafter Martin et al., *Lost Mothers*], <https://www.propublica.org/article/lost-mothers-maternal-health-died-childbirth-pregnancy> (observing that “up to 80 percent of mothers who develop amniotic fluid embolisms die”).

⁵¹ The CDC defines a death as preventable when it “may have been averted by one or more changes in the health care system related to clinical care, facility infrastructure, public health infrastructure, and/or patient factors.” See Creanga, *Maternal Mortality*, *supra* note 2, at 302 (citing CTRS. FOR DISEASE CONTROL & PREVENTION, STRATEGIES TO REDUCE PREGNANCY-RELATED DEATHS: FROM IDENTIFICATION AND REVIEW TO ACTION (Cynthia Berg et al. eds., 2001)).

⁵² REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 22.

⁵³ See Ozimek & Kilpatrick, *supra* note 28, at 177–78 (discussing studies conducted in the United States that showed an increase in chronic conditions as well as maternal mortality). Other patient-focused explanations of the comparatively high MMR in the United States assert that maternal deaths may be attributed to patients failing to report “warning signs” or “symptoms requiring health care assessment” to their providers. REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 35.

⁵⁴ See Creanga, *Maternal Mortality*, *supra* note 2, at 299.

⁵⁵ See, e.g., INST. FOR HEALTH METRICS & EVALUATION, THE GLOBAL BURDEN OF DISEASE: GENERATING EVIDENCE, GUIDING POLICY 20 (2013) (illustrating the rising disease burden from noncommunicable causes in, among other regions, North America, Central Asia, and Europe from 1990 to 2010); *Maternal Mortality: Key Facts*, WORLD HEALTH ORG. (Sept. 19, 2019), <https://www.who.int/news-room/fact-sheets/detail/>

2. Looking Broadly

If we look beyond the narrow, clinical explanations of maternal mortality in the United States that solely focus on medical conditions that lead to death, we would see the healthcare system upon which pregnant women and new mothers rely. Some researchers with this broadened focus have attributed the comparatively high MMR in the United States to the surfeit of medical interventions during labor and childbirth that have become de rigueur in the country.⁵⁶ Many observers have concluded that the typical birth in the United States is medically managed to an excessive extent.⁵⁷ Moreover, they have concluded that the country's comparatively high MMR is due to this excess.⁵⁸ However, other researchers disagree. They have been careful to note that although the rate of C-sections in the United States is high and many C-sections are unnecessary, we ought not to conclude that the nation's comparatively high MMR is attributable to its C-section rate. Instead, the medical condition that causes a pregnant

maternal-mortality (naming Central Asia and Europe as two subregions that have dramatically reduced their MMRs since 2000). Other explanations similarly do not hold up against analysis. Some have attributed the United States' high MMR to its large rural population—a population that might have to travel long distances to medical facilities, decreasing their ability to access medical care when faced with an obstetric emergency. See Moaddab et al., *supra* note 40, at 710. Yet, “Canada, a nation which is even more rural, has a maternal mortality ratio less than half of the United States’—10 per 100,000 live births.” *Id.*

⁵⁶ For example, it is not at all unusual for a pregnant woman to have her labor induced, which may necessitate the use of drugs, like Pitocin, to enhance the labor and strengthen contractions. *Inducing Labor*, AM. PREGNANCY ASS'N, <https://americanpregnancy.org/labor-and-birth/inducing-labor> (last visited July 4, 2020). The use of oxytocin (known by its brand name Pitocin) may have the effect of making the ensuing contractions unbearable, leading many laboring women to request an epidural. See *id.* (noting the existence of various measures to relieve pain during delivery). An epidural may slow or stop a pregnant woman's labor, which may require more medical interventions—the most dramatic of which is a cesarean delivery. See Bupesh Kaul, Manuel C. Vallejo, Sivam Ramanathan, Gordon Mandell, Amy L. Phelps & Ashi R. Daftary, *Induction of Labor with Oxytocin Increases Cesarean Section Rate as Compared with Oxytocin for Augmentation of Spontaneous Labor in Nulliparous Parturients Controlled for Lumbar Epidural Analgesia*, 16 J. CLINICAL ANESTHESIA 411, 412–13 (2004) (describing the results of a study that found a higher rate of cesarean deliveries among women whose labor was induced).

⁵⁷ See Bingham et al., *supra* note 35, at 191 (stating that in the United States, “women and infants are often exposed to more procedures than are medically necessary or beneficial”); Merelli, *supra* note 18 (quoting an obstetrician who describes maternity care in the United States as “over-medicalized” and noting that the “[e]xcessive interventions” that are part and parcel of this over-medicalization “carry serious additional risks”).

⁵⁸ See Bingham et al., *supra* note 35, at 191 (arguing that the “overuse of medical procedures increases injuries”); Erin K. Duncan, *The United States' Maternal Care Crisis: A Human Rights Solution*, 93 OR. L. REV. 403, 407 (2014) (“Medical interventions are at times necessary in birth. . . . However, when such interventions are used without clear evidence-based indications that the expected benefits will outweigh the potential harms, they can negatively impact women's health.”).

woman's death may be what makes a C-section medically indicated. As one set of researchers explains, the correlation between a C-section and a maternal death "does not reflect causation; the overwhelming majority of maternal deaths associated with cesarean delivery is a consequence of the indication for the cesarean delivery, not the operation itself."⁵⁹

Other researchers with a broadened approach to understanding the causes of maternal mortality attribute the United States' high MMR to the lack of postpartum care for women who have recently given birth. Many maternal deaths—especially those that are caused by infection, blood clots, and hemorrhage—occur some period of time after the woman has delivered her baby.⁶⁰ In order to avoid these deaths, recently postpartum women must be monitored, and they must have access to healthcare after their infant has been born. However, "[m]ost health plans in the United States only cover a single visit to a health care provider around 6 weeks after birth unless the woman has a recognized complication."⁶¹ The United States' parsimonious approach to postpartum care stands in stark contrast to the approach that many European nations take, in which "multiple home visits following birth are standard for all women."⁶²

Other researchers looking broadly at the question of the causes of maternal deaths in the United States have concluded that the high MMR in the country is due to the government's failure to oversee and regulate hospitals and healthcare providers. Many hospitals have not implemented measures that are known to identify pregnancy complications and prevent death.⁶³ California managed to cut its MMR in half over the course of just a few short years by training healthcare providers and hospital staff to identify and respond to potentially life-threatening conditions in their pregnant or recently postpartum patients.⁶⁴ These practices, which hospitals throughout the state implemented, have been "endorsed by leading medical societies as the

⁵⁹ Moaddab et al., *supra* note 40, at 710.

⁶⁰ See Bingham et al., *supra* note 35, at 190.

⁶¹ *Id.*

⁶² *Id.*

⁶³ Alison Young, *Mothers Are Dying. Will This Bill Help?*, USA TODAY (Dec. 19, 2018), <https://www.usatoday.com/story/news/investigations/deadly-deliveries/2018/12/19/maternal-mortality-rate-bill-targets-childbirth-deaths/2339750002> [hereinafter Young, *Mothers Are Dying*] (stating that many healthcare providers "fail[] to follow nationally promoted best practices that make childbirth safer"); BLACK MAMAS MATTER, *supra* note 40, at 44 (noting that "an appropriate clinical response" can often prevent death and severe injury when pregnancy complications develop, yet "not all providers and facilities are prepared to recognize and respond to these complications").

⁶⁴ Young, *Hospitals Know How to Protect Mothers*, *supra* note 6.

gold standard of care.”⁶⁵ Although these safety measures are now well-known⁶⁶—and although their efficacy has been proven—many hospitals outside of the state have failed to put them into practice. For example, safety experts in California recommend that whenever women develop elevated blood pressure readings, they should immediately be given a medication that will bring down their blood pressure to safe levels.⁶⁷ However, “[a]t dozens of hospitals in New York, Pennsylvania, and the Carolinas . . . [.] fewer than half of maternity patients were promptly treated for dangerous blood pressure that put them at risk of stroke. At some of those hospitals, less than 15 percent of mothers in peril got recommended treatments”⁶⁸ If the government regulated hospitals with an interest in patient safety and quality of healthcare, it could require that hospitals follow “the gold standard of care.”⁶⁹

It is undeniable that the disjointed character of healthcare financing and delivery in the United States makes government oversight and regulation of hospitals and healthcare providers difficult. Regulation of healthcare in a single-payer system is simple—a fact to which some have attributed the low MMR in the United Kingdom.⁷⁰ In contrast, in the United States, “[t]he fragmented nature of health care financing and delivery also leads to a fragmented and uncoordinated approach to oversight. The federal government’s involvement in reducing maternal mortality and addressing disparities lacks coordination; efforts are split between a number of federal agencies.”⁷¹ Nevertheless, some observers have concluded that the federal government is fully capable of regulating hospitals and healthcare providers when it

⁶⁵ *Id.*

⁶⁶ *See id.* (“[S]ome of [the safety practices] have been known for at least eight years.”).

⁶⁷ Tom Archer, Maurice Druzin, Laurence E. Shields & Nancy Peterson, California Maternal Quality Care Collaborative, *Antihyperintensive Agents in Preeclampsia*, in CMQCC PREECLAMPSIA TOOLKIT 3 (2013), <https://www.cmqcc.org/resource/2825/download>.

⁶⁸ Young, *Hospitals Know How to Protect Mothers*, *supra* note 6.

⁶⁹ *Id.*

⁷⁰ *See id.* (stating that some experts believe that the single payer system in Great Britain is responsible for the fact that women die from pregnancy-related causes at a third of the United States’ rate, as “[i]n countries with publicly funded national health care systems . . . it is easier to insist hospitals and health providers follow standard safety practices”).

⁷¹ AMNESTY INT’L, *DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA* 85 (2010) [hereinafter AMNESTY INT’L, *DEADLY DELIVERY*]. The report goes on to explain that “[w]hile litigation provides an avenue for individuals or families to seek redress, it rarely leads to systemic reform. Even when improved procedures and policies do result from such litigation, they are often piecemeal and localized.” *Id.*

comes to maternal healthcare quality, despite “[t]he fragmented nature of healthcare delivery and financing”⁷² in the United States.⁷³

B. Racial Disparities in Maternal Mortality

As noted above, the official MMR in the United States is 23.8 deaths for every 100,000 live births.⁷⁴ However, this figure obscures the fact that not all women in the United States are similarly situated when it comes to the likelihood that they will not survive pregnancy, childbirth, or the postpartum period. To be precise, the path to motherhood is significantly deadlier for black women than it is for their white counterparts. This is not to say that surviving pregnancy and childbirth is a sure shot for white women in the United States: Women in twenty-four other industrialized nations have better chances of avoiding a pregnancy-related death than white women in the United States.⁷⁵ Nevertheless, black women in the United States have even worse chances of surviving pregnancy than their white counterparts.

Black women are three to four times as likely to die from pregnancy-related causes than white women.⁷⁶ This racial disparity in maternal mortality has persisted across the generations.⁷⁷ Indeed, the gap has “widened.”⁷⁸ Eighty years ago, black women were twice as likely as white women to die on the path to motherhood.⁷⁹ Thirty years ago, black women were three times as likely as white women to die.⁸⁰ Presently, black women are nearly four times as likely to die as their white counterparts.⁸¹

⁷² *Id.*

⁷³ See Young, *Hospitals Know How to Protect Mothers*, *supra* note 6 (noting that the Centers for Medicare and Medicaid Services could condition funds on the recipient hospital’s or provider’s implementation of safety measures, as they do for certain surgeries and other medical services).

⁷⁴ Marian F. MacDorman, Eugene Declercq, Howard Cabral & Christine Morton, *Recent Increases in the U.S. Maternal Mortality Rate, Disentangling Trends from Measurement Issues*, 128 *OBSTETRICS & GYNECOLOGY* 447, 453 (2016).

⁷⁵ AMNESTY INT’L, *DEADLY DELIVERY*, *supra* note 71, at 1.

⁷⁶ See Petersen, *Vital Signs*, *supra* note 26, at 423–24 (reporting findings that black women have a pregnancy-related mortality ratio 3.3 times as high as that of white women); see also Creanga et al., *Pregnancy-Related Mortality, 2011-2013*, *supra* note 9, at 372 (reporting findings of a ratio of 3.4 for same).

⁷⁷ See YALE GLOB. HEALTH JUSTICE P’SHIP, *supra* note 40, at 16 (describing how this disparity has existed—and grown—since the Centers for Disease Control and Prevention have begun to record this information in 1940).

⁷⁸ See Howell, *Reducing Disparities*, *supra* note 45, at 387 (noting that racial disparities in maternal deaths have “widened over the last hundred years” (citations omitted)).

⁷⁹ YALE GLOB. HEALTH JUSTICE P’SHIP, *supra* note 40, at 16.

⁸⁰ *Id.*

⁸¹ AMNESTY INT’L, *DEADLY DELIVERY*, *supra* note 71, at 19.

Clinicians report that black women are dying from different causes than white women. While cardiovascular and coronary conditions, cardiomyopathy, and hemorrhage are among the most frequent causes of death for both groups of women, deaths from embolism as well as preeclampsia and eclampsia are much more common among black women than white women.⁸² Interestingly, the high numbers of deaths that black women suffer from preeclampsia and eclampsia appear to be, on the whole, avoidable. “Over a three-year period, the United Kingdom had only two deaths from preeclampsia and eclampsia, suggesting deaths from these hypertensive disorders of pregnancy are highly preventable.”⁸³ In essence, the technology and knowledge that could save black women’s lives exist. The United States simply has not deployed them.

That three to four times as many black women die from pregnancy-related causes as white women hides that there is significant variation in racial disparities in maternal mortality across cities and states. In other words, place matters. In New York City, a study of the period from 2006 to 2010 found that the MMR for black women is 56.3, while the ratio for white women is 4.7—making black women in the city twelve times more likely to die from a pregnancy-related cause than their white counterparts.⁸⁴ In Fulton County, Georgia, which includes Atlanta, the MMR for black women is ninety-four deaths per 100,000 live births, while the ratio for white women is “too insignificant to report at all.”⁸⁵ The MMR for black women in D.C. is one of the highest in the country;⁸⁶ meanwhile, the MMR for white women in D.C. is the *lowest* in the country—disturbing statistics that reveal that “[e]xcellent care is apparently available but is not reaching all the people.”⁸⁷ Dramatic racial disparities in maternal mortality are

⁸² REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 16–17. Deaths from infection and “[m]ental health conditions” were much more common among white women. *Id.*

⁸³ *Id.* at 6. For definitions of preeclampsia and eclampsia, see *supra* note 12.

⁸⁴ LORRAINE C. BOYD, TAMISHA JOHNSON, AILEEN LANGSTON, CANDACE MULREADY-WARD & JUAN PEÑA, N.Y.C. DEPT OF HEALTH & MENTAL HYGIENE, PREGNANCY-ASSOCIATED MORTALITY, NEW YORK CITY, 2006-2010, at 5, 9 (2010) <https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf> (“Black, non-Hispanic women were 12 times more likely than White, non-Hispanic women to die from pregnancy-related causes between 2006 and 2010.”). Racial disparities in maternal deaths have widened in NYC, as black women were just seven times more likely than their white counterparts to die from pregnancy-related causes from 2001 to 2005. *Id.* at 5. Fascinatingly, “[t]he increasing gap was largely driven by a 45% decrease in pregnancy-related mortality among White, non-Hispanic women.” *Id.*

⁸⁵ REPRODUCTIVE INJUSTICE, *supra* note 34, at 13.

⁸⁶ *See id.*

⁸⁷ Moaddab et al., *supra* note 40, at 711. The overall MMR in D.C.—a site in which black people comprise half of the population—is 41.6 deaths per 100,000 live births;

not unique to D.C., New York, or Georgia. “[I]n some areas of Mississippi, . . . the rate of maternal death for women of color exceeds that of Sub-Saharan Africa, while the number of White women who die in childbirth is too insignificant to report.”⁸⁸ Specifically, in Chicksaw County, Mississippi, 595 black women die from pregnancy-related causes for every 100,000 live births—a statistic that reveals that black women in the county would have a better chance at surviving birth if they lived in Kenya or Rwanda—poor, underdeveloped nations where the MMR is 400 and 320, respectively.⁸⁹

There may be a tendency to attribute racial disparities in maternal mortality to socioeconomic status. That is, it is no secret that black people disproportionately bear the burdens of poverty in the country.⁹⁰ Many may assume that racial disparities in maternal mortality are a function of the disproportionate poverty in which black people live.⁹¹ The assumption may be that black women are more likely to suffer a maternal death because more black women live in poverty, and poverty, of course, is known to compromise the health of those forced to live in it.⁹² If true, then racial disparities in maternal mortality are, at bottom, merely class-based disparities in maternal

meanwhile, the national average MMR is 28. REPRODUCTIVE INJUSTICE, *supra* note 34, at 13.

⁸⁸ REPRODUCTIVE INJUSTICE, *supra* note 34, at 6.

⁸⁹ *Id.* at 13 (citation omitted). Across Mississippi, the MMR for black women is fifty-four deaths for every 100,000 live births—a figure that is almost twice the MMR for white women in the state. BLACK MAMAS MATTER, *supra* note 40, at 21. The result is that “a Black woman in Mississippi is more likely to suffer a maternal death than a woman in Palestine, Mexico, or Egypt.” *Id.*

⁹⁰ See *Poverty in America Continues to Affect People of Colour Most*, ECONOMIST (Sept. 26, 2019) <https://www.economist.com/special-report/2019/09/26/poverty-in-america-continues-to-affect-people-of-colour-most> (“Across America, black people remain disproportionately poor. More than 20% live in poverty, twice the rate of whites.”); see also AMNESTY INT’L, DEADLY DELIVERY, *supra* note 71, at 25 (“Women of color are at least twice as likely as white women to be living in poverty; approximately a quarter of black and Latina women have incomes below the Federal Poverty Level” (citation omitted)).

⁹¹ See, e.g., Adi Hirshberg & Sindhu K. Srinivas, *Epidemiology of Maternal Morbidity and Mortality*, 41 SEMINARS PERINATOLOGY 332, 335 (2017) (“While exact causes of these disparities are not completely understood, current hypotheses include multiple risk factors such as . . . less education, later initiation to prenatal care, . . . and lower insurance coverage among some of these populations.” (citations omitted)); Daniel B. Nelson, Michelle H. Moniz & Matthew M. Davis, *Population-Level Factors Associated with Maternal Mortality in the United States, 1997-2012*, 18 BMC PUB. HEALTH 1007, 1012 (2018) (“Many factors likely play a role in perpetuating [racial disparities in maternal mortality], including poor access to prenatal care and lower educational attainment” (citations omitted)).

⁹² See Jane Goodman & Claire Conway, *Poor Health: When Poverty Becomes Disease*, U.C.S.F. (Jan. 6, 2016), <https://www.ucsf.edu/news/2016/01/401251/poor-health-when-poverty-becomes-disease> (quoting the Chief of University of California San Francisco’s Division of Developmental Medicine within the Department of Pediatrics as saying

mortality. But this logic is incorrect. In truth, *racial disparities in maternal mortality ratios persist across income levels and education status*.⁹³ Black women with class privilege are dying at higher ratios than white women with comparable class privilege. As obstetrician and activist Joia Crear-Perry explains it, “[a]s a black mother, I cannot buy or educate my way out of dying at 3 to 4 times the rate of a white mother in the United States.”⁹⁴ Indeed,

[a] White woman with less than a high school education has a better chance to live in childbirth than a Black woman with a college degree [A] Black woman who initiates prenatal care in the first trimester has a worse outcome in birth than a white woman with late or no prenatal care.⁹⁵

In essence, higher levels of income and education are not protecting black women attempting motherhood.

As discussed above, there are significant variations in MMR across states and cities.⁹⁶ Significantly, these variations closely correlate with the racial composition of the sites. Thus, states and cities with larger numbers of black people tend to have high MMRs; conversely, states and cities with smaller numbers of black people tend to do better when it comes to MMR.⁹⁷ Accordingly, when a state boasts that it is one of the safest places in the country to be pregnant and give birth, the state’s claim may be true simply because there are fewer

“[s]ocioeconomic status is the most powerful predictor of disease, disorder, injury and mortality we have”).

⁹³ See, e.g., Margaret A. Harper, Mark A. Espeland, Elizabeth Dugan, Robert Meyer, Kathy Lane & Sharon Williams, *Racial Disparity in Pregnancy-Related Mortality Following a Live Birth Outcome*, 14 ANNALS EPIDEMIOLOGY 274, 274 (2004) (“After controlling for gestational age at delivery, maternal age, income, hypertension, and receipt of prenatal care, African-American race remained a significant predictor variable.”); CRISTINA NOVOA & JAMILA TAYLOR, EXPLORING AFRICAN AMERICANS’ HIGH MATERNAL AND INFANT DEATH RATES, CTR. FOR AM. PROGRESS 4 (Feb. 1, 2018), <https://www.americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-maternal-infant-death-rates> (“Numerous studies show that after controlling for education and socioeconomic status, African American women remain at higher risk for maternal and infant mortality.”).

⁹⁴ *Better Data and Better Outcomes: Reducing Maternal Mortality: Hearing on H.R. 1318 Before the Subcomm. on Health of the Comm. on Energy & Commerce*, 115th Cong. (2018) (statement of Joia A. Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative), <https://docs.house.gov/meetings/IF/IF14/20180927/108724/HHRG-115-IF14-Wstate-CrearPerryJ-20180927.pdf>.

⁹⁵ *Id.*; see also Howell, *Reducing Disparities*, *supra* note 45, at 390–91 (discussing a study that “found the largest racial disparity among women with the lowest risk of pregnancy-related disease” (citation omitted)).

⁹⁶ See discussion *supra* notes 84–89 and accompanying text.

⁹⁷ See Moaddab et al., *supra* note 40, at 709 (finding “a significant correlation between state mortality ranking and the proportion of non-Hispanic black women in the delivery population and an inverse correlation with deliveries to non-Hispanic white women”).

pregnant black women in the state—not because the state offers superior maternal healthcare relative to other states.⁹⁸

1. *Explaining Racial Disparities in Maternal Mortality*

Researchers have identified multiple factors that likely contribute to racial disparities in maternal mortality. Notably, most of these factors are social. The weight of the research in this area establishes that the higher rates of maternal deaths among black women as compared to white women cannot fully be explained in terms of a higher prevalence among black women of risk factors that are known to lead to poor pregnancy outcomes. Differently stated, while black women are less likely to survive pregnancy and childbirth, this is not simply because black women have higher rates of obesity, diabetes, hypertension, or other chronic conditions that increase the likelihood of pregnancy complications.⁹⁹ Certainly, some of the racial disparity in maternal mortality and morbidity can be attributed to black women entering pregnancy unhealthier than their white counterparts;¹⁰⁰ undeniably, some of the disparity can be explained in terms of the higher rates of poverty—which, again, is known to compromise health—among black women.¹⁰¹ However, these traditional risk factors for poor pregnancy outcomes do not *fully* explain higher rates of maternal death among black women. The research in this area shows that in many cases, black women are dying on the path to motherhood not because they are poor, or sick, or obese, or unable to access medical care. Rather, in many important respects, black women are dying on the path to motherhood because they are *black*.¹⁰² In a multiple

⁹⁸ *Id.* at 711 (“[A]lthough low state maternal mortality ratios may reflect state-specific excellence in quality, leadership, organization, and funding of obstetric health care, such favorable ranking could simply reflect a different proportion of non-Hispanic black patients in the population rather than intrinsically superior medical care. The converse applies as well.”).

⁹⁹ Bingham et al., *supra* note 35, at 190 (“[C]ontrary to common assumptions, the racial and ethnic disparities in [pregnancy] outcomes are not always due to women of color having a higher prevalence of diseases.”).

¹⁰⁰ See Howell, *Reducing Disparities*, *supra* note 45, at 391 (“Data suggest that a web of factors including higher prevalence of comorbidities . . . contribute to but do not fully explain the elevated rates of severe maternal morbidity and mortality among racial and ethnic minority women.”).

¹⁰¹ See *id.* (stating that racial disparities in maternal mortality may, in part, be attributed to black women’s “lower socioeconomic status”); see also REPRODUCTIVE INJUSTICE, *supra* note 34, at 13 (“Socioeconomic factors . . . also drive disparities.”).

¹⁰² See, e.g., AMNESTY INT’L, DEADLY DELIVERY, *supra* note 71, at 74 (discussing a study that found that black women were 2.5 times more likely to die from an obstetric hemorrhage than white women, although both groups of women are equally likely to suffer this complication); Bingham et al., *supra* note 35, at 189 (“[I]n a national study of five medical conditions that are common causes of maternal death and injury . . . , black women

regression analysis conducted in 2007, researchers found that racial disparities in maternal mortality

could not be explained by other risk factors that were found to be significantly associated with adverse outcomes in univariable analysis. These included age, obesity, history of a chronic medical condition, prior cesarean delivery and gravidity. Education level, marital status and public medical insurance status, factors traditionally associated with sociodemographic status, could not explain the disparity.¹⁰³

The balance of this Section discusses the many factors that, acting in concert, likely produce the racial disparities in maternal mortality that are so well-documented. It begins with an exploration of biological race—an explanation for racial disparities in maternal mortality, and racial disparities in health, more generally, that critical scholars have rejected, and the weight of good science has disproved. It then turns to more likely contributors to racial disparities in maternal mortality—including different rates of poverty between racial groups, stress and weathering experienced by black people, and differences in quality of care provided to black and white women.

a. Biological Race—or a Problematic, if Popular, Explanation of Racial Disparities in Maternal Mortality

The belief that there is a genetic essence to race has a long history.¹⁰⁴ This idea proposes that the groups that we consider to be races (i.e., black, white, Asian, indigenous, etc.) exist as such because the individuals within each group are more genetically similar to one another than they are to individuals outside of their group. This

did not have a significantly higher prevalence than white women of any of these conditions . . . [but] were [still] two to three times more likely to die than the white women who had the same complication.”); William A. Grobman et al., *Racial and Ethnic Disparities in Maternal Morbidity and Obstetric Care*, 125 *OBSTETRICS & GYNECOLOGY* 1460, 1461 (2015) (noting that racial disparities in maternal mortality “do not appear to be related solely to a greater prevalence or severity of obstetric complications” and that “black women are more likely to have pregnancy-associated mortality even after accounting for severity of” the complication); Howell, *Reducing Disparities*, *supra* note 45, at 390 (“[T]he increased risk of maternal death among racial and ethnic minority women appears to be, at least in part, independent of sociodemographic risk. Adjustment for sociodemographic and reproductive factors has not explained the racial gap” (citation omitted)).

¹⁰³ Dena Goffman, Robert C. Madden, E.A. Harrison, Irwin R. Merkatz & Cynthia Chazotte, *Predictors of Maternal Mortality and Near-Miss Maternal Morbidity*, 27 *J. PERINATOLOGY* 597, 600 (2007).

¹⁰⁴ See Elizabeth Kolbert, *There’s No Scientific Basis for Race—It’s a Made-Up Label*, *NAT’L GEOGRAPHIC*, <https://www.nationalgeographic.com/magazine/2018/04/race-genetics-science-africa> (Mar. 12, 2018) (describing the experiments that physician Samuel Morton performed on the skulls of differently-raced individuals in the mid-nineteenth century and noting that these experiments earned him the title of “the father of scientific racism”).

notion, what we may call “biological race,” offers that people who have been racialized as black share a genetic profile—that is, they have certain genes, and lack other genes—that distinguishes them from people who are not black. Further, people who have been racialized as Asian share a genetic profile that distinguishes them from people who are not Asian. And so on and so forth. Although the weight of good science disproves the existence of biological race¹⁰⁵—and although history has demonstrated the terrors of the idea when lawmakers transform it into social policy¹⁰⁶—the idea has persisted.¹⁰⁷ Indeed, otherwise respected scholars with large platforms and loud microphones have insisted that there is a biological or genetic truth about race, despite all of the sound evidence to the contrary.¹⁰⁸

If there was a genetic or biological essence to race, it would go a long way towards explaining racial disparities in maternal mortality—and racial disparities in health, more generally. The racial disparities in health outcomes in the country that are so familiar to public health scholars would not be attributable to the United States’ two-tiered healthcare system, which provides superior care to the haves and inferior care to the have-nots.¹⁰⁹ Neither could they be attributed to different, substandard treatment that healthcare providers may, intentionally or unintentionally, give their black patients. Neither could they be attributed to the disadvantage that black people have inherited—disadvantage that may have biological consequences.¹¹⁰ Neither

¹⁰⁵ *Id.* (“Researchers who have . . . looked at people at the genetic level now say that the whole category of race is misconceived.”).

¹⁰⁶ Osagie K. Obasogie, *The Return of Biological Race? Regulating Race and Genetics Through Administrative Agency Race Impact Assessments*, 22 S. CAL. INTERDISC. L.J. 1, 4 (2012) (commenting that “the Holocaust exposed the horrors that ideas about biological race can produce”). Obasogie argues that “legal moments . . . [such as] anti-miscegenation laws, immigration laws, and eugenics . . . serve as guideposts for understanding the unholy alliance between law and science in fostering the growth of biological race.” *Id.* at 9.

¹⁰⁷ See, e.g., Neil Risch, Esteban Burchard, Elad Ziv & Hua Tang, *Categorization of Humans in Biomedical Research: Genes, Race and Disease*, 3 GENOME BIOLOGY 1, 4 (2002) (arguing for the continued use of racial and ethnic categories in biomedical and genetic research because of genetic differences between racial classifications).

¹⁰⁸ See, e.g., NICHOLAS WADE, *A TROUBLESOME INHERITANCE: GENES, RACE AND HUMAN HISTORY* (2014) (defending the idea that races are genetically coherent entities); David Reich, *How Genetics is Changing Our Understandings of ‘Race,’* N.Y. TIMES (Mar. 23, 2018), <https://www.nytimes.com/2018/03/23/opinion/sunday/genetics-race.html> (“[A]s a geneticist I also know that it is simply no longer possible to ignore average genetic differences among ‘races.’”).

¹⁰⁹ See, e.g., KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* 24, 26–30 (2011) [hereinafter BRIDGES, *REPRODUCING RACE*] (discussing the United States’ two-tiered healthcare system and the inferior care offered to those on the lower tier).

¹¹⁰ See Jones, *supra* note 19 (quoting the head of the maternal and infant health division at the CDC as asserting that racial disparities in maternal mortality and morbidity might be

could they be attributed to the health consequences of the hostile environments that black people constantly navigate. Instead, racial disparities in health would be in the genes. Racial disparities in maternal mortality, specifically, would be explained by a gene or complex of genes that predisposes the black women who possess these genes to poor maternal outcomes.

It bears repeating, time and again, that no credible theory of population genetics can support the idea that black people's genes are responsible for the poor states of health that they disproportionately inhabit. As legal scholar Dorothy Roberts has written, "It is implausible that one race of people evolved to have a genetic predisposition to heart failure, hypertension, infant mortality, diabetes, and asthma. There is no evolutionary theory that can explain why African ancestry would be genetically prone to practically every major common illness."¹¹¹ Nevertheless, the idea of biological race has endured.

The literature on racial disparities in maternal mortality and morbidity is replete with references to the potential genetic underpinnings of the phenomenon.¹¹² Indeed, a survey of this literature suggests that even if an author ultimately rejects the idea that race has a genetic or biological essence, she has to at least gesture to the possibility that black women's genes are killing them.¹¹³ Unfortunately, even the

a function of "the experience of being a black woman in America[] and the intergenerational effects of racism and segregation," and claiming that the social and historical context in which black people live and have lived may "play[] out through biology"). Legal scholar Dorothy Roberts describes this idea quite clearly when she explains that race is not a biological category that has had political and social consequences. Rather, it is a social, fundamentally political category that has had biological consequences. *Dorothy Roberts: What's Race Got to Do with Medicine?*, NPR: TED RADIO HOUR (Feb. 10, 2017), <https://www.npr.org/transcripts/514150399>.

¹¹¹ Dorothy E. Roberts, *What's Wrong with Race-Based Medicine?: Genes, Drugs, and Health Disparities*, 12 MINN. J.L. SCI. & TECH. 1, 15 (2011).

¹¹² See, e.g., Goffman et al., *supra* note 103, at 600 (refusing to dismiss biological notions of race, and stating that, whether race is understood in social or biological terms, it remains "a substantial risk factor for adverse maternal outcome"); Howell, *Reducing Disparities*, *supra* note 45, at 388 (stating that racial disparities in maternal morbidity and mortality "are complex and are the result of numerous factors including social, environmental, biological, genetic, behavioral, as well as healthcare factors" (emphasis added)).

¹¹³ Kevin Fiscella, *Racial Disparity in Infant and Maternal Mortality: Confluence of Infection and Microvascular Dysfunction*, 8 MATERNAL & CHILD HEALTH J. 45, 45 (2004) ("Exposure to lifelong stress, high rates of poverty and discrimination, unstable partner relationships, pregnancy wantedness, and urogenital tract infections, coupled with inadequate prenatal care and possibly genetic factors probably contribute to racial disparities in infant and maternal mortality." (emphasis added) (citations omitted)). Even articles that appear to evidence the authors' commitment to investigating the social factors that are responsible for racial disparities in health inevitably nod to the possibility that genes explain these disparities. See Moaddab et al., *supra* note 40, at 711 (theorizing that based on the available data, racial disparities in maternal mortality can be explained in terms of "social rather than medical or geographic factors" and asserting that "[e]xcellent

American College of Obstetricians and Gynecologists has failed to clearly and definitively reject the idea that race has a biological or genetic essence.¹¹⁴

That said, there are also clear rejections of biological race in the literature on racial disparities in maternal health.¹¹⁵ For example, one study begins with the authors' clear articulation of their position that biological race is a myth and their commitment to investigating racial disparities in maternal mortality as a product of the way that we have organized society—and not a product of the unhealthy genes that black people possess. They write:

Categories of race and ethnicity do not represent differences in individual behaviors or biology, but rather acknowledge historic inequities implicated in health outcomes. For the purposes of this article,

care is apparently available, but is not reaching all the people," but also stating that "[e]thnic genetic differences may also be involved").

¹¹⁴ The American College of Obstetricians and Gynecologists convened a committee to issue a statement about racial disparities in gynecological and obstetrical outcomes. Unfortunately, the statement generated offers a rather confused take on the nature of race. See AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, COMM. OPINION NO. 649: RACIAL AND ETHNIC DISPARITIES IN OBSTETRICS AND GYNECOLOGY, at 1 (Dec. 2015). The opinion begins by stating, quite clearly, that "[r]ace and ethnicity represent social rather than biological constructs . . ." *Id.* at 3. However, it goes on to say that some genes may be more prevalent in some racial groups and that these genes may be responsible for some of the racial health disparities that we observe. *Id.* ("Genetic polymorphisms associated with increased susceptibility to disease also may vary in frequency in different racial and ethnic groups." (citation omitted)). Thus, the committee statement leaves us with the contradictory proposition that race is not a genetic entity, but genetic variations may explain racial disparities in health. See *id.* ("[A]lthough race and ethnicity are primarily social constructs, the effect of common ancestral lineage on the segregation and frequency of genetic variations . . . cannot be ignored and should be considered a potential contributor to health disparities."). The statement also highlights the possibility that environments may interact with genes to produce negative effects. Thus, even if the genetic variations that increase susceptibility to disease are equally prevalent in white and nonwhite people, nonwhite people will have higher rates of disease if they more frequently are exposed to harmful environments. See *id.* ("Genetic variations, even those that do not vary in frequency among racial or ethnic groups, may enhance susceptibility to an environmental exposure that occurs more frequently in a particular racial or ethnic group."). Thus, while partly disavowing that race has a genetic essence, the committee ultimately seems to suggest that further research into the role of genetics in racial disparities in obstetric and gynecologic outcomes is warranted. See *id.*

¹¹⁵ See, e.g., Allison S. Bryant, Ayaba Worjolah, Aaron B. Caughey & A. Eugene Washington, *Racial/Ethnic Disparities in Obstetrical Outcomes and Care: Prevalence and Determinants*, 202 AM. J. OBSTETRICS & GYNECOLOGY 335 (2010) (arguing for "the need to look beyond a genetic explanation for disparities in obstetrics" and discussing a CDC report that showed that "foreign-born women had better birth outcomes than their U.S.-born racial/ethnic counterparts despite later initiation of prenatal care and less education"—results that are inconsistent with a genetic basis for racial disparities in maternal health and that suggest that the social context in which nonwhite people live poses the greatest risk to their health (citation omitted)).

we assume race and ethnicity to be social constructs closely related to the social determinants of health, rather than biological or genetic categories, as well as constructs that may intersect with health care utilization, social determinants, and medical risk to generate observable differences in maternal health outcome.¹¹⁶

These rejections of biological race intentionally seek to draw attention away from the distraction of a fantasied gene that makes pregnancy and childbirth dangerous to black women and bring the focus back to the social context in which black women are tragically, and avoidably, dying along the path to motherhood.

Those committed to eliminating racial disparities in maternal mortality believe that it is essential to retire the myth of biological race, as it gives society an excuse not to address a tragedy of its own making. Biological race allows society to throw up its hands at the problem of racial disparities in maternal mortality and claim that, as a phenomenon originating in individuals' genes, there is nothing we can do about it.

b. Less Problematic, and More Probable, Explanations of Racial Disparities in Maternal Mortality

There are three possible explanations for racial disparities of maternal mortality that are more likely. The first relates to the disproportionate burden of poverty that black people bear and their consequent decreased ability to access healthcare. The second relates to the race-based stress that black people experience and the effect of this stress on their body systems. The third relates to the inferior quality of the care that black people receive.

i. Poverty and Access

It is undeniable that the disproportionate indigence in which black people live explains some portion of racial disparities in maternal mortality—and racial disparities in health, more generally. However, it bears repeating that class cannot entirely explain racial disparities in maternal mortality.¹¹⁷ This is because racial disparities in

¹¹⁶ Alexis Gadson, Eloho Akpovi & Pooja K. Mehta, *Exploring the Social Determinants of Racial/Ethnic Disparities in Prenatal Care Utilization and Maternal Outcome*, 41 SEMINARS PERINATOLOGY 308, 308–09 (2017) (citations omitted).

¹¹⁷ Although class cannot entirely explain racial disparities in health, there are plenty of studies that insist that class is the sole cause of the phenomenon. *See, e.g.*, Moaddab et al., *supra* note 40, at 711 (“We conclude that the increased mortality ratios seen in the United States in recent years . . . are closely related to lack of access to health care in the non-Hispanic black population.”).

maternal mortality persist across income levels.¹¹⁸ Middle and upper middle class black women die from pregnancy-related causes at rates that are higher than middle and upper middle class white women.¹¹⁹ Thus, racial disparities in maternal health cannot and should not be understood as a problem primarily of socioeconomic status. Race matters.

That said, the higher rates of poverty in which black people live relative to their white counterparts likely contributes to the oft-cited statistic describing black women as being three to four times more likely than white women to die from a pregnancy-related cause. This is because it is well-established that poverty has a deleterious effect on health.¹²⁰ People who are poor oftentimes live in unhealthy environments, where they are exposed to pollutants and toxins that are known to compromise health.¹²¹ Poor people frequently are unable to afford healthy foods, leaving as their only dietary options the high-sodium, high-fat, high-sugar, low-nutritional-value foods that are inexpensive and readily available in poor neighborhoods.¹²² Poor people may find healthcare inaccessible—disallowing them from either taking preventative measures to protect their health or from monitoring the medical conditions that they may have already developed.¹²³ To be poor is to be exposed to constant stress, which might have an independent negative effect on health, as discussed below.¹²⁴ Because people

¹¹⁸ See Neel Shah, *A Soaring Maternal Mortality Rate: What Does It Mean for You?*, HARV. HEALTH PUB.: HARV. HEALTH BLOG (Oct. 16, 2018, 11:15 AM), <https://www.health.harvard.edu/blog/a-soaring-maternal-mortality-rate-what-does-it-mean-for-you-2018101614914> (“[T]he risk [of dying during childbirth] is consistently three to four times higher for black women than white women, irrespective of income or education.”).

¹¹⁹ Nina Martin & Renee Montagne, *Nothing Protects Black Women from Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017) <https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth> (“[E]ven relatively well-off black women . . . die or nearly die at higher rates than whites.”).

¹²⁰ SHELLEY PHIPPS, CANADIAN POPULATION HEALTH INITIATIVE, *THE IMPACT OF POVERTY ON HEALTH: A SCAN OF RESEARCH LITERATURE* 13 (2003) (“[T]here is little doubt that poverty leads to ill health.”).

¹²¹ See, e.g., Cheryl Katz, *People in Poor Neighborhoods Breathe More Hazardous Particles*, SCI. AM. (Nov. 1, 2012), <https://www.scientificamerican.com/article/people-poor-neighborhoods-breathe-more-hazardous-particles> (describing a study that shows that tiny particles of air pollution have more hazardous materials in non-white and low-income communities than in affluent white communities).

¹²² See generally Angela Hilmers, David C. Hilmers & Jayna Dave, *Neighborhood Disparities in Access to Healthy Foods and Their Effects on Environmental Justice*, 102 AM. J. PUB. HEALTH 1644, 1644 (2012) (describing how a survey of fast-food locations identified that low-income neighborhoods had much greater access than high-income neighborhoods to unhealthy fast-food outlets).

¹²³ See PHIPPS, *supra* note 120, at 16 (noting that individuals with very low incomes have very limited access to health, thus restricting their ability to improve their wellbeing).

¹²⁴ See discussion *infra* Section I.B.1.b.ii and accompanying text.

of color, specifically black people, disproportionately bear the burdens of poverty in the United States, greater proportions of them have the poor health that is the known and expected consequence of poverty. Accordingly, greater proportions of people of color enter pregnancy with poverty-related chronic conditions—like diabetes, hypertension, and obesity.¹²⁵ These chronic conditions, especially when unmanaged, increase the likelihood that those who have them will suffer poor pregnancy outcomes.¹²⁶ This likely plays some role in generating racial disparities in maternal mortality.

Further, even when they are insured, poor pregnant women may find healthcare unreachable. This occurs when there are no healthcare providers close to the neighborhoods that poor people call home. It also occurs when the providers that are physically proximate to poor neighborhoods refuse to accept the Medicaid insurance on which poor people rely. This has been the case in Washington, D.C., parts of which have the highest maternal mortality ratios in the nation.¹²⁷ The obstetrics units of two hospitals that serve poor communities in D.C. had closed by 2018, and the obstetrics unit of a third limited the number of Medicaid patients that it sees.¹²⁸ Fiscal reasons prompted the ward closures—the obstetrics units were running in the red.¹²⁹ Medicaid reimbursed the hospitals at rates well under the costs that the hospitals incurred by providing services.¹³⁰ In fact, Medicaid reimbursement rates were a full third of private insurers' rates.¹³¹ Thus, the

¹²⁵ See AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 6 (“Insufficient access to quality health care services over a woman’s lifetime means that women are entering into pregnancy with health conditions that are untreated or unmanaged.”).

¹²⁶ *Id.* (noting that when women enter pregnancy with an unmanaged chronic condition, it “poses added risks for both the woman and her child” and offering as an example that women with “uncontrolled diabetes are more likely to have a miscarriage or develop pre-eclampsia” (citation omitted)); see also Amy Metcalfe, James Wick & Paul Ronksley, *Racial Disparities in Comorbidity and Severe Maternal Morbidity/Mortality in the United States: An Analysis of Temporal Trends*, 97 ACTA OBSTETRIA ET GYNECOLOGICA SCANDINAVICA 89, 93 (2018) (“[M]any women who died during their pregnancies, or shortly thereafter, had poorly managed chronic conditions prior to pregnancy.”).

¹²⁷ ROBYN RUSSELL, CAROLYN RODEHAU & PATRICIA QUINN, D.C. PRIMARY CARE ASS'N, HUMAN-CENTERED SOLUTIONS TO IMPROVE REPRODUCTIVE AND MATERNAL HEALTH OUTCOMES IN WASHINGTON, D.C. 2 (2018), <http://www.dcpca.org/includes/storage/brio/files/204/The%20D.C.%20Womens%20Health%20Improvement%20Project.%209.12.18.pdf>.

¹²⁸ Tara Wilson, *Medicaid Approaches to Addressing Maternal Mortality in the District of Columbia*, 20 GEO. J. GENDER & L. 215, 223 (2018).

¹²⁹ See *id.* at 229.

¹³⁰ See *id.*

¹³¹ See *id.* at 230 (explaining that in D.C., the Medicaid “reimbursement rate for vaginal deliveries is \$1,943.54 and \$2,156.67 for cesarean deliveries” while the “cost to private insurers for childbirth in DC in 2016 and 2017 is \$6,388 for vaginal delivery and \$7,439 for cesarean deliveries”).

hospitals that served poor, Medicaid-insured patients—who, because of the poverty-induced poor health, are more *expensive* to treat than more affluent, privately-insured patients—were left with a shortfall. It was in these hospitals' fiscal interest to shutter their obstetrics wards or reduce the number of pregnant Medicaid patients in their care.¹³² This, in turn, leaves poor pregnant women in D.C., who are disproportionately black, “at risk for not receiving the care [that is] associated with healthy pregnancies.”¹³³ The relationship between Medicaid reimbursement rates, the closures of obstetrics units, access to prenatal care, and racial disparities in maternal mortality and morbidity should be apparent.

ii. Stress and Weathering

In the early 1990s, public health researcher Arline Geronimus began investigating why black women who gave birth at younger ages had better health outcomes than their white counterparts; meanwhile, black women who gave birth at older ages had worse outcomes than their white counterparts.¹³⁴ In essence, the puzzle was why older age was health protective for white women, but not for black women. Geronimus concluded that stress explained the puzzle, writing that “the health of African-American women may begin to deteriorate in early adulthood as a physical consequence” of chronic stress.¹³⁵ Although many scholars panned Geronimus's research when she first published it,¹³⁶ her ideas have gained traction over the years, and scholars have looked to them to explain racial disparities in health, generally.¹³⁷

¹³² See *id.* at 229.

¹³³ *Id.* at 223.

¹³⁴ See Arline T. Geronimus, *The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations*, 2 *ETHNICITY & DISEASE* 207 (1992).

¹³⁵ *Id.* at 207.

¹³⁶ See Gene Demby, *Making the Case that Discrimination Is Bad for Your Health*, NPR: CODE SWITCH (Jan. 14, 2018, 7:00 AM), <https://www.npr.org/sections/codeswitch/2018/01/14/577664626/making-the-case-that-discrimination-is-bad-for-your-health>.

¹³⁷ See Patia Braithwaite, *Biological Weathering and Its Deadly Effect on Black Mothers*, SELF (Sept. 30, 2019), <https://www.self.com/story/weathering-and-its-deadly-effect-on-black-mothers/amp> (citing Geronimus's research in an article about racial disparities in maternal mortality that was written for lay audiences and published in a mainstream magazine); Amy Roeder, *America Is Failing Its Black Mothers*, HARV. PUB. HEALTH MAG. (2019), https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers (stating that “Geronimus' ideas have become mainstream in the field” of public health). See generally Arline T. Geronimus, Margaret Hicken, Danya Keene & John Bound, “Weathering” and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States, 96 *AM. J. PUB. HEALTH* 826 (2006).

The idea is that chronic stress—measured in terms of “allostatic load”—increases the speed at which body systems deteriorate.¹³⁸ The physiologic responses to persistent stress may result in the “weathering” of body systems, making them age more rapidly.¹³⁹ One study on “chromosomal markers of aging indicate that black women ages 49-55 appear on average 7.5 ‘biological’ years older than white women.”¹⁴⁰ Other studies propose that chronic stress can impact the adrenal system, resulting in “obesity, hypertension, and diabetes.”¹⁴¹ If racism is a source of chronic stress for black people, and if chronic stress has negative physiological impacts, then racism could explain the higher rates of morbidity and mortality among black women. Indeed, weathering would explain why black women who report encountering race-based stresses are more likely to give birth to preterm infants or infants with lower birth weights than black women who do not report encountering these stresses.¹⁴²

That said, the research on weathering and its effect on health is in its early stages. Accordingly, we will have to stay tuned to see if the research will be funded and, if so, whether investigators can determine the precise mechanisms by which racism-qua-chronic stress impacts health.¹⁴³

¹³⁸ See generally Bruce S. McEwen & Teresa Seeman, *Protective and Damaging Effects of Mediators of Stress: Elaborating and Testing the Concepts of Allostasis and Allostatic Load*, 896 ANNALS N.Y. ACAD. SCI. 30 (1999).

¹³⁹ See Geronimus et al., *supra* note 137, at 826.

¹⁴⁰ YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 34; see also Nina Martin & Renee Montagne, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 7, 2017, 7:51 PM), <https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why> (quoting Michael Lu, former head of the Maternal and Child Health Bureau of the Health Resources and Services Administration, who explains that “[a]s women get older, birth outcomes get worse. . . . If that happens in the [ir] 40s for white women, it actually starts to happen for African-American women in their 30s”).

¹⁴¹ YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 34.

¹⁴² See *id.* at 10 (“Self-reported experiences of racism over the lifecourse and prenatal maternal stress have been linked to adverse birth outcomes such as declines in birth weight, increases in low birth weight, and higher rates of preterm delivery.”). As one set of researchers explains, “[t]he search for a biological explanation [of how] . . . stress might affect preterm birth risk has led to an extensive literature It remains likely . . . that neuroendocrine pathways underlie the relationship between acute and chronic stressors on preterm birth and low birth weight risk.” Bryant et al., *supra* note 115, at 337–38.

¹⁴³ See Gadson et al., *supra* note 116, at 310 (noting that “[w]hile some have posited the potential role that stress and racism may play in endothelial damage and therefore in maternal morbidity and mortality . . . , there are no studies to our knowledge that clearly operationalize the mechanism by which stress may affect . . . adverse maternal outcomes”).

iii. Quality of Care

As stated in a recent report about the racial inequities that dot the reproductive landscape, “[d]isparities in quality of care for racial minorities in the U.S. have long been documented.”¹⁴⁴ Researchers are beginning to investigate how these long-documented disparities in quality of care may relate to racial disparities in health, and, more specifically, racial disparities in maternal mortality. Indeed, studies show that while thirty-three percent of pregnancy-related deaths of white women are deemed preventable, forty-six of pregnancy-related deaths of black women are deemed the same.¹⁴⁵ Investigators have concluded that more black women die preventable deaths than white women because black women are receiving inferior care.¹⁴⁶

c. Individual Level

Healthcare providers may be giving their black patients inferior care,¹⁴⁷ which may ultimately endanger their patients’ lives. In 2005, the Institute of Medicine (IOM)¹⁴⁸ released a report finding that people of color receive lower-quality health care than white people even when one controls for insurance status, income, age, and severity

¹⁴⁴ REPRODUCTIVE INJUSTICE, *supra* note 34, at 13. The report goes on to explain that “[a]ccording to the 2013 National Healthcare Disparities Report, African Americans and Latinos received worse care on 40% of measures compared to Whites . . .” *Id.*

¹⁴⁵ AMNESTY INT’L, DEADLY DELIVERY, *supra* note 71, at 20.

¹⁴⁶ *See id.* (citing a study that found a lack of quality care was a factor in more than half of preventable maternal deaths).

¹⁴⁷ Relatedly, low-income women have reported being treated differently because they are poor or are “on Medicaid.” *See* YALE GLOB. HEALTH JUSTICE P’SHIP, *supra* note 40, at 11 (observing that “some women report being treated with disdain by health workers who know, or assume, that they are uninsured or on Medicaid”). Importantly, class-privileged black women have reported that their incomes and educational attainments have not guaranteed them positive interactions with OB/GYNs and other healthcare providers. When Pamela Merritt, who has been active in the fight to eliminate racial disparities in maternal mortality, was diagnosed with uterine fibroids and endometriosis, she had a disturbingly negative interaction with an OB/GYN who came at the recommendation of her work colleagues: “‘There I sat with my perfect English, wearing my expensive suits and my expensive handbag, and I walked into that office and got treated like shit,’ Merritt says.” Jones, *supra* note 19. Merritt recalls being told she “‘needed to have a baby as soon as possible, because ‘most of you have had kids by now.’ I was spoken to like a piece of meat by specialists who never once asked me if I was in pain.” *Id.* When Merritt shared her story with her black female friends, she found her experience was not uncommon: “So many of them had experiences like mine and worse. And we were all what you would consider upper middle class.” *Id.*

¹⁴⁸ The Institute of Medicine has since been renamed the Health and Medicine Division. *See About the Health and Medicine Division*, NAT’L ACAD., <https://www.nationalacademies.org/hmd/about> (last visited June 19, 2020).

of conditions.¹⁴⁹ By “lower quality health care,” the IOM meant the materially inferior care that physicians give their nonwhite patients. The IOM reported that racial minorities are less likely than white people to be given appropriate cardiac care, to receive kidney dialysis or transplants, and to receive the best treatments for stroke, cancer, or AIDS.¹⁵⁰ The IOM concluded by describing an “uncomfortable reality”: “[S]ome people in the United States [are] more likely to die from cancer, heart disease, and diabetes simply because of their race or ethnicity, not just because they lack access to health care.”¹⁵¹

The theory here is not that a substantial number of healthcare providers are bigots—people who consciously feel animus or antipathy for people of color and who act on these negative feelings by intentionally giving their patients of color inferior care. Instead, most scholars posit that differences in treatment can be attributed to providers’ implicit biases—subconscious aversions or negative associations of which an individual may not be aware, but that impact the individual’s behavior nonetheless.¹⁵² The idea is that if a provider has an anti-black or pro-white implicit bias, she may unintentionally provide inferior care to her black patients and superior care to her white patients—for example, prescribing appropriate medication to her white patient with elevated blood pressure while failing to do the same for a black patient.¹⁵³ In this way, providers’ implicit biases may

¹⁴⁹ See INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 5 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003).

¹⁵⁰ See *id.* at 30, 52, 57, 61.

¹⁵¹ INST. OF MED., *ADDRESSING RACIAL AND ETHNIC HEALTH CARE DISPARITIES: WHERE DO WE GO FROM HERE?* 3 (2005), http://cretscmhd.psych.ucla.edu/healthfair/PDF%20articles%20for%20fact%20sheet%20linking/Addressing_health_disparities.pdf.

¹⁵² See *Understanding Implicit Bias*, KIRWAN INST., <http://kirwaninstitute.osu.edu/research/understanding-implicit-bias> (last visited June 19, 2020).

¹⁵³ Studies have shown that there are racial disparities in gynecological and obstetric treatment that extend beyond matters of life and death. For example, Asian women are more likely to be given episiotomies, although they are not more likely to have characteristics that make episiotomies medically indicated. See Grobman et al., *supra* note 102, at 1466 (“[T]he frequency of receiving an episiotomy was significantly higher for Asian women. The reasons for this increased utilization are not clear, because other patient characteristics, such as BMI and parity, did not account for this difference.”). Further, studies document that nonwhite women are screened for sexually transmitted infections more often than white women. See Ngozi F. Anachebe & Madeline Y. Sutton, *Racial Disparities in Reproductive Health Outcomes*, 188 AM. J. OBSTETRICS & GYNECOLOGY S37, S41 (2003) (discussing research that showed pediatric providers in one southeastern U.S. county routinely failing to screen their “predominately white, privately insured . . . sexually active adolescent[]” patients for chlamydia “because they did not believe their patients to be at high risk and they associated high risk for chlamydial infection with low-income minorities”); see also AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, COMM. OPINION No. 649, *supra* note 114, at 3 (“[S]ocial and demographic biases have been shown to affect practitioners’ recommendations for long-

contribute to racial disparities in maternal mortality and morbidity, and racial disparities in health, generally.¹⁵⁴ Many scholars, activists, observers, and even providers have argued that some important part of racial disparities in maternal deaths may be attributed to providers' implicit bias.¹⁵⁵ Indeed, one of the four initiatives that comprise New York City's thirteen million dollar effort to address the high rates of pregnancy-related deaths among women of color in the city involves "[e]ngaging relevant private and public health care providers across the City in adopting implicit bias training"¹⁵⁶

Notably, scholars have observed that if the care that black patients are offered is inferior, they will sense it.¹⁵⁷ They may feel that their doctors are dismissing their concerns, are treating them rudely, or are simply giving them care that is different from what they imagine more privileged patients are receiving. This, in turn, may

acting reversible contraceptive methods to women at risk of unintended pregnancies. It is unclear whether these biases also affect practitioners' recommendations for cesarean delivery or referrals for infertility." (footnote omitted)).

¹⁵⁴ See generally DAYNA BOWEN MATTHEW, *JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE* 33–54 (2015). For a discussion of the limitations of the literature around implicit biases, see KHIARA M. BRIDGES, *CRITICAL RACE THEORY: A PRIMER* 157–80 (2019) [hereinafter BRIDGES, *CRITICAL RACE THEORY*].

¹⁵⁵ See, e.g., Anachebe & Sutton, *supra* note 153, at S41 (asserting that “preformed biases and stereotypes explain a large part of the racial health disparities in this country”); AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, *COMM. OPINION NO. 649*, *supra* note 114, at 3 (“Evidence suggests that factors such as stereotyping and implicit bias on the part of health care providers may contribute to racial and ethnic disparities in health.”); Jones, *supra* note 19 (quoting the Chief of the Maternal and Infant Health Branch in the Division of Reproductive Health at the Centers for Disease Control and Prevention, who offers that “[t]here’s all kinds of implicit bias, racial and unconscious bias” that impacts how providers judge the things that their patients of color say to them); Press Office, *De Blasio Administration Launches Comprehensive Plan to Reduce Maternal Deaths and Life-Threatening Complications from Childbirth Among Women of Color*, N.Y.C. (July 20, 2018), <https://www1.nyc.gov/office-of-the-mayor/news/365-18/de-blasio-administration-launches-comprehensive-plan-reduce-maternal-deaths-life-threatening> (quoting Chanel L. Porchia-Albert, the founder of a Brooklyn-based organization that provides antiracist doula services to women of color, as stating that “[w]e must collectively strive to shift the narrative of birthing in NYC to one that addresses implicit bias and racism within maternal health”); *id.* (quoting Nicole Jean-Baptiste, a doula based in the Bronx who provides pregnancy and birth support to women of color, as saying that “the application of implicit bias and anti-racist trainings within maternal healthcare institutions must be at the core” of New York City’s plan to reduce racial disparities in maternal mortality and morbidity).

¹⁵⁶ Press Office, *De Blasio Administration Launches Comprehensive Plan*, *supra* note 155. The other three initiatives relate to improving the collection and analysis of information about maternal deaths, improving the quality of care provided in the city’s public hospitals, and expanding education about maternal mortality and preventative healthcare among the communities most impacted. See *id.*

¹⁵⁷ Gadson et al., *supra* note 116, at 310 (describing a study in which participants reported communication issues during prenatal care and “Black or Hispanic race/ethnicity was associated with almost three times higher odds of discrimination due to race, language, or culture”).

cause patients not to heed their providers' advice and direction—or to avoid going to the doctor altogether.¹⁵⁸ This, of course, may contribute to racial disparities in maternal mortality.¹⁵⁹

d. Systems Level

Recent research suggests that the inferior quality of the hospitals in which black women deliver their babies may partly explain racial disparities in maternal mortality and morbidity. Remarkably, seventy-five percent of black women in the country deliver their babies in just twenty-five percent of the nation's hospitals.¹⁶⁰ This means that there are hospitals that serve an exceedingly low number of black women, and there are hospitals that serve an exceedingly high number of black women.¹⁶¹ The MMR in hospitals that serve large numbers of black women tends to be much higher than the MMR in hospitals that serve small numbers of black women.¹⁶² Indeed, while the MMR in “high black-serving hospitals” tends to be tragic, the MMR in “low black-serving hospitals” tends to be enviable.¹⁶³ Notably, “high black-serving hospitals” provide inferior care to all those who enter: Even white women who find themselves receiving care in “high black-serving hospitals” are more likely to suffer an adverse outcome than if they had received their care in a “low black-serving hospital.”¹⁶⁴

¹⁵⁸ See YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 9 (stating that black women may “intentionally decide not to seek [pregnancy services] given histories of negative interactions and discrimination within formal healthcare systems”); Gadson et al., *supra* note 116, at 312 (discussing a study of 872 black women in which “delayed initiation of prenatal care was associated with endorsement of experiences of racism affecting family and community”).

¹⁵⁹ See Gadson et al., *supra* note 116, at 312 (observing that “distrust of the health care system . . . may be an important additional mediator in the relationship between utilization and outcomes for those at risk of disparities”).

¹⁶⁰ See Howell, *Reducing Disparities*, *supra* note 45, at 391 (noting that “75% of black deliveries in the United States occurred in a quarter of hospitals, whereas only 18% of whites delivered in those same hospitals”).

¹⁶¹ As one might expect, the hospitals that serve high numbers of black women tend to serve low numbers of white women. Less than two percent of births to white women take place in these “high black-serving hospitals.” See Elizabeth A. Howell, Natalia Egorova, Amy Balbierz, Jennifer Zeitlin & Paul L. Herbert, *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OBSTETRICS & GYNECOLOGY 122.e1, 122.e3 (2016) [hereinafter Howell et al., *Black-White Differences*] (noting that 1.8% of white deliveries took place in hospitals that serve a high number of black women).

¹⁶² *Id.* (“Women who delivered in high and medium black-serving hospitals had higher severe maternal morbidity rates than those in low black-serving hospitals.”).

¹⁶³ See *id.* at 122.e5 (“[W]hite patients at low black-serving hospitals had the lowest rates of adjusted severe maternal morbidity (12.3 per 1000 deliveries), and black patients at high black-serving hospitals had the highest rates (20.5 per 1000 deliveries).”).

¹⁶⁴ See *id.* (“We found that both black and white patients who delivered in black-serving hospitals had a higher risk of severe maternal morbidity after accounting for patient characteristics.”). Unsurprisingly, the poor quality of care found in the obstetric wards at

Nevertheless, black women, who predominate in these “high black-serving hospitals,” bear the brunt of the substandard care that they provide. One researcher writes that “[i]f black . . . mothers delivered in the same hospitals as white women, our simulation model estimated that they would experience 940 fewer severe morbid events, leading to a reduction of black severe maternal morbidity rates by 47.7%”¹⁶⁵ If true, a likely effective avenue to reducing or eliminating racial disparities in maternal mortality is to improve the quality of the care offered at the (functionally segregated) hospitals where black women find themselves giving birth in large numbers.¹⁶⁶

What the above demonstrates is that there is no quick fix to the problem of racial disparities in maternal mortality. It is not a matter of ridding hospital wards of bigoted nurses or doctors. It is certainly not a matter of finding the elusive race-specific gene that predisposes black women to injury and death. The problem is complex—as is the solution. The answer to the challenge of racial disparities in maternal mortality likely begins well before the doctor-patient encounter—well before the pregnancy.¹⁶⁷ It involves redistributing wealth, elevating black people out of the poverty that they disproportionately bear. It involves eliminating residential segregation, enabling black people to move out of the neighborhoods that possess characteristics that compromise their residents’ health—like violence, environmental hazards, underfunded and overburdened schools, food deserts, and a dearth of jobs that pay a livable wage. It involves reorganizing society such that it becomes unusual and surprising for individuals, both white and black, to develop anti-black and pro-white implicit biases. It involves reconstructing our country such that hostility is not a banality for black people—such that chronic stress does not “weather” their body systems. It, of course, involves improving the quality of care that preg-

high black-serving hospitals can be found in other departments throughout the hospital. *See id.* at 122.e6 (“[D]isparities in receipt of appropriate care such as thrombotic therapy, angioplasty, carotid imaging, and provision of timely antibiotics for pneumonia are lower in hospitals that serve a high proportion of black women.”).

¹⁶⁵ Elizabeth A. Howell, Natalia Egorova, Amy Balbierz, Jennifer Zeitlin & Paul L. Herbert, *Site of Delivery Contribution to Black-White Severe Maternal Morbidity Disparity*, 215 AM. J. OBSTETRICS & GYNECOLOGY 143, 146 (2016).

¹⁶⁶ *See* Howell et al., *Black-White Differences*, *supra* note 161, at 122.e5 (concluding that “quality of care at hospitals that disproportionately serve black women is lower than quality at low black-serving hospitals”).

¹⁶⁷ *See* Elizabeth A. Howell & Jennifer Zeitlin, *Improving Hospital Quality to Reduce Disparities in Severe Maternal Morbidity and Mortality*, 41 SEMINARS PERINATOLOGY 266, 267 (2017) (noting there is a limited ability to intervene during the clinical encounter in the social factors that compromise the health of people of color—like “[p]overty, lack of education, poor nutritional status, smoking, and . . . [l]iving in an area of higher crime”).

nant black women receive in providers' offices and hospital delivery rooms.

Congress recently waded into the complexity that is the issue of racial disparities in maternal health with the passage of the Preventing Maternal Deaths Act. The Act is intended to address the United States' high MMR by funding state maternal mortality review commissions—bodies of experts that examine each maternal death in the state, seeking to understand why the death occurred and identifying specific interventions that might prevent similar deaths in the future.

Before exploring the Act and its shortcomings, however, the next Part critiques the current discourse surrounding racial disparities in maternal mortality. As the next Part argues, the conversation that is taking place around the issue of maternal deaths in the United States is problematic in many respects. Importantly, the inadequacies of the discourse surrounding the issue have come to inform the solutions that have been proposed. Accordingly, if the Preventing Maternal Deaths Act is a deficient tool with which to address the relatively poor state of maternal health in the United States, then this is partly due to the deficiencies in the prevailing discourse about maternal health in the United States. The next Part outlines those deficiencies.

II

CRITIQUES OF THE GENERAL DISCOURSE AROUND MATERNAL MORTALITY IN THE UNITED STATES

This Part identifies three problems in the conversation that the nation is currently having about maternal deaths. First, there is a latent racism underlying the oft heard assertion that maternal mortality “shouldn't be happening here.” Second, many of the proposals that have been offered to address racial disparities in maternal mortality raise the possibility that black women will be subjected to increased surveillance and regulation. And third, given the tendency of the United States to ignore the structural causes of problems in favor of blaming individual bad actors, there is a risk that racial disparities in maternal mortality will be conceptualized as a problem of black women failing to take care of themselves.

A. *A Critique of the Claim that Maternal Deaths Should Not Be Happening “Here”*

Ninety-nine percent of pregnancy-related deaths occur in the developing world.¹⁶⁸ This means that of the 295,000 women who died of pregnancy-related causes in 2017, the last year for which worldwide figures were calculated, 292,050 of them lived in a resource-poor country.¹⁶⁹ This makes for startling statistics, as when one report asserts, “If you are a woman in a wealthy country, your chance of dying during pregnancy is about 1 in 7,000. In Niger, it’s 1 in 7.”¹⁷⁰

Africa, particularly sub-Saharan Africa, bears the brunt of maternal mortality. As one scholar describes it:

At 480 deaths per 100,000 live births, the average MMR in Africa dwarfs that of other regions. The rate in the next underperforming region (East Mediterranean) is nearly one-half of Africa’s. . . . The lifetime risk of maternal death in Africa is astronomical, one in sixteen, compared to one in 2800 in affluent countries.¹⁷¹

Eighty-six percent of all maternal deaths occur in Africa and Southern Asia.¹⁷² The maternal deaths that occur in developing nations in other continents brings the percentage one point shy of perfect: Again, ninety-nine percent of the women who die of pregnancy-related causes live in the developing world.¹⁷³

While the developing world has been described as having “catastrophically high rates” of maternal mortality, the developed world—of which the United States counts itself a member—is usually described as having a “low rate.”¹⁷⁴

It is important to recognize that the concept of the “developed” world is racialized, as is the concept of the “developing” world.¹⁷⁵

¹⁶⁸ Obiajulu Nnamuchi, *Millennium Development Goal 5, Human Rights, and Maternal Health in Africa: Possibilities, Constraints, and Future Prospects*, 23 ANNALS HEALTH L. 92, 99 (2014).

¹⁶⁹ See *Maternal Mortality: Key Facts*, WORLD HEALTH ORG. (Sept. 19, 2019), <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>.

¹⁷⁰ Katzive, *supra* note 42, at 383.

¹⁷¹ Nnamuchi, *supra* note 168, at 98.

¹⁷² See *id.* at 99.

¹⁷³ See *id.*

¹⁷⁴ Cook & Dickens, *supra* note 37, at 91; see also Sofia Gruskin, Jane Cottingham, Adriane Martin Hilber, Eszter Kismodi, Ornella Lincetto & Mindy Jane Roseman, *Using Human Rights to Improve Maternal and Neonatal Health: History, Connections, and a Proposed Practical Approach*, 86 BULL. WORLD HEALTH ORG. 589, 590 (2008) (describing the chance of a woman in an “industrialized countr[y]” dying from a pregnancy-related cause as “remote, both statistically and historically”).

¹⁷⁵ See generally PAULETTE GOUDGE, *THE WHITENESS OF POWER: RACISM IN THIRD WORLD DEVELOPMENT AND AID* (2003); Christiana Abraham, *Race, Gender, and “Difference”: Representations of “Third World Women” in International Development*, 2 J. CRITICAL RACE INQUIRY 4 (2015).

That is, the idea of “developed” world has acquired racial connotations, as has the idea of the “developing” world. Specifically, while the “developed” world is racialized as white, the “developing world” figures as its nonwhite counterpart.¹⁷⁶ In this way, to refer to the “developed” world is to refer to white nations; meanwhile, to refer to the “developing” world is to refer to nonwhite nations.

Most conceptualize maternal mortality as a problem of the developing world—in large part because the overwhelming majority of maternal deaths takes place in developing countries. As such, the problem of maternal mortality acquires the racialization of the regions where it so frequently takes place. Which is to say: The problem of maternal mortality has been racialized as nonwhite.¹⁷⁷ Accordingly, when commentators in the United States assert that maternal mortality should not be happening “here,”¹⁷⁸ they can be heard to say that an (implicitly) nonwhite phenomenon should not be happening inside of an (implicitly) white nation. Indeed, this may explain why the problem of maternal mortality has come to be thought of as a problem deserving of congressional action: The borders of the United States have been infiltrated by a nonwhite scourge.

Developing countries commonly figure as the Other in the American imaginary.¹⁷⁹ They are poor, while we are wealthy.¹⁸⁰ They are undemocratic, while we are bastions of democracy.¹⁸¹ They have problematic values, ethics, and cultures; meanwhile, our values, ethics, and culture are above reproach.¹⁸² Thus, when a nonwhite problem of the developing world finds its way into the United States, those deficient characteristics that describe the developing world—backwardness, state-mandated patriarchy, failure to be governed by democratic

¹⁷⁶ See GOUDGE, *supra* note 175, at 6 (explaining that “[g]lobal relations generally, and relations within the ambit of development and aid in particular, can be situated within the context of a white/black binary”). This racialization of “developed” and “developing” corresponds to the racialization of “western” and “nonwestern” countries, the “global North” and the “global South” and “industrialized” and “not industrialized” nations.

¹⁷⁷ Indeed, maternal mortality may be racialized as black insofar as most maternal deaths take place in black countries—in sub-Saharan Africa—and are suffered by black women.

¹⁷⁸ See Young, *Hospitals Know How to Protect Mothers*, *supra* note 6 (reporting that an administrator running a training session for hospitals on maternal mortality and morbidity stated, “[w]e’re not talking about a Third World country, we’re talking about us, here” and concluded, “[t]his shouldn’t be happening here”).

¹⁷⁹ See GOUDGE, *supra* note 175, at 6 (explaining that development and aid are “perceived as peripheral to serious issues of real global concern”).

¹⁸⁰ See *id.* (describing the Western “conception that the ‘Third World’ is inferior in every way – economically, socially, culturally, morally –” and that “those countries” need to “get their act together” and “throw out their corrupt governments”).

¹⁸¹ See *id.*

¹⁸² See *id.*

norms, etc.—become associated with “us.” It becomes an “embarrassment.”¹⁸³ And if we act hastily to purge ourselves of the problem, we can rid ourselves of the imputation that the things that happen over “there” are happening “here.” It is through this lens that we can understand California Senator Kamala Harris’s assertion that “[a]ccording to the CDC, Black mothers are 243% more likely to die from pregnancy or delivery complications than a white woman. *This is in America, not a developing nation.*”¹⁸⁴ It is through this lens that we can comprehend the statement made by Representative Jaime Herrera Beutler, the sponsor of the Preventing Maternal Deaths Act: “The numbers [of maternal deaths] are staggering. This is not the developing world. This is the United States of America.”¹⁸⁵ If the United States of America is anything, it is not the developing world. It is not all the things that are associated with those poor, benighted, nonwhite parts of the globe.¹⁸⁶ Consider in this vein an argument that one scholar makes:

The great majority of women who die as a result of pregnancy-related complications have lived lives marked by poverty, deprivation and discrimination. From the moment of their births, these girls and women often face a funnel of narrowing choices whereby they are unable to exercise meaningful agency with respect to what they will do with their lives, how much they will be educated, with whom they will partner, when they will have sex, whether they will use

¹⁸³ Martin et al., *Lost Mothers*, *supra* note 50 (noting that the failure of states and the federal government to do more to combat the high MMR in the country has been called “an international embarrassment”).

¹⁸⁴ Kamala Harris (@KamalaHarris), TWITTER, (Dec. 28, 2017, 9:18 PM) (emphasis added), <http://twitter.com/kamalaharris/status/946565940183027712?lang=en>.

¹⁸⁵ Laura Ungar, *What States Aren’t Doing to Save New Mothers’ Lives*, USA TODAY (Nov. 14, 2019, 2:15 PM), <https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/09/19/maternal-death-rate-state-medical-deadly-deliveries/547050002>.

¹⁸⁶ Sometimes the damning of developing nations, and the veneration of developed nations, occurs more explicitly, as when one scholar attributes the high MMR in Africa to the “kleptocracy” that runs governments, as well as “political cronyism, covetousness, [] self-aggrandizement,” and bald-faced theft committed by public officials. Nnamuchi, *supra* note 168, at 137–38. This scholar explicitly compares the excess and immorality that African government officials exhibit to the noble restraint that officials in the United States exercise and impose on themselves and others. *Id.* at 137 (comparing the “brazen avarice and profligacy” of Nigerian senators making “\$1.7 million in annual salaries and allowances,” while American senators are paid \$174,000 per annum). Nnamuchi elaborates on what accounts for this stark difference, noting that “political elites in Africa tend to think of themselves first, their associates and relatives second, and the people last. In the vast majority of the countries in the region, lavish and ostentatious lifestyles have supplanted the peoples’ business, including health and health care, as the reason for seeking leadership positions.” *Id.* Nnamuchi finds that this “[] irresponsible governance [model] holds sway even as lives of pregnant women are lost daily on account of the deficit of healthcare and social or underlying determinants of health.” *Id.* at 137–38.

contraception, and finally what care they will get when they are pregnant or delivering, even when their lives hang in the balance.¹⁸⁷

This description suggests that maternal mortality is not primarily a consequence of poverty. Instead, maternal mortality is principally a product of sexism and patriarchy. Women in the developing world are dying at terrifying rates from pregnancy-related causes because of the misogyny that runs rampant in the societies in which they live. The argument in this Section is that this is *not* supposed to describe the United States—a country that imagines itself to sit in diametrical opposition to *those places* where women lack basic freedoms, like the ability to attend school and get an education, freely move through public spaces, control when, whether, and with whom they have sex, and choose who they will marry. In essence, what is killing pregnant women and new mothers in the developing world is sex inequality—something that countries in the “West” purport to have ridded themselves of long ago.¹⁸⁸ Accordingly, the sex inequality that is supposed to describe the West’s Others becomes imputed to the United States when maternal deaths proliferate within the country’s borders. The suggestion that the United States is “like” its Others in any significant respect is quite a damning charge.

Further, there is an interesting racial shaming that occurs when the United States’ MMR is compared to the MMRs of countries that are nonwhite and the comparison reveals that those countries are out-performing the United States. Consider a statement made by a set of researchers:

With 99% of maternal deaths occurring in developing countries, it is too often assumed that maternal mortality is not a problem in wealthier countries. Yet, statistics released in September of 2010 by the United Nations place the United States 50th in the world for maternal mortality—with maternal mortality ratios higher than almost all European countries, *as well as several countries in Asia and the Middle East*.¹⁸⁹

When one considers the racialization of maternal mortality, as well as the racialization of the developing/developed world dichotomy, one hears a racial shaming when observers point out that the United States’ MMR is higher than the MMRs of some countries in Asia and

¹⁸⁷ Yamin, *supra* note 42, at 95.

¹⁸⁸ See Emily Hill, *The End of Feminism*, SPECTATOR (Oct. 24, 2015), <https://www.spectator.co.uk/2015/10/the-decline-of-feminism> (“The totemic battles [against sexism] were hard fought — and they were won. The next generation should be encouraged to enjoy the spoils, not worry old wounds.”); Danielle Paquette, *More Than Half of US Men Think Sexism is Over*, WORLD ECON. F. (Aug. 25, 2016), <https://www.weforum.org/agenda/2016/08/more-than-half-of-men-in-the-us-think-sexism-is-over>.

¹⁸⁹ Bingham et al., *supra* note 35, at 189 (emphasis added).

the Middle East: Several *nonwhite* countries are doing a better job at expunging a nonwhite phenomenon from their borders.¹⁹⁰ Meanwhile, the United States—developed, white—sits 50th on the list of nations ranked by their prevalence of a killer of nonwhite women.¹⁹¹

Of course, there is a place for comparisons with other nations. Indeed, there is a compelling claim that international comparisons are essential to racial progress in this country. Professor Derrick Bell has argued that if the Civil Rights Movement achieved gains for black people, it was not simply because powerful white people in the nation found black people's demand for equal treatment and full citizenship morally compelling.¹⁹² Bell's argument is that the Civil Rights Movement was a success—insofar as formal racial equality was achieved—because it was in the country's interest to acknowledge black people's dignity and humanity in light of the Cold War and the threat that Russia posed to the United States' global dominance.¹⁹³

As Bell contends, and historian Mary Dudziak explores more extensively,¹⁹⁴ the United States and the Soviet Union were pitted in a heated battle for influence and power on the world stage after the end of the violent conflict of World War II.¹⁹⁵ During this time, the United States asserted that it was the superior nation—and countries should ally themselves with it—because while privation, communism, and a disturbing lack of freedom characterized the Soviet Union, abundance, democracy, and liberty described the United States.¹⁹⁶ However, the Soviet Union gave the lie to the United States' portrayal of itself by bringing attention to the reality that a significant portion of the United States' citizenry was destitute and living under a pro-

¹⁹⁰ See also *id.* at 191 (noting that the United States' failure to reduce its MMR is inexcusable “when we consider the fact that . . . numerous developing countries, such as Vietnam . . . , with much fewer resources than the United States, are making strides towards meeting their goals of reducing preventable maternal deaths, while the United States is backsliding”).

¹⁹¹ See *id.* at 189.

¹⁹² See Derrick A. Bell, Jr., *Brown v. Board of Education and the Interest-Convergence Dilemma*, 93 HARV. L. REV. 518, 524 (1980) [hereinafter Bell, *Interest-Convergence Dilemma*]; Derrick A. Bell, Jr., *Racial Remediation: An Historical Perspective on Current Conditions*, 52 NOTRE DAME L. REV. 5, 12 (1976) [hereinafter Bell, *Racial Remediation*] (“[I]t is highly unlikely that the white self-interest factors which so clearly motivated earlier, less significant civil rights breakthroughs were absent when the Brown decisions were formulated.”).

¹⁹³ See Bell, *Racial Remediation*, *supra* note 192, at 12.

¹⁹⁴ See generally MARY L. DUDZIAK, *COLD WAR CIVIL RIGHTS: RACE AND THE IMAGE OF AMERICAN DEMOCRACY* 79–114 (2011).

¹⁹⁵ See Bell, *Racial Remediation*, *supra* note 192, at 12.

¹⁹⁶ See DUDZIAK, *supra* note 194, at 12–14.

foundly antidemocratic regime.¹⁹⁷ To be precise, Soviets brought attention to black people living in the Jim Crow South. Legal historian Michael Klarman gives the example of “Soviet foreign minister V. M. Molotov ask[ing] Secretary of State Jimmy Byrnes how Americans could justify pressing the Soviets to conduct free elections in Poland when America did not guarantee them in South Carolina or Georgia.”¹⁹⁸

Bell argues that the formal equality that black people achieved in the 1950s and 1960s was not the result of powerful white people having a change of heart in the face of the Civil Rights Movement.¹⁹⁹ Rather, it was the result of an interest convergence between subjugated black people and powerful white people.²⁰⁰ As most black people wanted to dismantle the formal system of apartheid, many white people came to want an end to this system as well. However, while most black people desired the end of apartheid because they knew that it was incompatible with their dignity, humanity, and citizenship, many white people desired the end of apartheid because it was the only way that the United States could achieve ideological and political dominance in the international arena.²⁰¹

Inasmuch as the high ratios of maternal mortality in the United States are a *racial* problem, the lesson of the Civil Rights Movement and the Cold War may be that we ought to be pessimistic that those with the power to effect change will do so because they simply will come to believe that it is a moral imperative.²⁰² The lesson of the Civil Rights Movement and the Cold War may be that the United States must come to see it as in its interest to rectify a racial injustice. The circumstances under which the United States would perceive racial disparities in maternal mortality as such are impossible to predict. It may be wise, however, for those interested in racial justice to continue to bring international attention to the racial tragedy unfolding within our borders.²⁰³ When the circumstances develop that would make the

¹⁹⁷ See *id.* at 12 (“The Soviet Union capitalized on this weakness, using the race issue prominently in anti-American propaganda.”).

¹⁹⁸ MICHAEL J. KLARMAN, *BROWN V. BOARD OF EDUCATION AND THE CIVIL RIGHTS MOVEMENT* 30 (2007).

¹⁹⁹ See Bell, *Interest-Convergence Dilemma*, *supra* note 192, at 524–26.

²⁰⁰ See *id.*

²⁰¹ See *id.* at 524 (contending that the decision in *Brown* increased America’s political credibility abroad).

²⁰² This might be especially true if addressing or eliminating racial disparities in maternal mortality threatens white people’s status—as was the case in dismantling Jim Crow.

²⁰³ Notably, international human rights bodies have already paid attention to racial disparities in maternal mortality in the United States. In 2014, the United Nations Committee on the Elimination of Racial Discrimination called on the United States to

United States interested in doing something about it, the international community will already be aware of it.

B. A Critique of the Solutions Proposed to Eliminate Racial Disparities in Maternal Mortality

There is a danger that an unsophisticated effort to eliminate racial disparities in maternal mortality will produce new forms of disenfranchisement. That is, there is a strong possibility that black women will suffer increased surveillance if policymakers design initiatives to lower MMR among black women without paying close attention to the fact that these initiatives will be implemented on a terrain that is rife with racism, sexism, and classism.

In earlier work, I have explored the intense surveillance to which governments subject poor pregnant women.²⁰⁴ These works investigate how New York's Medicaid program compels Medicaid-reliant pregnant women in the state to disclose large amounts of highly intimate information upon their initiation of prenatal care.²⁰⁵ Poor pregnant women are forced to confess the details of their diets; their histories with sexual violence, intimate violence, and substance use; any contact they have had with the criminal legal system or the child protective system; any bouts of homelessness that they have suffered; and other intimate facts about themselves.²⁰⁶ The government's reasons for compelling these confessions are many.²⁰⁷ On its face, the state is interested in protecting children and, as such, seeks to ensure that a pregnant woman is capable of competently parenting the child that she will birth.²⁰⁸ Additionally, the state is aware that poverty exposes the poor to violence—in the form of food insecurity, housing insecurity, lack of access to healthcare, and interpersonal violence.

make efforts to eliminate these disparities, as the failure to do so left the United States in violation of its human rights obligation to end racial discrimination in all forms. COMM. ON THE ELIMINATION OF RACIAL DISCRIMINATION, *Concluding Observations on the Combined Seventh to Ninth Periodic Reports of the United States of America*, U.N. Doc. CERD/C/USA/CO/7-9, at 7 (Sept. 25, 2014).

²⁰⁴ BRIDGES, *REPRODUCING RACE*, *supra* note 109; Khiara M. Bridges, *Privacy Rights and Public Families*, 34 HARV. J.L. & GENDER 113 (2011).

²⁰⁵ See Bridges, *supra* note 204, at 124–32.

²⁰⁶ See *id.*

²⁰⁷ *The Poverty of Privacy Rights* argues that the underlying reason for the state's requirement that poor pregnant women and poor mothers disclose intimate information about themselves is the moral construction of poverty and the presumption that people are poor because there is something wrong with them. KHIARA M. BRIDGES, *THE POVERTY OF PRIVACY RIGHTS* 37–64 (2017). As such, the surveillance of poor mothers is imperative, as their children are being cared for by people who, by definition, have something presumptively wrong with them. *Id.*

²⁰⁸ *Id.* at 1–10.

Accordingly, the state seeks to protect poor women from these varieties of violence—at least during the period of their pregnancies.²⁰⁹

This is to say that the state's reasons for subjecting poor pregnant women to interrogation and regulation are not nefarious. Indeed, the state's intentions are golden. However, because poverty impacts, and damages, multiple aspects of a person's life—the psychological, the emotional, the physical—the state must intervene in multiple aspects of a person's life in order to address all of poverty's impacts. Accordingly, the interrogations and interventions to which the pregnant poor are subjected are wide-ranging and deep.²¹⁰

Further complicating the matter is that the state's interventions into poor women's pregnancies occur within a social context of racial inequality, xenophobia, and classism. Thus, society tolerates excesses—when, for example, the state errs on the side of protecting children and wholly dismisses a woman's interest in keeping her private life private—because the women subjected to these interventions have been discursively maligned. The consequence is a system that, although designed with the best of intentions, is quite punitive and has pernicious effects on the ground.²¹¹

The concern is that something similar will develop in the context of racial disparities in maternal mortality. The best of intentions may motivate these efforts. However, because racism, like poverty,²¹² impacts and damages multiple aspects of a person's life, the state will have to intervene in multiple aspects of a person's life in order to address all of racism's impacts.

As many observers have argued, the high frequency of pregnancy-related death that black women encounter is a product of racism.²¹³ Accordingly, in order to address black maternal mortality—

²⁰⁹ *Id.*

²¹⁰ THE POVERTY OF PRIVACY RIGHTS extends this analysis beyond pregnancy, arguing that poor mothers are surveilled as they try to raise their children within conditions of poverty. *Id.* at 101–32.

²¹¹ See BRIDGES, REPRODUCING RACE, *supra* note 109 (discussing the harms that pregnant women reliant on Medicaid endure).

²¹² It may be inaccurate to say that racism is “like poverty” because the analogy may suggest that racism and poverty are entirely distinct phenomena. In reality, racism may be inextricable from poverty. That is, the United States may allow poverty to persist—and it may support those social arrangements that produce poverty—because those who disproportionately bear the burdens of poverty are nonwhite. See BRIDGES, CRITICAL RACE THEORY, *supra* note 154, at 215–32. In like manner, poverty may be inextricable from racism to the extent that the impoverishment of disproportionate numbers of nonwhite people may give truth to the racist notion that nonwhite people are fundamentally different from white people.

²¹³ See, e.g., Joia Crear-Perry, *Race Isn't a Risk Factor in Maternal Health. Racism Is.*, REWIRE.NEWS (Apr. 11, 2018), <https://rewire.news/article/2018/04/11/maternal-health-replace-race-with-racism/>; see also Elizabeth Dawes Gay, *Serena Williams Could Insist that*

that is, in order to address a phenomenon that racism has wrought—the state may have to subject black women to wide-ranging, privacy- and dignity-denying interrogations and interventions in order to save their lives. In other words, *racism creates the risk that efforts to address the effects of racism will further marginalize and subordinate the victims of racism*. Moreover, because the women subjected to these efforts will be black, we should expect that, due to the marginalizing discourses that attach to black bodies, society will tolerate excesses and indignities. Consider the following proposals for addressing racial disparities in maternal mortality:

[Because] Black women are more likely to have a delayed entry into prenatal care[, there is a] need for a comprehensive assessment of maternal health (beyond reproductive health) to occur both at the first prenatal visit, whenever that occurs, and at the six-week postpartum visit to ensure that appropriate referrals and interventions are offered to optimize the management of preexisting conditions and to ensure that pregnancy-associated conditions have resolved and are not merely late diagnoses of preexisting conditions.²¹⁴

The structured psychosocial risk screening interview . . . [that the author recommends] include[s] assessments for moderate/high risk of depression, lack of telephone access, food insecurity, housing instability, lack of social support, and transportation access, a strategy that may allow for real-time engagement with social determinants of health. *Screening for impact of psychosocial determinants of health may be most effective if systematically repeated throughout pregnancy.*²¹⁵

[P]opulation-level data [should be shared] with health care providers to improve their understanding of factors that contribute to health inequities. Providers can tailor interventions to the health care needs and risks inherent in the patient populations they serve.²¹⁶

[A]n active, systematic mental health and violence risk screening, during both antepartum and postpartum periods, should be prioritized for at-risk pregnancies.²¹⁷

Doctors Listen to Her. Most Black Women Can't., THE NATION (Jan. 18, 2018), <https://www.thenation.com/article/archive/serena-williams-could-insist-that-doctors-listen-to-her-most-black-women-cant>.

²¹⁴ Metcalfe et al., *supra* note 126, at 94.

²¹⁵ Gadson et al., *supra* note 116, at 313 (emphasis added).

²¹⁶ N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, SEVERE MATERNAL MORBIDITY IN NEW YORK CITY, 2008–2012, at 24 (2016).

²¹⁷ LA. DEP'T OF HEALTH & HOSPS., LOUISIANA PREGNANCY-ASSOCIATED MORTALITY REVIEW, 2008, at 10 (2012). Questions remain about how populations will be identified as

It should be apparent that these efforts are extremely invasive. In threatening to strip the pregnant women of any privacy that she enjoys—before, during, and after pregnancy—they also threaten her dignity.

Nevertheless, it is difficult to describe these proposals as nefarious. They appear to be well-reasoned efforts to get at the root of the elevated MMR among black women. However, because the root of elevated MMR is in racism—in the fact that black women may be more likely to enter pregnancy with chronic conditions and comorbidities, may be more likely to live in physical environments that compromise their health, may be subjected to the chronic stress that results in the weathering of body systems, may be more likely to be poor, and may be more likely to find healthcare inaccessible—the efforts will have to be grand in scope. Indeed, racism itself has been grand in scope.

Moreover, because of the racist discourses that have attached to black women—about the hardness of their bodies,²¹⁸ about their sexual profligacy,²¹⁹ about their fecundity,²²⁰ about their undeserved sense of entitlement²²¹—we should expect that society will tolerate the excesses of a system designed to intervene in the multiple causes of racial disparities in maternal mortality. We should expect that these excesses will be politically acceptable.²²²

In essence, the point is that if we do not think particularly highly of the women that we are trying to save—if they are the subjects of discourses that allow us to despise them—we will likely marginalize them in our attempts to save them.

In truth, we are “damned if we do, damned if we don’t.” We will injure black women if we try to save them. And we will injure black

“at-risk.” See generally BRIDGES, REPRODUCING RACE, *supra* note 109, at 144–200 (discussing how poverty influences which populations are labeled “at-risk”).

²¹⁸ See Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT’L ACAD. SCI. U.S. 4296 (2016) (discussing a study documenting that black Americans are undertreated for pain).

²¹⁹ See DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 10–12 (2d ed. 2017) (describing the United States’ historical reliance on myths of black promiscuity).

²²⁰ See *id.* at 12 (referencing specifically the United States’ myth of black hyperfertility and providing examples of this myth’s perpetuation through literature and more scholarly treatments).

²²¹ See *id.* at 17–19 (analyzing the origins and perpetuation of “The Welfare Queen” myth).

²²² See Dorothy E. Roberts, *Rust v. Sullivan and the Control of Knowledge*, 61 GEO. WASH. L. REV. 587, 597 (1993) (discussing how the Court’s decision in *Rust v. Sullivan*, which upheld regulations barring care providers from counseling an indigent clientele on abortion, was “politically acceptable” due to the race of those affected by the regulations).

women if we do not try to save them. But it is important to underscore that the paradox is created because racial injustice is so pernicious that even the efforts to address racial injustice will likely have pernicious effects.

C. *A Critique of the Practice of Blaming Women for Dying*

A common theory as to why the United States has a higher MMR than other industrialized nations—and, specifically, as to why the frequency of maternal death has increased in more recent years—is that the health of the population of women of reproductive age in the United States has worsened.²²³ Specifically, researchers have posited that more women are obese when they become pregnant; further, more women are entering pregnancy with chronic conditions—namely, hypertension, diabetes, and heart disease.²²⁴ Additionally, many researchers have observed that women are delaying pregnancy and, therefore, are older when they attempt pregnancy.²²⁵ Hypertension, diabetes, heart disease, obesity, and advanced maternal age are all risk factors for pregnancy complications.²²⁶ According to this theory, if the MMR in the United States is ticking upwards, then it is an expected consequence of women not being as healthy when they

²²³ See Metcalfe et al., *supra* note 126, at 92–93 (stating that in recent years, women are “more likely to enter pregnancy with a preexisting chronic disease,” observing that “[m]aternal health status before pregnancy is an important contributor to obstetric outcomes,” and asserting that the incidence of severe maternal morbidity may be decreased if “women enter[] pregnancy in a healthier state”).

²²⁴ See Creanga, *Maternal Mortality*, *supra* note 2, at 299 (“Studies have shown that an increasing number of pregnant women in the United States have chronic health conditions such as hypertension, diabetes, and chronic heart disease, and presence of such conditions do indeed put a pregnant woman at a higher risk of pregnancy complications.”); Nelson et al., *supra* note 91, at 1007 (“[I]ndividual-level factors may explain worsening U.S. obstetric outcomes over the last two decades, such as . . . increased prevalence of obesity and other chronic health conditions . . .”).

²²⁵ See Nelson et al., *supra* note 91, at 1007 (stating that the worsening of obstetric outcomes in the United States may be attributed to “temporal trends in the number of births to women of advanced maternal age”); Andreea A. Creanga, Cynthia J. Berg, Carla Syverson, Kristi Seed, F. Carol Bruce & William M. Callaghan, *Pregnancy-Related Mortality in the United States, 2006–2010*, 125 *OBSTETRICS & GYNECOLOGY* 5, 9–10 (2015) [hereinafter Creanga et al., *Pregnancy-Related Mortality, 2006–2010*] (“U.S. women have been delaying childbearing, and although less than 15% of live births are to women 35 years of age or older, 27.4% of pregnancy-related deaths were among this age group . . .”); see also Creanga, *Maternal Mortality*, *supra* note 2, at 300 (noting that “[i]n vitro fertilization techniques permit older women, some with chronic medical conditions, to become pregnant,” and as a result, “[n]ot surprisingly, causes of pregnancy-related death have changed over time”).

²²⁶ See Creanga, *Maternal Mortality*, *supra* note 2, at 299; Nelson et al., *supra* note 91, at 1012 (“Maternal obesity . . . has been consistently reported to increase the risk of pregnancy complications, including thromboembolic disease, gestational diabetes mellitus, and hypertensive disorders of pregnancy.”).

become pregnant as they were in decades past.²²⁷ Further, if black women are dying more frequently than other groups of women, then it is simply because black women are not as healthy when they become pregnant as their non-black counterparts.²²⁸

We ought to be sensitive to how this narrative about the causes of racial disparities in maternal mortality can function to blame black women for dying or nearly dying when they attempt motherhood. This narrative can have the effect of placing responsibility for maternal deaths on the women dying from pregnancy-related causes. When black women die from pregnancy complications that have some relationship to obesity, diabetes, heart disease, and hypertension, the sense may be that black women did it to themselves.²²⁹ They let themselves go. They gorged themselves on unhealthy foods. They did not exercise. They did not take care of themselves. If they die when they

²²⁷ See LYN KIELTYKA, POOJA MEHTA, KARIS SCHOELLMANN & CHLOE LAKE, LA. DEP'T OF HEALTH, LOUISIANA MATERNAL MORTALITY REVIEW REPORT, 2011–2016, at 13 (2018) (noting that “increased chronic disease burden and increasing maternal age may be contributing factors” to the increase in pregnancy-related deaths); Nelson et al., *supra* note 91, at 1011 (noting a study that showed that thirty-one percent of the increase in maternal deaths “was attributable to the proportion of obese women of childbearing age” and that seventeen percent of the increase was due to the “proportion of births to women with diabetes”); Creanga et al., *Pregnancy-Related Mortality, 2006-2010*, *supra* note 225, at 10 (“Studies show that an increasing number of pregnant women in the United States have chronic health conditions such as hypertension, diabetes, chronic heart disease, and obesity, [and] these conditions put pregnant women at risk of adverse outcomes.” (citations omitted)); REPRODUCTIVE INJUSTICE, *supra* note 34, at 13 (noting that the “Centers for Disease Control and Prevention (CDC) points to an increase in pregnant women with chronic health conditions as a driving factor for the rise in maternal mortality between 2006 and 2009”); see also Young, *Hospitals Know How to Protect Mothers*, *supra* note 6 (“For decades, hospitals and medical experts have often blamed rising maternal deaths and injuries on women for being unhealthy or overweight, or pointed to risk factors such as poverty or the age of mother.”); Martin, *supra* note 22 (“[M]any researchers and clinicians have formed a distorted picture of why mothers die, often putting the blame unfairly on women themselves . . .”).

²²⁸ See, e.g., Bryant et al., *supra* note 115, at 339 (“Racial/ethnic minorities are at increased risk of pregnancy overweight and obesity, and these conditions are associated with an ever-growing list of pregnancy complications . . .”); N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, *supra* note 216, at 6 (2016) (“There are likely many contributors to these [racial] disparities, including pre-conception health status, prevalence of obesity and other co-morbidities and access to care.”) (emphasis added); REPRODUCTIVE INJUSTICE, *supra* note 34, at 13 (“Compared to white women, women of color fare significantly worse in key general health indicators including diabetes, obesity, heart disease, and hypertension. These poor health indicators are often exacerbated during pregnancy, especially if they remain untreated, and are a driving force behind preventable maternal deaths.”). Of note, one rarely sees the claim that racial disparities in maternal mortality can be attributed to black women being older than white women when they become pregnant.

²²⁹ See YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 16 (noting that “the increased prevalence of [certain chronic conditions, like hypertension, diabetes, and obesity] is often used to shift the responsibility of poor maternal outcomes to women for so-called personal ‘lifestyle’ decisions”).

become pregnant, the story concludes, then they have only themselves to blame.²³⁰

This narrative might be redeemed if it works to place within view the structural forces that have led black women to suffer from chronic conditions at higher rates.²³¹ If the narrative causes observers to consider the social contexts within which black women live their lives, then observers may see that women are not freely making choices that lead them to become obese and/or develop other chronic conditions. For example, it is inordinately difficult to maintain a healthy diet when healthy foods are not affordable or when they are physically inaccessible. It is quite challenging to exercise regularly when work and caretaking consumes one's days. That is, there are *structural* reasons for the disproportionate rates at which black women suffer from hypertension, diabetes, heart disease, and obesity.²³² The fact of the "preexisting condition"—when it is not subjected to critical analysis—may work to lay blame at black women's feet while simultaneously removing attention from the social arrangements that have made black women sicker than their white counterparts. If the fact of the "preexisting condition" is not set within its structural context, it may function to absolve society of responsibility for the poor states of health that black women disproportionately inhabit.

Importantly, there is strong evidence against the claim that disproportionate rates of chronic conditions among black women fully

²³⁰ A series on maternal mortality in the United States published by *USA Today* identified a disturbing number of instances in which pregnant women have been blamed for the United States' high MMR. It notes that many state MMRCs have chosen to emphasize "lifestyle choices and societal ills"—like intimate violence and the opioid epidemic—in their analyses of maternal deaths. Ungar, *supra* note 185. The article reports that Representative Mike Moon "said during . . . debate on the House floor that women smoking, being overweight and not going to the doctor while pregnant" explains the high incidence of maternal mortality in the United States. *Id.* The same series also reports that officials of a hospital in Utah where one out of every nine patients suffered a hemorrhage "were quick to blame the women as being unusually high risk." Young, *Hospitals Know How to Protect Mothers*, *supra* note 6.

²³¹ Moreover, if advanced maternal age is a risk factor for pregnancy complications, then we ought to pay attention to the structural reasons for women's choice to delay childbearing. How have we structured the labor force such that women think it advisable to wait until they are more established in their careers before having children? How has the economy transformed such that it is unadvisable for women and their partners to create families when they are younger?

²³² Bryant et al., *supra* note 115, at 339 (observing that obesity among women of color may be attributable to "physical and built environments [that] are not conducive to exercise" and that "are often more prevalent among minority populations"); YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 17 (stating that "[l]ifestyle decisions . . . are influenced by context-dependent socioeconomic, cultural, and political environments, which in turn are shaped by policy-level decisions" and asserting that "risk factors, such as obesity and diabetes," need to be contextualized within "structures and systems").

explain racial disparities in maternal mortality. Many studies have documented that even if one controls for the increased prevalence of preexisting conditions among black women, black women *still* have a greater chance of dying from a pregnancy complication than their white counterparts.²³³ We ought to interrogate why the narrative that black women are dying because they are unhealthy has been as believable as it has been to so many observers.

Moreover, it seems clear that the frequency of maternal death and near-death need not increase simply because there is an increase in prevalence of chronic conditions among the population of women of reproductive age. There have been increases in the incidence of hypertension, diabetes, and obesity in other industrialized nations; however, the MMR in those nations has not increased.²³⁴ In fact, it has decreased.²³⁵ This demonstrates that having a chronic condition when one enters pregnancy need not be a death sentence.²³⁶ If we wanted to make pregnancy and childbirth survivable for women with these conditions, we could.

Substance use during pregnancy provides a revealing context for exploring the phenomenon of faulting women for dying. Substance use disorders have played a significant role in maternal mortality and morbidity. For example, New York City's MMRC calculated that between 2006 and 2010, 18.2% of fatal injuries associated with preg-

²³³ See Bingham et al., *supra* note 35, at 190 (“[C]ontrary to common assumptions, the racial and ethnic disparities in outcomes are not always due to women of color having a higher prevalence of diseases. . . . [W]omen of color often are less likely to receive beneficial treatments that could have prevented their death or injury.”); Goffman et al., *supra* note 103, at 600 (stating the results of an analysis that showed that racial disparities in maternal morbidity and mortality “could not be explained by other risk factors that were found to be significantly associated with adverse outcome in univariable analysis,” including “age, obesity, history of a chronic medical condition, prior cesarean delivery and gravidity”). See also BOYD ET AL., *supra* note 84, at 5 (noting that while New York City’s “Black population” is disproportionately affected by “obesity” and “underlying chronic illness,” a “causal relationship” between these conditions and the increased risk of maternal mortality for black women has not been established); Moaddab et al., *supra* note 40, at 710 (“Although medical factors such as hypertensive disease, tobacco use, and obesity have been shown to be correlated with increased maternal morbidity, statewide population differences in rates of these conditions were not significantly correlated with mortality ratios.”).

²³⁴ See YALE GLOB. HEALTH JUSTICE P’SHP, *supra* note 40, at 5 (“In the past two decades, the percentage of maternal deaths attributable to chronic conditions such as hypertension and diabetes has risen sharply in the U.S.; however, globally no parallel rise in maternal deaths has been seen alongside increasing rates of obesity and other risk factors.”).

²³⁵ See *id.*

²³⁶ See Young, *Hospitals Know How to Protect Mothers*, *supra* note 6 (quoting the medical director of the California Maternal Quality Care Collaborative as saying “[j]ust because you’re older and heavier, doesn’t mean you should die,” and “[t]hat just means [the healthcare provider] should be on guard, you should bring your A game”).

nancy were due to “substance abuse.”²³⁷ The MMRC in Louisiana determined that “substance abuse” was present in 26% of pregnancy-associated deaths in the state.²³⁸ And the MMRC in Missouri concluded that “maternal deaths due [to] drug overdose” were “a significant public health concern.”²³⁹

If substance use during pregnancy has contributed to maternal deaths and near misses—which it undoubtedly has²⁴⁰—then it is reasonable to conclude that some of these cases of mortality and morbidity might have been avoided if a provider knew about and managed a pregnant woman’s substance misuse or dependency. A provider might direct her towards a drug treatment facility. If she has an opioid dependency, a provider might provide her medication-assisted treatment (MAT) so as to stabilize her and avoid the risk that she might overdose.²⁴¹ Consequently, in order to reduce the number of maternal deaths or near-misses that substance use causes or to which substance use contributes, policymakers may think it advisable to screen all women for substance use, misuse, and dependency. And this is precisely what some experts have recommended. For example, a report issued by nine MMRCs suggests that if a review of a maternal death reveals that “a lack of provider assessment” of substance use contributed to the death, then “an actionable recommendation could be that prenatal care providers should screen all patients for substance use disorders at their first prenatal visit.”²⁴² Another commission concluded in 2008 that “[g]iven the prevalence of substance abuse as a clinical risk indicator, the development of enhanced resources for behavioral health/substance abuse screening during preconception, antenatal and birth/postpartum time periods needs to be emphasized.”²⁴³ The same commission arrived at a similar conclusion six years later, recommending that the state “[o]ffer universal substance use screening . . . during pregnancy.”²⁴⁴

²³⁷ BOYD ET AL., *supra* note 84, at 17.

²³⁸ LA. DEP’T OF HEALTH & HOSPS., *supra* note 217, at 9.

²³⁹ VENKATA PS GARIKAPATY, MO. DEP’T OF HEALTH & SENIOR SERVS., PREGNANCY ASSOCIATED MATERNAL MORTALITY REVIEW (PAMR) IN MISSOURI (2015), <https://nurturekc.org/wp-content/uploads/2015/01/Missouri-Maternal-Mortality-System.pdf>.

²⁴⁰ *See, e.g.*, Gadson et al., *supra* note 116, at 309 (“Substance use disorders in particular may coincide with medical and social vulnerabilities to increase risk of maternal death.”).

²⁴¹ *See* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, ACOG COMM. OPINION NO. 711: OPIOID USE AND OPIOID USE DISORDER IN PREGNANCY 6 (Aug. 2017) (documenting that medication-assisted treatment remains the gold-standard treatment for opioid dependency during pregnancy).

²⁴² REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 29.

²⁴³ LA. DEP’T OF HEALTH & HOSPS., *supra* note 217, at 11.

²⁴⁴ KIELTYKA ET AL., *supra* note 227, at 28.

These proposals, as motivated by good intentions as they may be, will have disastrous consequences if implemented within a context wherein it is politically acceptable, and desirable, to punish pregnant women for their substance use. Essentially, a well-intentioned policy that endeavors to save women's lives could result in substance-using and -dependent women being funneled into the criminal legal system.²⁴⁵

We have already seen government's response to substance use during pregnancy. During the crack cocaine crisis of the 1980s—when the pregnant women who were struggling with cocaine dependencies were disproportionately black—the state responded with arrest, prosecution, and incarceration.²⁴⁶ States charged and convicted women who had used cocaine during their pregnancies with crimes ranging from child maltreatment, assault, and, in cases where there was a fetal death, homicide.²⁴⁷

In the face of the opioid epidemic, many states continue to respond to substance use during pregnancy with the criminal law.²⁴⁸ Tennessee passed the first law that was designed to criminalize substance use during pregnancy—a law that legislators allowed to expire after advocates in the state mounted a campaign to achieve that result.²⁴⁹ Prosecutors in Alabama have been using a law that was intended to punish individuals who manufacture crystal methamphetamine in the presence of children—thereby exposing the children to the risk of an explosion injuring or killing them—to prosecute women who use controlled substances while pregnant.²⁵⁰ And

²⁴⁵ Pregnant women who use substances might be funneled into the criminal legal system unless there is a concerted effort to prevent that very result. With this in mind, while the Louisiana MMRC recommends screening pregnant women for substance use disorders, it is careful to note that the response to a positive drug screen should not be punitive. It specifically recommends that the state should “[m]aintain linkages to evidence-based decriminalized medication assisted therapy for opioid use disorder” in pregnant women. *Id.*

²⁴⁶ Khiara M. Bridges, *Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy*, 133 HARV. L. REV. 770, 775 (2020); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1420–21 (1991).

²⁴⁷ See Bridges, *supra* note 246, at 807.

²⁴⁸ See *id.* at 776.

²⁴⁹ See TENN. CODE ANN. § 39-13-107(c)(2) (2014); Blake Farmer, *Tennessee Lawmakers Discontinue Controversial Fetal Assault Law*, NPR (Mar. 23, 2016 4:24 PM), <https://www.npr.org/2016/03/23/471622159/tennessee-lawmakers-discontinue-controversial-fetal-assault-law>.

²⁵⁰ See ALA. CODE § 26-15-3.2 (2006); Grace Howard, *The Limits of Pure White: Raced Reproduction in the “Methamphetamine Crisis”*, 35 WOMEN'S RTS. L. REP. 373, 374 (2014) (describing how Alabama's law has been used to arrest “pregnant women on charges ranging from chemical child endangerment to manslaughter for their behaviors during pregnancy, primarily for alleged illegal substance use”).

prosecutions for substance use during pregnancy continue at a steady pace in South Carolina—the state where one woman who used cocaine while pregnant spent eight years in jail after being convicted for murder subsequent to the birth of her stillborn baby.²⁵¹

Inasmuch as it has been politically acceptable for the state to respond punitively to pregnant women with substance use disorders when they are believed to harm their fetuses, we might not be optimistic that society will have much sympathy if pregnant women who use controlled substances harm *themselves*. If a pregnant woman's death or near-miss pregnancy complication can be traced to a substance that she intentionally ingested, we should expect that many in society would find it easy, and morally acceptable, to blame her for injuring or killing herself. Again, if we do not think particularly highly of the women that we are trying to save, we run a significant risk of marginalizing them in our attempts to save them.

Commentators have critiqued the willingness of some analysts to blame women for dying or nearly dying during their pregnancies. In its “Deadly Deliveries” series on maternal mortality in the United States, *USA Today* observed the tendency to fault women for dying from pregnancy-related causes, and it sought to shift responsibility towards the physicians and nurses that provide healthcare to pregnant women and the hospitals where women receive this care. The series observed that inquiries into maternal mortality very rarely focus on the quality of the care that women receive,²⁵² and it criticized the Preventing Maternal Deaths Act for failing to require that the MMRCs it funds pay attention to the quality of the care that women are being given.²⁵³ The series endeavored to bring attention to the possibility that provider negligence and inferior care likely bear some

²⁵¹ Press Release, Drug Policy All., South Carolina Supreme Court Reverses 20-Year Homicide Conviction of Regina McKnight (May 11, 2008), <https://www.drugpolicy.org/news/2008/05/south-carolina-supreme-court-reverses-20-year-homicide-conviction-regina-mcknight>. The court that convicted the woman disregarded medical evidence that the stillbirth was caused by an infection, as well as studies showing no link between cocaine use and heightened risk for stillbirths. Jeanne Flavin & Lynn M. Paltrow, *Punishing Pregnant Drug-Using Women: Defying Law, Medicine, and Common Sense*, 29 J. ADDICTIVE DISEASES 231, 235 (2010).

²⁵² See Ungar, *supra* note 185 (“Fewer than 20 states that have panels studying mothers’ deaths identify medical care flaws such as delayed diagnoses, inadequate treatments or the failures of hospitals to follow basic safety measures. . . . Among 10 states with the highest death rates, just four panels reported on flaws in medical care.”); Young, *Mothers Are Dying*, *supra* note 63 (noting that many “state maternal death review committees across the country often avoid scrutinizing medical care that occurred in the days and hours before mothers’ deaths”).

²⁵³ See Young, *Mothers Are Dying*, *supra* note 63 (criticizing the fact that the Preventing Maternal Deaths Act “does not specifically require states to examine whether flawed medical care played a role” in a pregnancy-related death).

significant responsibility for the comparatively high rates of maternal mortality in the United States.

While *USA Today*'s intervention is an important one inasmuch as it acknowledges the unfairness and cruelty of holding the dead responsible for dying, it is important that the search for the causes of maternal mortality—and racial disparities in maternal mortality, specifically—does not simply become a search for the “real” bad actor. Those who assert that women are to blame for dying during pregnancy because they have given themselves obesity, diabetes, hypertension, or heart disease err because, in addition to ignoring the social constraints within which women live, they individualize the problem. The problem becomes individual women and the poor lifestyle choices that they have made. However, those, like *USA Today*, who seek to shift the focus to bad providers and bad hospitals make a similar error: They also individualize the problem. The difference is simply that those in the latter camp identify different individual bad actors: careless physicians and nurses and negligent hospitals.

Certainly, some number of maternal deaths might be due to medical negligence. However, systemic and structural factors—like “weathering,” our two-tiered healthcare system, residential segregation and the concentration of health-damaging factors in neighborhoods of color, the closure of obstetric units in public hospitals, the racist discourses that attach to pregnant bodies of color—likely bear a greater share of the responsibility for the indefensibly high MMR among black women in the United States. In essence, it is important that we are not myopic in our identification of the causes of maternal mortality in the United States. Searching for the blameworthy actor—both when the actor is identified as the woman who dies during pregnancy, or the physician who delivers substandard care—simplifies an exceedingly complex issue whose roots are in the structures that arrange our society.²⁵⁴ The solutions that society pursues when it

²⁵⁴ See Laura Katzive, *Maternal Mortality and Human Rights*, 104 AM. SOC. INT'L L. PROC. 383, 385 (2010) (“In some settings, a preventable maternal death may look like a case of provider malpractice. The task . . . is to show that responsibility lies beyond a single provider and can be attributed to a health system failure.”); Wilson, *supra* note 128, at 239 (criticizing when a problem of maternal mortality and the solutions proposed to it are “restricted to individual behaviors or interactions between doctors and patients” and advocating that attention be paid to “[c]ity policy action, or lack thereof”); Yamin, *supra* note 42, at 96–97 (noting that pursuing “effective accountability” in the arena of maternal deaths “requires moving beyond . . . punishing individual perpetrators” and towards advocating for the promotion of “systemic and institutional changes that create conditions under which women can enjoy their rights to maternal health, and not just [the punishment of] identified lapses in performance”).

believes that individual bad actors are the cause of a problem will hardly be effective or satisfactory.

In this Part, we have seen that racism inflicts a multifaceted injury on black women: 1) racism is a structural determinant of poor health, 2) racism produces a moralizing/punitive discourse about those who suffer from poor health, and 3) racism limits efforts to address poor health outcomes. In light of the layered nature of the harm that racism perpetrates, there should be little wonder that the black maternal death rate is as elevated as it is.

The next Part elaborates on the claim that racism limits efforts to address poor health outcomes. Specifically, it describes Congress's recent foray into addressing the United States' relatively high MMR: the Preventing Maternal Deaths Act. Widely hailed as an important first step in lowering the country's MMR, the Act, nevertheless, is woefully inadequate—and potentially dangerous.

III

THE PREVENTING MATERNAL DEATHS ACT

On December 21, 2018, the president signed the Preventing Maternal Deaths Act into law.²⁵⁵ The law, which many observers believe is a direct result of the attention that the media recently have given to the United States' comparatively high MMR,²⁵⁶ allocates twelve million dollars annually for five years to the issue.²⁵⁷ The sixty million dollars that the government has devoted to reducing the frequency of maternal mortality is more than the Act's supporters had imagined Congress would allot to addressing the problem.²⁵⁸

²⁵⁵ Katy Backes Kozhimannil, Elaine Hernandez, Dara D. Mendez & Theresa Chapple-McGruder, *Beyond The Preventing Maternal Deaths Act: Implementation and Further Policy Change*, HEALTH AFFAIRS BLOG (Feb. 4, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190130.914004/full>. The avowed purposes of the law are to “support States in their work to save and sustain the health of mothers during pregnancy, childbirth, and in the postpartum period, to eliminate disparities in maternal health outcomes for pregnancy-related and pregnancy-associated deaths, [and] to identify solutions to improve health care quality and health outcomes for mothers” Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, 132 Stat. 5047 (2018).

²⁵⁶ See 162 CONG. REC. H10,060 (2018) (“The media’s attention to the issue of maternal morbidity and mortality has shed light on serious problems within our healthcare system in terms of pre- and postpartum care and complications in the delivery room.”).

²⁵⁷ See Jones, *supra* note 19.

²⁵⁸ See Elizabeth Chuck, “An amazing first step”: Advocates Hail Congress’s Maternal Mortality Prevention Bill, NBC NEWS (Dec. 19, 2018, 2:38 AM), <https://www.nbcnews.com/news/us-news/amazing-first-step-advocates-hail-congress-s-maternal-mortality-prevention-n948951> (discussing advocates’ hope in the bill’s success).

Notably, support for the law was bipartisan.²⁵⁹ Indeed, it unanimously passed both houses of Congress.²⁶⁰ Historically speaking, perceptions that the issue of maternal mortality was a “Democratic” cause hampered efforts to tackle the issue.²⁶¹ In the past, Republicans failed to support proposed laws that endeavored to address the problem.²⁶² The Preventing Maternal Deaths Act represented a dramatic departure from this history inasmuch as the lead sponsor of the bill, Representative Jaime Herrera Beutler, is a “staunchly anti-abortion” Republican.²⁶³ The success of the Preventing Maternal Deaths Act is owed to its failure to be identified with either party, allowing it to escape the perils of partisan politics. The next Part returns to a discussion of this aspect of the Act.

The primary aim of the law is to improve the quality of the information that exists about maternal mortality. Many have argued that the United States’ comparatively high MMR is attributable to the poor quality of the data that is currently available about maternal deaths.²⁶⁴ Understanding why people have made this argument requires some background on the present state of data-gathering about maternal mortality.

At present, there are two systems on the national level that collect information about maternal mortality, both of which are housed in the Centers for Disease Control and Prevention (CDC). The

²⁵⁹ See Martin, *supra* note 22 (noting that both Democrats and Republicans introduced the House and Senate bills into their respective houses of Congress).

²⁶⁰ *Id.*

²⁶¹ *Id.* (“Members of Congress have introduced other bills in recent years . . . [but] the legislation was usually associated with one political party, Democrats. The bills did not gain traction.”).

²⁶² See *id.*

²⁶³ See Leslie Larson, *Republican Rep. Jaime Herrera Beutler Celebrates ‘Miracle’ Baby Girl Born with Potter’s Sequence*, N.Y. DAILY NEWS (July 29, 2013), <https://www.nydailynews.com/news/politics/republican-rep-jaime-herrera-beutler-celebrates-miracle-baby-girl-born-potter-sequence-article-1.1411714>.

²⁶⁴ See *Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S., Hearing Before the Subcomm. on Health of the Comm. on Energy & Commerce*, 115th Cong. 10 (2018) [hereinafter *Hearing on H.R. 1318*] (statement of Rep. Jaime Herrera Beutler) (“[T]he truth is that the available data is woefully inadequate, which greatly hinders our ability to understand why mothers are dying.”); *Hearing on H.R. 1318*, at 49 (statement of Stacey D. Stewart, President, March of Dimes) (“Our nation cannot prevent maternal mortality if we lack data about where and why it takes place.”); AMNESTY INT’L, DEADLY DELIVERY, *supra* note 71, at 87 (stating that a “lack of comprehensive data collection and effective systems to analyze the data is contributing to the failure to improve maternal health” and that the absence of good data “is masking the full extent of maternal mortality and morbidity in the USA and is hampering efforts to analyze and address the problems and so improve maternal health overall”); Martin, *supra* note 22 (describing the “shortage of reliable data about what kills American mothers” as “one of the most fundamental problems underlying the maternal mortality crisis in the United States”).

National Center for Health Statistics (NCHS) administers the first system, which uses information found on death certificates to identify deaths from pregnancy-related causes that occur during a woman's pregnancy, during childbirth, or up to forty-two days postpartum.²⁶⁵ Epidemiologists can usually identify pregnancy-related deaths by examining death certificates because states have included a "pregnancy checkbox" on their death certificates that allows a physician, coroner, or medical examiner to indicate that the deceased was recently pregnant.²⁶⁶ The other system is the Pregnancy Mortality Surveillance System (PMSS), which is the product of a collaboration between several state health departments and the Maternal Mortality Special Interest Group of the American College of Obstetricians and Gynecologists.²⁶⁷ Like NCHS's program, PMSS uses death certificates and the "pregnancy checkbox" to identify pregnancy-related deaths.²⁶⁸ Unlike NCHS's program, however, PMSS also identifies cases of maternal deaths through birth certificates or fetal death certificates that have been linked to a woman's death certificate.²⁶⁹ Additionally, PMSS considers a maternal death to be one that occurs *up to a year* postpartum.²⁷⁰

Most experts have concluded that NCHS and PMSS are incapable of producing the data that the nation needs to reduce the frequency of maternal deaths.²⁷¹ This is because the NCHS and PMSS

²⁶⁵ REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 9.

²⁶⁶ *Id.* at 10. Although the "pregnancy checkbox" allows for the identification of more pregnancy-related deaths than would be identified if the checkbox were not included on death certificates, a significant number of pregnancy-related deaths likely are still missed. Observers say that researchers would catch more of these deaths if they could link death certificates to birth certificates and/or fetal death certificates. *See* BLACK MAMAS MATTER, *supra* note 40, at 58–59 ("Studies have found that pregnancy-related deaths are substantially underestimated when cases are identified through death certificates alone, and that linking records lowers the number of missed cases."). Notably, this is the method for identifying cases of maternal mortality that the Pregnancy Mortality Surveillance System has adopted. *See* REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 9–10.

²⁶⁷ Creanga, *Maternal Mortality*, *supra* note 2, at 297.

²⁶⁸ *See* REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 9.

²⁶⁹ *See id.* Some maternal deaths may come to the attention of PMSS through media searches. *See* Creanga, *Maternal Mortality*, *supra* note 2, at 297 (stating that information on maternal deaths occasionally comes to PMSS through "computerized media searches using key terms in Lexis Nexis").

²⁷⁰ *See* REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 9.

²⁷¹ *See* Trude A. Bennett & Melissa M. Adams, *Safe Motherhood in the United States: Challenges for Surveillance*, 6 MATERNAL & CHILD HEALTH J. 221, 225 (2002) ("Surveillance can provide the basis for the research and public health actions that are needed for improvement, but current surveillance methods are inadequate.").

must rely on the limited information contained in a death certificate in order to attempt to understand why an individual death occurred. Death certificates communicate the reasons for a death through the International Classification of Diseases (ICD) codes, which allow a physician, coroner, or medical examiner to identify what she believes to be the cause of an individual's death.²⁷² However, the ICD codes lack “diagnostic nuance.”²⁷³ Further, they do “not communicate the interconnected stressors and system failures, often community-specific, that contributed to a particular maternal death.”²⁷⁴ The incomplete nature of the data that NCHS and PMSS receive limits the quality of the review that these bodies can conduct. As a result, these national-level surveillance systems can only identify disparities and trends; they are incapable of answering the more difficult question of *why* women are dying and what could be done to prevent these deaths.²⁷⁵

Further, the existing national-level surveillance systems likely miss many cases of maternal mortality.²⁷⁶ While the introduction of the “pregnancy checkbox” undeniably allows NCHS and PMSS to identify more maternal deaths, the fact that both surveillance systems operate at the national level—as opposed to a state or local level—increases the likelihood that they will overlook some pregnancy-related deaths. If effective surveillance is to take place at a national level, it would be through a system that could compel states to provide detailed information about every maternal death and that analyzes the

²⁷² See Donna L. Hoyert, Sayeedha F.G. Uddin & Arialdi M. Miniño, *Evaluation of the Pregnancy Status Checkbox on the Identification of Maternal Deaths*, 69 NAT'L VITAL STAT. REP. 1, 15 (2020). The pregnancy-related causes of death that can be identified through ICD codes are “hemorrhage, infection/sepsis, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders of pregnancy, anesthesia complications, cerebrovascular accidents, cardiomyopathy, cardiovascular disease, and noncardiovascular medical conditions.” Creanga, *Maternal Mortality*, *supra* note 2, at 297.

²⁷³ YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 56.

²⁷⁴ *Id.*

²⁷⁵ See REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 55 (identifying state- and local-level MMRCs as the “gold standard” for review and prevention).

²⁷⁶ The problem of missing maternal deaths was even more pronounced prior to the advent of the “pregnancy checkbox” on death certificates. One study estimates that while the checkbox allows for the identification of ninety-eight percent of all maternal deaths, researchers identified only sixty-two percent of such deaths before the introduction of the checkbox. See Hirshberg & Srinivas, *supra* note 91, at 333. Another study concludes that some thirty percent of pregnancy-related deaths would go uncounted without the checkbox. See *id.*

data with an eye towards identifying interventions that could prevent future deaths.²⁷⁷ Such a system does not exist in the United States.²⁷⁸

Even if the government created a national system with these elements, most experts agree that it simply would not be as good as state-level efforts to compile and analyze data about pregnancy-related deaths. The assumption is that local bodies are in a much better position than a national body to generate a nuanced, contextual understanding of a maternal death and, as such, are better able to identify the interventions that need to be made to prevent similar maternal deaths from happening in the future. These local bodies are state MMRCs.²⁷⁹

MMRCs, which experts have described as the “gold standard” for analyzing maternal deaths,²⁸⁰ consist of a multidisciplinary group of professionals with expertise that relates to maternal health: obstetricians, nurse practitioners, midwives, doulas, hospital administrators, epidemiologists, mental health experts, community members, and

²⁷⁷ See BLACK MAMAS MATTER, *supra* note 40, at 27 (“[T]here is no nationwide standard or system to compel, collect, and analyze high-quality, comprehensive data on maternal deaths and complications.”).

²⁷⁸ A national program for reviewing individual cases of maternal mortality exists in the UK. See Ozimek & Kilpatrick, *supra* note 28, at 181. This program, called Confidential Enquiries into Maternal Deaths, has been quite successful at reducing maternal deaths—despite the fact that it operates on a national level. See Kate Womersley, *Why Giving Birth Is Safer in Britain Than in the U.S.*, PROPUBLICA (Aug. 31, 2017), <https://www.propublica.org/article/why-giving-birth-is-safer-in-britain-than-in-the-u-s> (commenting on the success of the UK’s approach). The efficacy of the program may be tied to the fact that the UK, unlike the United States, has a nationalized, single-payer healthcare system. Experts caution that the success of a similar system in the United States could be hampered if it does not address other “non-medical determinants” of health outcomes, like race and income. See JOHN BAUER, C. HICKS & R. CASSELMAN, WASH. STATE INST. FOR PUB. POLICY, SINGLE-PAYER AND UNIVERSAL COVERAGE HEALTH SYSTEMS: FINAL REPORT 6, 12, 38 (2019) (“Adopting a single-payer or universal coverage system of health care without addressing underlying risk factors may not allow the US to achieve the health outcomes attained in other high-income countries.”). The Confidential Enquiries into Maternal Deaths program requires hospitals and providers to report all maternal deaths to a central database. See Ozimek & Kilpatrick, *supra* note 28, at 181. After the program administrators obtain full medical records, a pathologist and obstetrician confirm a cause of death. See *id.* A multidisciplinary committee of experts then reviews the care that the woman received. See *id.* A separate committee writes a report that highlights themes that emerged from analysis of the case. See *id.* If experts believe that it is possible to make effective interventions in light of the case, they design them with the committee’s report in mind. See *id.*

²⁷⁹ See REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 6 (stating that state and local MMRCs “are best positioned to comprehensively assess maternal deaths and identify opportunities for prevention”); YALE GLOB. HEALTH JUSTICE P’SHIP, *supra* note 40, at 13 (“[State] MMRCs can carry out on-the-ground inquiries on incidences of maternal death, develop case-level context-specific narratives in addition to raw data, and help create policies that respond to state-specific needs.”).

²⁸⁰ See Creanga, *Maternal Mortality*, *supra* note 2, at 297.

mothers.²⁸¹ The committee conducts an in-depth investigation into every maternal death. The point of the investigation is to look beyond the clinical factors that may have led to the death—although these clinical factors remain an important part of the inquiry.²⁸² The MMRC’s focus is supposed to be broader—analyzing the healthcare system that dispensed the care, the quality of the hospital that provided the care, the accessibility of providers to the pregnant woman, and the social context in which a woman lived.²⁸³ At the end of the investigation, the answer to the question of why a woman died should go beyond an answer of “she suffered from cardiomyopathy” or “she developed sepsis.” Instead, the MMRC ideally has put itself in a position to identify as factors in a death phenomena that exceed the strictly medical—like the distribution of hospital facilities in an area, poor communication within a hospital or between hospitals, a hospital’s failure to implement policies or practices regarding treatment regimens for women presenting with certain symptoms,²⁸⁴ or the premature termination of postpartum care at eight weeks after birth. In this way, after analyzing a pregnancy-related death, MMRCs should

²⁸¹ *Hearing on H.R. 1318, supra* note 264, at 64 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative).

²⁸² See Cynthia S. Shellhaas, Julia Zaharatos, Linda Clayton & Afshan B. Hameed, *Examination of a Death Due to Cardiomyopathy by a Maternal Mortality Review Committee*, 221 AM. J. OBSTETRICS & GYNECOLOGY 1, 1 (2019) (stressing the urgency of “[d]ocumenting both clinical and nonclinical contributors to maternal death”).

²⁸³ See U.N. High Comm’r for Human Rights, *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality*, U.N. Doc. A/HRC/21/22, at 17 (July 2, 2012) (“[R]eviews of all maternal deaths should be conducted routinely in order that lessons may be learned at all levels of the health system: from individuals’ behaviour and practices to national policies, and along the continuum of care from home to hospital.”); YALE GLOB. HEALTH JUSTICE P’SHP, *supra* note 40, at 59 (noting that international human rights bodies have directed the MMRCs that operate in countries across the globe to move “beyond the medical facts of each individual case [sic] to assess the health system as a whole, through asking questions about the distribution and quality of health facilities in a given region and exploring issues of access to those health facilities”); Yamin, *supra* note 42, at 98 (describing a maternal mortality review as a process “whereby individual deaths of women are investigated with the aim of promoting reflection on institutional and systemic failures as well as individual failures”). In the UK, observers describe MMRCs as performing a “social autopsy,” interviewing a range of individuals that have some connection to a maternal death, including “friends, family, and community members.” YALE GLOB. HEALTH JUSTICE P’SHP, *supra* note 40, at 59. The goal of the social autopsy is to identify the “social, behavioral, and health systems contributors to maternal and child deaths.” *Id.*

²⁸⁴ The maternal mortality review process in the UK was able to reduce the national incidence of deep vein thrombosis, or blood clots, after a thorough investigation of each individual case of the complication. See Bingham et al., *supra* note 35, at 191. The process culminated in improved assessment of risk for the complication and a recommendation of a prophylaxis, which have “led to fewer deaths from this cause.” *Id.*

have acquired the capacity to pinpoint “opportunities for systems change” that might save lives in the future.²⁸⁵

The twelve million dollars that the Preventing Maternal Deaths Act allocates annually is primarily designed to fund these state MMRCs.²⁸⁶ At the time of the passage of the Act, only thirty-six states had formed such committees.²⁸⁷ Moreover, due to a lack of funding, many of these thirty-six MMRCs were not operating fully.²⁸⁸ Congress intended the Preventing Maternal Deaths Act to support the creation of MMRCs in the states that had not yet organized them or had allowed the ones that existed to fall into desuetude.²⁸⁹

Moreover, Congress also intended the funds that the Preventing Maternal Deaths Act allots to states to address the great variability in the quality of the work that existing state MMRCs are doing. As ProPublica reports, some MMRCs are not very good, “rely[ing] on volunteers to do their work. They publish reports irregularly and, in some cases, do not address the issue of preventability at all.”²⁹⁰ While some MMRCs review all pregnancy-related deaths, others review only a sample of cases.²⁹¹ The Act responds to the inconsistency in the quality of state MMRCs by establishing guidelines for the work that these bodies perform.²⁹²

State MMRCs have the potential to greatly reduce the incidence of maternal mortality in the United States. Observers credit them with accomplishing that very goal in the United Kingdom. The Confidential Enquiries into Maternal Deaths program—which con-

²⁸⁵ BLACK MAMAS MATTER, *supra* note 40, at 61.

²⁸⁶ Martin, *supra* note 22.

²⁸⁷ *Hearing on H.R. 1318*, *supra* note 264, at 64 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative).

²⁸⁸ *Id.* Interestingly, there were more MMRCs in the past. In 1968, forty-five states had MMRCs. See YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 57. However, the number fell over the years—owing to the sense that as the maternal mortality ratio dropped, the problem had been solved. See *id.* There are also some indications that state MMRCs shuttered because there was a growing sense that the focus of medical, and societal, attention should be on the fetus, and not necessarily on the woman gestating the fetus. See *id.* By the year 2000, only twenty states had MMRCs. See *id.*

²⁸⁹ See *Hearing on H.R. 1318*, *supra* note 264, at 6 (statement of Rep. Greg Walden) (asserting that the bill would provide support for MMRCs in every state).

²⁹⁰ Martin, *supra* note 22.

²⁹¹ AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 89.

²⁹² See Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, § 2, 132 Stat. 5047, 5048 (codified at 42 U.S.C. § 247b-12 (2018)) (stating that MMRCs receiving federal funds must “include [a] multidisciplinary and diverse membership that represents a variety of clinical specialties” as well as “individuals or organizations that represent the populations . . . that are most affected by pregnancy-related deaths or pregnancy-associated deaths and lack of access to maternal health care services”); see *id.* § 2, 132 Stat. at 5049 (stating that MMRCs must be able to demonstrate to the CDC that they “use best practices to reliably determine and include all pregnancy-associated deaths and pregnancy-related deaths”).

ducts the detailed, yet broad-focused investigations into pregnancy-related deaths in the UK that state MMRCs would ideally conduct in the United States—has been responsible for

decreasing the already low maternal mortality in the United Kingdom via implementation of recommended clinical guidelines. More recently, the system has also been credited with narrowing the gap related to pregnancy outcomes and racial disparities, significantly lowering the maternal mortality among black African women. These positive changes occurred while the maternal population in the United Kingdom faces similar health challenges that face the United States, including an older and less healthy maternal population.²⁹³

Thus, the potential of the Preventing Maternal Deaths Act is great. However, there are profound limitations that have been built into the Act. The next Part discusses three. First, and most significantly, the Act insists upon *not* naming the racial character of the maternal mortality disaster in the United States. The Act commits a telling racial omission, prompting us to interrogate why this obfuscation came to be and the consequences thereof. Second, the Act fails to embed an allegiance to social justice into itself and, by association, the funds that will be dispensed to state MMRCs in accordance with it. This allows for the MMRCs that the Act commissions, funds, and supports to do work that is not at all in the interests of women at risk of dying during pregnancy, childbirth, or shortly thereafter. Third, the Act can be justifiably accused of fetishizing data. That is, the Act embodies a dangerous commitment to the idea that information, as opposed to action, will save us.

IV

CRITIQUES OF THE PREVENTING MATERNAL DEATHS ACT

A. *Racial Erasure*

One of the most remarkable aspects of the Preventing Maternal Deaths Act is its omission of the fact that the national shame that is maternal mortality in the United States is a *racial* one.²⁹⁴

²⁹³ Ozimek & Kilpatrick, *supra* note 28, at 181.

²⁹⁴ In many ways, the Preventing Maternal Death Act represents Congress's adoption of a colorblind lens to address a profoundly racial issue: *racial* disparities in maternal mortality. Insofar as this Article critiques this lamentable colorblindness, it joins a voluminous literature that is highly critical of colorblindness as a political and legal ideology. See, e.g., EDUARDO BONILLA-SILVA, *RACISM WITHOUT RACISTS: COLOR-BLIND RACISM AND THE PERSISTENCE OF RACIAL INEQUALITY IN AMERICA* (5th ed. 2018) (describing the wide array of "colorblind" arguments and narratives that are used to justify racial inequality); Devon W. Carbado & Cheryl I. Harris, *The New Racial Preferences*, 96 CALIF. L. REV. 1139, 1147–48 (2008) (arguing that colorblind admissions processes

Many scholars, activists, and observers who seek to bring attention to maternal mortality in the United States often point out that the country is doing much worse than other rich, industrialized nations when it comes to keeping pregnant women and new mothers alive.²⁹⁵ These thinkers and writers frequently underscore that the United States has the highest MMR of all of the developed nations.²⁹⁶ They emphasize that the MMR in the United States is even higher than some developing nations, a point that this Article explores above.²⁹⁷ However, the unquestionable reality is that if the United States eliminated racial disparities in maternal mortality—that is, if black women began to die from pregnancy-related causes as (in)frequently as white women—then the MMR in the United States would come to approximate the MMR of countries in the developed world.²⁹⁸ The United States is a deadly place for women to give birth in large part because it is a dangerous place for *black women* to give birth. The tragedy of maternal mortality in the United States is a profoundly racial tragedy.²⁹⁹

privilege white applicants over applicants of color because the former are less likely to think that their racial identities have played an integral part of their lives and experiences); Neil Gotanda, *A Critique of "Our Constitution Is Color-Blind,"* 44 STAN. L. REV. 1, 2 (1991) (asserting that "color-blind constitutionalism—a collection of legal themes functioning as a racial ideology—fosters white racial domination"); Ian F. Haney López, *"A Nation of Minorities": Race, Ethnicity, and Reactionary Colorblindness,* 59 STAN. L. REV. 985, 1062 (2007) [hereinafter Haney López, *"A Nation of Minorities"*] ("Colorblindness . . . protects and validates as 'not-racism' the actions of intentional discriminators who exercise the smallest modicum of caution as well as, much more significantly, the inertial persistence of entrenched patterns of racial hierarchy."); Ian Haney-López, *Intentional Blindness,* 87 N.Y.U. L. REV. 1779, 1832 (2012) ("The colorblind claim to oppose any government use of race is misleading, for in practice colorblindness opposes race-conscious remedies and nothing more."); Gary Peller, *Race Consciousness,* 1990 DUKE L.J. 758, 762 (1990) (arguing that "conservatives utilize the very rhetoric of tolerance, color-blindness, and equal opportunity that once characterized progressive discourse to mark the limits of reform").

²⁹⁵ See *supra* notes 28–32 and accompanying text.

²⁹⁶ See, e.g., *Hearing on H.R. 1318, supra* note 264, at 51 (statement of Lynne Coslett-Charlton, M.D., Pennsylvania District Legislative Chair, American College of Obstetricians and Gynecologists) ("We have higher maternal mortality rates than any other developed country.").

²⁹⁷ See *supra* Section II.A.

²⁹⁸ The MMR among white women in the United States is thirteen per 100,000 live births. Petersen, *Vital Signs, supra* note 26, at 424. The World Health Organization estimates that the global average MMR in high-income countries is eleven per 100,000 live births. WORLD HEALTH ORG., TRENDS IN MATERNAL MORTALITY 2000 TO 2017: ESTIMATES BY WHO, UNICEF, UNFPA, WORLD BANK GROUP AND THE UNITED NATIONS POPULATION DIVISION 89 (2019).

²⁹⁹ See S. Nadia Hussain, *Addressing Racial Disparities in Maternal Health,* LAW MARGINS <https://lawatthemargins.com/addressing-racial-disparities-in-maternal-health> (last visited May 31, 2020) ("The bottom line is that the high maternal death and

Nevertheless, the Preventing Maternal Deaths Act wholly obscures this reality. As obstetrician and activist Joia Crear-Perry observed in her congressional testimony in advance of the Act's passage, "[t]hroughout the bill there is no mention of race, racism, or racial disparities."³⁰⁰ The closest the Act gets to naming the racial nature of the catastrophe is when it states that, among the many reasons for its existence, it is intended "to eliminate disparities in maternal health outcomes for pregnancy-related and pregnancy-associated deaths."³⁰¹ In refusing to acknowledge that the disparities around maternal health outcomes that have garnered the media's attention and have been the focus of sustained advocacy are *racial* disparities, the Act allows itself to be understood as one that is about eliminating disparities of all kinds—between older mothers and younger mothers, between those who live in rural areas and those who live in more densely-populated locales, between those who have been pregnant only once and those who are multiparous, etc.³⁰²

Perhaps more disturbingly, it allows for the work that is conducted under its banner to ignore the race of the epidemic. Which is to say: there may be material consequences that flow from the Act's discursive framing of the issue. One particularly perverse consequence of the Act's racial erasure is that it may cause racial disparities in maternal mortality to *increase*. This perversion will happen if the interventions made as a result of the Act function to save white

complication rates in our nation cannot be sufficiently addressed without focusing on closing racial disparities . . .").

³⁰⁰ *Hearing on H.R. 1318, supra* note 264, at 65 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative).

³⁰¹ Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, p.mbl., 132 Stat. 5047, 5048 (codified at 42 U.S.C. § 247b-12 (2018)); *see also Hearing on H.R. 1318, supra* note 264, at 65 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative) (criticizing the colorblind nature of the Act).

³⁰² There may be an analogy to the use of the language of "diversity" in the affirmative action context: As Congress was only willing to speak about "disparities" in maternal health outcomes, although it (may have) had *racial* disparities in mind, institutions have only been willing to speak about "diversity," although they have *racial* diversity in mind. *See* Jed Rubenfeld, *Affirmative Action*, 107 *YALE L.J.* 427, 471 (1997) ("Everyone knows that in most cases a true diversity of perspectives and backgrounds is not really being pursued. . . . The purpose of affirmative action is to bring into our nation's institutions more blacks, more Hispanics, more Native Americans, more women, sometimes more Asians, and so on—period."); Antonin Scalia, *The Disease as Cure: "In Order to Get Beyond Racism, We Must First Take Account of Race,"* 1979 *WASH. U. L.Q.* 147, 148 (1979) ("When it comes to choosing among these manifold diversities in God's creation, . . . it is a safe bet that though there may not be a piano player in the class, there are going to be close to sixteen minority students.").

women while having no, or only a marginal, effect on the frequency of black maternal deaths.³⁰³

If a generalized effort to save pregnant women's lives benefits the most privileged, then those who are not privileged will continue to die at the same, or slightly reduced, rates.³⁰⁴ If those who are most privileged are white, and those who are unprivileged are not white, this would exacerbate racial disparities in maternal deaths. Indeed, there is precedent for this. Eighty years ago, black women were twice as likely as white women to die on the path to motherhood.³⁰⁵ Today, black women are close to four times as likely as white women to die during pregnancy, childbirth, or shortly thereafter.³⁰⁶ Although the frequency of maternal deaths has decreased over the past eighty years, racial disparities in maternal mortality have increased. This is due to the simple fact that interventions that we have made to save pregnant women have benefited white women the most.³⁰⁷

The lesson here is that *the inability or unwillingness to speak about race and racism risks making attempts to address the effects of racism ineffective*.³⁰⁸ As it applies to the sad state of black maternal health in the country, the inability to name race in the Preventing Maternal Deaths Act risks making attempts to address the effects of racism—that is, racial disparities in maternal mortality—unsuccessful. This is true even though the Preventing Maternal Deaths Act is likely

³⁰³ See *Hearing on H.R. 1318*, *supra* note 264, at 65 (statement of Joia Crear-Perry, M.D., Founder and President, National Birth Equity Collaborative) (“The [Act’s] inability to name [race, racism, or racial disparities] as a key focus to reduce RACIAL disparities in maternal mortality and morbidity will continue to exacerbate the problem.”); YALE GLOB. HEALTH JUSTICE P’SHP, *supra* note 40, at 23 (“Some strategies, if not reviewed with this critical lens, might be more politically feasible, but likely to ignore or increase racial disparities.”).

³⁰⁴ See YALE GLOB. HEALTH JUSTICE P’SHP, *supra* note 40, at 23 (identifying the unfortunate consequences of failing to prioritize the needs and experiences of the most marginalized, which occurs when “many interventions work to improve median health by benefiting only certain parts of the population, leaving the most marginalized untouched”).

³⁰⁵ See *supra* note 79 and accompanying text.

³⁰⁶ See *supra* note 81 and accompanying text.

³⁰⁷ This precise phenomenon—whereby efforts to reduce maternal mortality result in increases in *racial disparities* in maternal mortality—occurred in New York City. Black women in the city used to be just seven times more likely than white women to die from pregnancy-related causes; they are now twelve times more likely to die. See N.Y.C. DEP’T OF HEALTH & MENTAL HYGIENE, PREGNANCY-ASSOCIATED MORTALITY: NEW YORK CITY, 2006–2010, at 5. Crucially, “[t]he increasing gap was largely driven by a 45% decrease in pregnancy-related mortality among White, non-Hispanic women.” *Id.* White women disproportionately benefited from the efforts that New York City made to reduce maternal deaths, which had the effect of increasing racial disparities in maternal mortality in the city.

³⁰⁸ Of course, there is the very valid question of whether it is even accurate to describe the Preventing Maternal Deaths Act as an “attempt to address the effects of racism.”

a product of the increased attention that society has given to maternal mortality as a *racialized* problem. The Preventing Maternal Deaths Act is the result of racial inequities having brought attention to the issue of maternal mortality in the country. Nevertheless, in eliding the racial dimensions of the phenomenon, the Act threatens to exacerbate the racial inequities. The irony is profound.

It may be that the authors of the Preventing Maternal Deaths Act ignored the race of the maternal health debacle in the United States in order to affirm that maternal mortality is not “about” race—that it is a deracialized issue. However, as argued above,³⁰⁹ maternal mortality is already profoundly racialized, as evidenced by the statement that “it” (i.e., a problem of the nonwhite, developing world) should not be happening “here” (i.e., in the white, developed United States).³¹⁰ Had the architects of the Preventing Maternal Deaths Act acknowledged race, they might have affirmed their desire to save black lives. In ignoring race, they only managed to affirm their belief that a phenomenon from the nonwhite world has no place in the United States. The discursive chasm between these two possibilities is immense.

The erasure of race in the Preventing Maternal Deaths Act likely explains why the law was “bipartisan.” Inattention to the fact that the United States is a dangerous place for *black* women to give birth probably accounts for why it was easy for lawmakers to reach across the aisle and find a point of agreement with lawmakers who share different political commitments.³¹¹

³⁰⁹ See *supra* Section II.A.

³¹⁰ Notably, supporters of the Preventing Maternal Deaths Act publicly made this statement. See Ungar, *supra* note 185 (quoting the sponsor of the Preventing Maternal Deaths Act, Rep. Jaime Herrera Beutler, saying, “[t]he numbers [of maternal deaths] are staggering. This is not the developing world. This is the United States of the America”).

³¹¹ While, as this Section argues, this racial elision does not bode well for the Act actually reducing or eliminating racial disparities in maternal mortality, it also indicates the persistence of the phenomenon whereby things that are identified with people of color are politically unpopular or unsupportable. Much work has been done on the racialization of “welfare.” See generally MARTIN GILENS, *WHY AMERICANS HATE WELFARE: RACE, MEDIA, AND THE POLITICS OF ANTIPOVERTY POLICY* (1999). Because many, if not most, associate “welfare” with black people, “welfare” is extremely unpopular. See *id.* The likelihood that there would be a bipartisan law—supported unanimously in both houses of Congress—that involves “welfare” is woefully minuscule in large part because “welfare” is understood as a racial issue, and history has demonstrated the difficulty of building a political consensus around issues that are “about” race. See, e.g., Desmond S. King & Rogers M. Smith, *On Race, the Silence Is Bipartisan*, N.Y. TIMES (Sept. 2, 2011), <https://www.nytimes.com/2011/09/03/opinion/on-race-the-silence-is-bipartisan.html> (describing how, “[s]ince the end of legal segregation in the 1960s, there have been two approaches to ameliorating racial inequality,” one championed by “[c]onservatives and most Republican politicians” and the other supported by “[l]iberals and most Democratic politicians”).

Ignoring the racial dimensions of the maternal health tragedy in the United States facilitated its depoliticization,³¹² which, in turn, was key to the passage of the Preventing Maternal Deaths Act. The country now evidences a will to know more about maternal deaths in the country. The country might have refused to produce any knowledge around why women are finding the path to motherhood a particularly dangerous road to travel. That is, the government might have embraced a “will not to know” in the context of maternal mortality. This “will not to know” would find precedent in at least one other context: officer-involved homicides. Indeed, the government has decided not to know the number of civilians killed by the police and the circumstances surrounding their deaths.³¹³

The following Section explores the government’s commitment not to know more about officer-involved homicides. The exploration demonstrates the consequences of a failure to achieve the depoliticization of maternal mortality. Officer-involved homicides demonstrate that information—the mere collection of data—can be a political act. It is because of the particular politicization—indeed, the racialization—of police use of force that the government has committed itself to ignorance about this issue.

In the context of officer-involved homicides, we see the incredible stakes of the Faustian bargain that those working to eliminate the frequency of pregnancy-related deaths faced. Had these advocates insisted upon centering the *racial* nature of the maternal health tragedy in any congressional effort to address it, the effort likely would have died a brutal, partisan death in the halls of Congress. So, they acquiesced to a racial erasure. However, while this acquiescence might have enabled the congressional effort to address maternal mortality to become law, the racial erasure presages the inability of the

³¹² It is inaccurate to say that ignoring the racial dimensions of the sad state of maternal health in the United States—that is, approaching the issue through a colorblind lens—functions to “depoliticize” the issue. This is because colorblindness is itself a political strategy. See Haney López, “*A Nation of Minorities*,” *supra* note 294, at 1062 (noting that colorblindness has been deployed to protect the race-neutral processes that produce and reiterate racial inequality and hierarchy). More accurately, ignoring the racial dimensions of maternal mortality in this country allowed the issue to be politicized in a particular way—one that was acceptable to politicians with variable political commitments.

³¹³ It may be that when the aggrieved parties are white—or are imagined to be white—the government develops a “will to know” the phenomenon. See, e.g., Yuvraj Joshi, *Measuring Diversity*, 117 COLUM. L. REV. ONLINE 54, 56, 60 (2017), <https://columbialawreview.org/wp-content/uploads/2017/03/Joshi-vFinal-031317-2.pdf> (noting that when “typically white applicants . . . are denied admission . . . and bring cases that challenge racial preferences in college admissions, . . . their political resistance becomes inscribed into law,” and the Court develops a “concern with numbers,” demanding that colleges and universities measure the levels of diversity that their race-conscious programs achieve).

law to be an effective tool in the fight against a *racial* injustice, as argued above. In essence, the phrase “damned if you do, damned if you don’t” ably describes the situation that activists for black maternal health encountered.

1. *What Officer-Involved Homicides Can Teach Us About the Politics of Racial Erasure*

Officer-involved homicides present a revealing analogy to the maternal mortality context. As explored below, observers have claimed that collecting data about maternal deaths is the “first step” towards preventing pregnancy-related deaths.³¹⁴ Similarly, observers who believe that police violence is a problem have also claimed that collecting data about officer-involved homicides is the “first step” towards preventing these deaths.³¹⁵ As Ben Brucato writes,

there is a sense that better methods of collecting, analyzing, and reporting on use-of-force incidents is a necessary early step to fulfill prior to intervention. [Many] treat the problem of police violence as a knowledge problem. Data is treated as offering some unique access to certain knowledge, without which neither governments nor publics could legitimately act to intervene. Among those in government, academics, journalists, and many activists, police use of force is a social problem to be resolved through better data collection, analysis, and reporting. This discursive maneuver articulates a view of transparency in which *databases enable and legitimate social and political action*. By implication, this work also functions to communicate that action may be illegitimate without recourse to data.³¹⁶

³¹⁴ See discussion *infra* notes 373–75 and accompanying text.

³¹⁵ See Trymaine Lee & Safia Samee Ali, *Why Doesn't the Government Track Nationwide Police Use of Force?*, NBC NEWS (Nov. 14, 2016, 4:46 AM), <https://www.nbcnews.com/news/us-news/why-doesn-t-government-track-nationwide-police-use-force-n682626> (quoting a civil rights attorney as saying “the more data you have, the more evaluations and judgments you can make on reform” and “[w]ithout [data] you’re at a loss”); *id.* (quoting an advocate for police reform as saying “[y]ou can’t fix what you can’t measure”); Tom McCarthy, *The Uncounted: Why the US Can’t Keep Track of People Killed by Police*, GUARDIAN (Mar. 18, 2015), <https://www.theguardian.com/us-news/2015/mar/18/police-killings-government-data-count> (noting that a government count of the number of deaths “that happened in the presence of a local or state law enforcement officer,” “was more than a count of killings by police,” as “[i]t was meant to be the elusive key to a problem”); *id.* (noting that after the uprising in Ferguson that occurred after a police officer killed Michael Brown, then-President Obama “spoke of the ‘need to collect more data’”); Brian Karl Finch, *Police Homicides in the United States*, U. SOUTHERN CAL. SCHAEFFER: THE EVIDENCE BASE (May 2, 2018), <https://healthpolicy.usc.edu/evidence-base/police-homicides-in-the-united-states> (“The first step in reducing police homicides was to document the extent of the problem.”).

³¹⁶ Ben Brucato, *Big Data and the New Transparency: Measuring and Representing Police Killings*, 4 BIG DATA & SOC. 1, 3–4 (2017) (emphasis added).

Currently, the government does not collect systemic data about officer-involved homicides. There is no doubt that the government *could* collect this data if it wanted to. Commentators have observed that the government collects robust, complete data on an assortment of issues, ranging from the significant—like the number of people who have died from pneumonia, influenza, measles, malaria, mumps, and Hepatitis A³¹⁷—to the not-so-significant. As colorfully described in *The Guardian*:

The federal government counts many things well. . . . It counts the average number of hours American men spend weekly on lawn care (almost two). It counts the monthly production of hens' eggs (8.31bn in November). It counts nut consumption by non-Hispanic white men over the age of 20 (42.4% enjoyed nuts on any given day in 2009-2010).³¹⁸

Accordingly, the government's failure to engage in systemic data collection on the issue of officer-involved homicides is not an issue of capability but of will. Notably, the government has compiled accurate statistics about the number of police officers killed in the line of duty; in telling contrast, no reliable government-produced statistics exist about the number of civilians killed by the police.³¹⁹

It is stating the obvious to observe that the question of police use of force is politicized.³²⁰ This is true, in large part, because the issue is

³¹⁷ See Nancy Krieger, Jarvis T. Chen, Pamela D. Waterman, Mathew V. Kiang & Justin Feldman, *Police Killings and Police Deaths Are Public Health Data and Can Be Counted*, 12 PLOS MED. 1, 2 (Dec. 8, 2015).

³¹⁸ McCarthy, *supra* note 315; see also Lee & Ali, *supra* note 315 (“Even in an age of exhaustive monitoring of everything from public school competency to national park attendance, there is no single government agency tasked with collating data on how often police injure citizens.”).

³¹⁹ See Krieger et al., *supra* note 317, at 1–2 (“[A]lthough the number of US law enforcement agents killed in the line of duty is well documented . . . no reliable official data exist on the number of US persons killed by the police.”); see also James Bovard, *Under Four Presidents, the Feds Neglected Duty to Collect Statistics on Police Killings*, USA TODAY (June 11, 2020, 1:23 PM), <https://www.usatoday.com/story/opinion/2020/06/11/george-floyd-police-killings-violence-neglected-federally-column/5320501002> (noting that despite legislative attempts to collect data on officer-involved homicides, such as the Violent Crime Control and Law Enforcement Act and the Death in Custody Reporting Act, “[f]ederal criminal neglect of police killings has continued for more than 25 years under both Democratic and Republican administrations”).

³²⁰ See, e.g., Anna Brown, *Republicans More Likely than Democrats to Have Confidence in Police*, PEW RES. CTR.: FACT TANK (Jan. 13, 2017), <https://www.pewresearch.org/fact-tank/2017/01/13/republicans-more-likely-than-democrats-to-have-confidence-in-police> (finding that about three-quarters of Republicans believe that police are “using the right amount of force for each situation” while only about a quarter of Democrats agree). The killing of George Floyd by the police has made the politicization of police use of force all the more obvious. See Paul Kane & John Wagner, *Democrats Unveil Broad Police Reform Bill as Floyd's Death Sparks Protests Nationwide*, WASH. POST (June 9, 2020, 10:24 AM), <https://www.washingtonpost.com/powerpost/democrats-unveil-broad-police-reform-bill->

racialized. Society has come to understand the phenomenon of officer-involved homicides as one that is about the deaths of unarmed black men at the hands of white police officers.³²¹ (This is true although black women, too, are often killed by police.³²²) The most familiar names of the victims of officer-involved homicides all, or mostly, belong to black men (or boys): Michael Brown, Philando Castile, Alton Sterling, Stephon Clark, Tamir Rice, Freddie Gray, and George Floyd.³²³ The racialization of officer-involved homicides has politicized the phenomenon. Where one stands on the issue of officer-

pledge-to-transform-law-enforcement/2020/06/08/1ed07d7a-a992-11ea-94d2-d7bc43b26bf9_story.html (contrasting Democrat and Republican responses to police reform); Claudia Grisales, Kelsey Snell & Susan Davis, *Senate Democrats Block GOP Police Reform Bill*, NPR (June 24, 2020, 12:58 PM), <https://www.npr.org/2020/06/24/882530458/democrats-vow-to-block-gop-police-reform-bill-unless-republicans-agree-to-negoti> (“[T]he GOP bill does not outlaw chokeholds, neck holds, carotid holds or other maneuvers, an area where Democrats are not willing to bend.”).

³²¹ See, e.g., Devon W. Carbado & L. Song Richardson, *The Black Police: Policing Our Own*, 131 HARV. L. REV. 1979, 1989 (2018) (reviewing JAMES FORMAN JR., *LOCKING UP OUR OWN: CRIME AND PUNISHMENT IN BLACK AMERICA* (2017)) (“Discussions about race and policing almost always have as their predicate the idea that the agents of racial profiling and police violence are white.”); L. Song Richardson, *Police Racial Violence: Lessons from Social Psychology*, 83 FORDHAM. L. REV. 2961, 2961–62 (2015) (“[P]olice killing [of] unarmed black men has brought national attention to the persistent problem of policing and racial violence. . . . Data reported to the FBI indicate that white police officers killed black citizens almost twice a week between 2005 and 2012.”).

³²² See generally KIMBERLÉ WILLIAMS CRENSHAW & ANDREA J. RITCHIE WITH RACHEL ANSPACH ET AL., CTR. FOR INTERSECTIONALITY & SOC. POLICY STUDIES, AFR. AM. POLICY FORUM, *SAY HER NAME: RESISTING POLICE BRUTALITY AGAINST BLACK WOMEN* (2015). While numerous examples abound of black women dying at the hands of police and, as compared to black men, receiving little to no justice or wide-scale public outcry, recent police killings acutely expose this disparity. The death of George Floyd sparked global protests and resulted in the relatively swift firing and criminal charging of the four officers involved. *Protests Across the Globe After George Floyd’s Death*, CNN: WORLD (last updated June 13, 2020, 3:22 PM), <https://www.cnn.com/2020/06/06/world/gallery/intl-george-floyd-protests/index.html>; Rich Shapiro, *How the Officers Charged in George Floyd’s Death Could Get Their Jobs Back*, NBC (June 27, 2020, 6:01 AM), <https://www.nbcnews.com/news/us-news/how-officers-charged-george-floyd-s-death-could-get-their-n1232236> (noting the officers’ respective firings and criminal charges). Meanwhile, the three policemen who killed Breonna Taylor in her own home, as she lay sleeping, have yet to be criminally charged and only one has been fired to date. Anna North & Fabiola Cineas, *Protests Across the Globe After George Floyd’s Death*, VOX (July 13, 2020, 12:36 PM), <https://www.vox.com/2020/5/13/21257457/breonna-taylor-louisville-shooting-ahmaud-arbery-justiceforbreonna> (“The four officers involved in the killing of George Floyd were fired four days after Floyd’s death By contrast, not much has happened in Taylor’s case.”).

³²³ Sarah Almkhitar et al., *Black Lives Upended by Policing: The Raw Videos Sparking Outrage*, N.Y. TIMES, <https://www.nytimes.com/interactive/2017/08/19/us/police-videos-race.html> (last updated April 19, 2018) (collecting videos of police killings of, and violence against, unarmed black people); see *Breonna Taylor: Timeline of Black Deaths Caused by Police*, BBC (Sept. 23, 2020), <https://www.bbc.com/news/world-us-canada-52905408> (highlighting nine high-profile police killings since 2014, only one of which involves a black woman).

involved homicides—whether one thinks they represent racism at its most brutal or the unfair vilification of heroes who do not wear capes—evidences a political commitment.³²⁴

Because of the politicization of officer-involved homicides, society has come to understand that the choice to collect data about the issue is a political decision that *there is an issue*—that the number of people that police have killed is unacceptably high or that the police need to be monitored more closely. Gathering data about police killings has come to be a political claim that the police ought not to be left to police themselves—that outside entities ought to hold police officers and police departments accountable for their use of force.³²⁵ Accordingly, we can understand the government’s refusal to engage in data collection about this issue as an opposing political position. It is a position in which the government has sided with those on one side of the political divide—the side that believes that any scrutiny of the police is unadvisable, unwanted, and unnecessary.³²⁶

This is not to say that the government has made no overtures towards collecting data on police killings. The Bureau of Justice Statistics (BJS), Federal Bureau of Investigation (FBI), and Centers for Disease Control and Prevention all have had separate programs that have attempted to gather information about police use of force.³²⁷ However, the programs have all been inadequate, and the data that they have generated have been unreliable, as they all have depended either on police departments and states volunteering information about police use of force or on reports by medical examiners and coroners.³²⁸ The BJS ultimately abandoned its attempt to collect data on police use of force on account of the woefully incomplete

³²⁴ See, e.g., Dara Lind, *How “Blue Lives Matter” Went from a Reactive Slogan to White House Policy*, VOX (Feb. 9, 2017, 3:50 PM), <https://www.vox.com/policy-and-politics/2017/2/9/14562560/trump-police-black-lives> (noting the rise of a “culture war” between racial justice advocates and law enforcement).

³²⁵ See, e.g., Paul Kane & John Wagner, *Democrats Unveil Broad Police Reform Bill as Floyd’s Death Sparks Protests Nationwide*, WASH. POST (June 9, 2020, 10:24 AM), https://www.washingtonpost.com/powerpost/democrats-unveil-broad-police-reform-bill-pledge-to-transform-law-enforcement/2020/06/08/1ed07d7a-a992-11ea-94d2-d7bc43b26bf9_story.html.

³²⁶ See Lind, *supra* note 324 (discussing the “powerful” idea that “criticism of police officers puts their lives in danger,” which has been broadly supported by conservatives and has fueled the “Blue Lives Matter” response).

³²⁷ See McCarthy, *supra* note 315.

³²⁸ See *id.* (explaining that the BJS and FBI rely on police departments, localities, and states while the CDC looks to medical examiners and coroners); see also Brucato, *supra* note 316, at 2 (“[T]he Violent Crime Control and Law Enforcement Act of 1994 established a federal mandate for the collection and reporting on use of force by police in the United States. . . . [But] there are no requirements that local police departments provide requisite data.”).

information that it was receiving from the few police departments that elected to respond to its request for data.³²⁹ However, before calling off the project, the BJS had compiled enough information to conclude that the FBI's numbers on police killings were a substantial undercount.³³⁰ Indeed, in almost a decade's worth of data, the BJS estimated that the FBI was missing at least *half* of those whom the police have killed.³³¹

In 2014, as a partial response to the public outcry that the police killing of Michael Brown in Ferguson, Missouri sparked, Congress passed the Death in Custody Reporting Act of 2013 (DICRA).³³² DICRA reauthorized the Death in Custody Reporting Act of 2000, which required certain state agencies to report deaths that occur while an individual is in state custody,³³³ including, after 2003, arrest-related deaths.³³⁴ Expiring in 2006, this predecessor statute gave rise to the BJS's inconsistent and ultimately unsuccessful data-collection efforts, discussed above.³³⁵ In an effort to "restore" that earlier law,³³⁶

³²⁹ See McCarthy, *supra* note 315 ("With some states never participating, and major police departments such as the NYPD failing to report for some years, [BJS] statisticians were never satisfied with their data pool. In March of [2014], the bureau pulled the plug on the project . . .").

³³⁰ See *id.* ("[The BJS program] allowed the statisticians to estimate just how bad the FBI's numbers were.").

³³¹ See *id.* ("The FBI was counting fewer than half of homicides by police officers, BJS discovered. From 2003 to 2009, plus 2011, the FBI counted an average of 383 'justifiable homicides by law enforcement' each year. The actual number, as estimated by the BJS study, was closer to 928.").

³³² See Steve Horn, *Report Finds Lack of Reporting on Deaths in Law Enforcement Custody, Even After Landmark Legislation*, CRIM. LEGAL NEWS (July 17, 2019), <https://www.criminallegalnews.org/news/2019/jul/17/report-finds-lack-reporting-deaths-law-enforcement-custody-even-after-landmark-legislation> ("Passage of The Death in Custody Reporting Act of 2013 in December 2014 came in the aftermath of the shooting of Michael Brown, an unarmed black teen in Ferguson, Missouri. . . . In turn, some began calling it the 'Ferguson Bill.'").

³³³ See Deborah M. Golden, *Looking Behind the Locked Door: Prison Law Reform Proposals for the New Administration*, 3 HARV. L. & POL'Y REV. ONLINE 1, 7–8 (2008) ("Before it expired in 2006, the Act required state agencies that received federal funds to report basic information about any deaths that occurred while a person was in state custody."); Grace E. Leeper, Note, *Conditional Spending and the Need for Data on Lethal Use of Police Force*, 92 N.Y.U. L. REV. 2053, 2088 (2017) ("DICRA was first passed in 2000, but expired in 2006 and was not revived until 2013."); Bryan Schatz & Allie Gross, *Congress Is Finally Going to Make Local Law Enforcement Report How Many People They Kill*, MOTHER JONES (Dec. 17, 2014), <https://www.motherjones.com/politics/2014/12/death-custody-reporting-act-police-shootings-ferguson-garner> ("The bill . . . is the reauthorization of the original act, passed in 2000.").

³³⁴ See Schatz & Gross, *supra* note 333 ("[L]awmakers inserted a provision requiring tallies of arrest-related deaths in 2003.").

³³⁵ See Franklin E. Zimring, *How Many Killings by Police?*, 2016 U. CHI. LEGAL F. 691, 698–99, 706 (describing the predecessor statute's authorization of BJS to collect information about arrest-related deaths, and noting that, after the statute's expiration in

DICRA purported to require police departments to report to the Attorney General all cases in which an individual died while in police custody.³³⁷ While supporters of DICRA submitted that the law addressed the lack of high-quality information surrounding police use of force,³³⁸ DICRA, like all of the federal government's existing data collection programs, did not oblige police departments or individual states to send the Attorney General the relevant data. Instead, DICRA gave the Attorney General the *option* of withdrawing a small portion of the federal funds that states receive if they failed to comply with reporting requests.³³⁹ Indeed, one proposed (but unrealized) iteration of DICRA would have had the BJS supplement state-produced data with open-source information, suggesting a recognition of DICRA's inability to prompt complete reporting by states.³⁴⁰ What is more, implementation of data-gathering under DICRA has faced substantial delay, even though the statute itself requires implementation by 2016.³⁴¹ In 2018, after a transfer of responsibility from the BJS to

2006, the BJS's efforts became an "orphan program that was continued at lower visibility and effort"); Schatz & Gross, *supra* note 333 (discussing the Justice Department's failures to enforce the statute's penalties and incentivize states to file reports); *see also* OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, REVIEW OF THE DEPARTMENT OF JUSTICE'S IMPLEMENTATION OF THE DEATH IN CUSTODY REPORTING ACT OF 2013, at 10 (2018), <https://www.oversight.gov/sites/default/files/oig-reports/e1901.pdf> ("[A]n assessment of its historical Arrest-Related Death . . . Program indicated that BJS had been collecting only about 50 percent of all law enforcement homicides for its 2003–2009 and 2011 collections.").

³³⁶ OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, *supra* note 335 (stating that DICRA "restored and expanded" its predecessor statute).

³³⁷ *See* 34 U.S.C. § 60105(a) (2018); *see also* Lee & Ali, *supra* note 315 (suggesting the Act has not been effective in gathering information).

³³⁸ *E.g.*, Press Release, Congressman Bobby Scott, Senate Passes Death in Custody Reporting Act (Dec. 11, 2014), <https://bobbyscott.house.gov/media-center/press-releases/senate-passes-death-in-custody-act> (quoting Senator Richard Blumenthal's view that "[t]his legislation will fix that unacceptable factual gap [in reliable information]").

³³⁹ *See* 34 U.S.C. § 60105(c)(2) (2018) ("[A] State that fails to comply with subsection (a), shall, at the discretion of the Attorney General, be subject to not more than a 10-percent reduction of the funds"); *see also* 9to5, National Association of Working Women et al., Comment Letter on Proposed Implementation of Deaths in Custody Reporting Act (DICRA) 2 (Oct. 3, 2016), <https://www.amnestyusa.org/pdfs/DICRA%20Coalition%20Comments.pdf> (stating that DICRA only "gives the Attorney General the discretion to subject states that do not report deaths in custody to a ten percent reduction of Edward Byrne Memorial Justice Assistance Grant Program . . . funds").

³⁴⁰ *See id.* at 1–2 (stating that the proposed implementation of DICRA suggests that the BJS will "rely primarily upon publicly available information" like "news sources"); 81 Fed. Reg. 51,489, 51,490 (Aug. 4, 2016) (describing a redesigned BJS methodology which explicitly relies on "open sources"); OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, *supra* note 335, at 11 ("This methodology would use both open-source and local agency-reported data in an effort to increase the capture of reportable deaths.").

³⁴¹ *See* 34 U.S.C. § 60105(f)(2) (2018) (requiring the Attorney General to submit a report to Congress "[n]ot later than 2 years after December 18, 2014," detailing the

the Bureau of Justice Assistance (BJA),³⁴² the Department of Justice implemented a reporting program under DICRA that commentators have condemned for abandoning earlier, more robust proposals for assembling data (including the use of open-source data).³⁴³ Voluntary reporting under this program began in 2019³⁴⁴—three years after the deadline in the statute and five years after enactment—and there appear to be no plans to make the data public.³⁴⁵ To those holding the political view that police use of force is a problem, DICRA is wildly insufficient—a continuation of the government’s will not to know.³⁴⁶

It deserves underscoring that to date, DICRA still has not been fully implemented.³⁴⁷ Ultimately, the federal government has decided against using its spending powers to encourage individual police departments and states to provide information about how often and under what circumstances police officers kill someone.³⁴⁸ Observers

findings of a study of information gathered from states); OFFICE OF THE INSPECTOR GEN., U.S. DEP’T OF JUSTICE, *supra* note 335, at 10 (noting this delay).

³⁴² See OFFICE OF THE INSPECTOR GEN., U.S. DEP’T OF JUSTICE, *supra* note 335, at 11 (explaining that the switch was due, among other things, to an Office of Management and Budget requirement for “statistical agencies to operate separately from policy-making activities”); see also Ethan Corey, *How the Federal Government Lost Track of Deaths in Custody*, APPEAL (June 24, 2020), <https://theappeal.org/police-prison-deaths-data> (noting a “prohibit[ion] on the government from using BJS data for law enforcement purposes”).

³⁴³ See American Civil Liberties Union et al., Comments in Response to Notice Regarding “Agency Information Collection Activities; Proposed eCollection eComments Requested; New Collection: Death in Custody Reporting Act Collection,” at 3 (Aug. 29, 2018), https://www.aclu.org/sites/default/files/field_document/dcra_sign_on_9-28-18.pdf; Corey, *supra* note 342 (noting various commentators’ views that the implementation will prove ineffective); see also OFFICE OF THE INSPECTOR GEN., U.S. DEP’T OF JUSTICE, *supra* note 335, at 13–19 (listing numerous factors that could make data collection under the implementation “duplicative and incomplete”).

³⁴⁴ See BUREAU OF JUSTICE ASSISTANCE, U.S. DEP’T OF JUSTICE, DEATH IN CUSTODY REPORTING ACT PERFORMANCE MEASUREMENT TOOL – FREQUENTLY ASKED QUESTIONS 2 (2020), https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/DCRA-FAQ_508.pdf (noting that a state’s reporting obligations would begin in 2019); see also Bureau of Justice Assistance, *Edward Byrne Memorial Justice Assistance Grant (JAG) Program: Reporting Requirements*, U.S. DEP’T OF JUSTICE (Dec. 9, 2019), <https://bja.ojp.gov/program/jag/reporting-requirements> (“Beginning in FY 2019, BJA will require reporting from states pursuant to DCRA.”).

³⁴⁵ See BUREAU OF JUSTICE ASSISTANCE, U.S. DEP’T OF JUSTICE, *supra* note 344, at 3 (“The Office of Justice Programs will maintain this information internally, however some data may be subject to the Freedom of Information Act.”); Corey, *supra* note 342 (noting a BJA spokesperson’s recent statement that no such plans to make the data public exist).

³⁴⁶ See, e.g., Roxanne Ready, Hannah Gaskill & Nora Eckert, *Government Fails to Release Data on Deaths in Police Custody*, ASSOCIATED PRESS (June 19, 2019), <https://apnews.com/de404fd6795d4a61bc72c7df188eb9cd> (noting the concern of advocacy groups that “the lack of accountability is letting law enforcement officials off the hook”).

³⁴⁷ Kristina Roth, *Police Use of Excessive Force*, AMNESTY INT’L U.S., <https://2020electionscovid.amnestyusa.org/police> (last visited July 19, 2020).

³⁴⁸ See *New York v. United States*, 505 U.S. 144, 161–62, 171–73 (1992) (affirming that the Spending Clause allows Congress to encourage states’ regulation of hazardous waste).

have noted that the federal government could make federal funding contingent on police departments' compiling the relevant information and submitting it to the appropriate federal agencies.³⁴⁹ Alternatively, the federal government might provide funds to police departments to subsidize their efforts to compile the desired information. Indeed, observers have noted that some police departments may have failed to participate in the federal government's information collection efforts because it would have been financially burdensome to do so.³⁵⁰ However, the federal government has done neither—leaving the data that it collects about police killings radically incomplete as well as sending a clear message about where it stands on the political question of the “problem” of police use of force.³⁵¹

To return to the issue of maternal mortality, political support of the Preventing Maternal Deaths Act likely depended on its refusal to name the racial dimensions of this country's maternal health catastrophe. The Act's very passage might have depended on its attempt to deracialize maternal mortality—an attempt at deracialization that might have functioned to depoliticize the issue. A pragmatist may argue that this un-naming is defensible. And in light of the lessons taught by the government's will not to know much about the profoundly racialized issue of officer-involved homicides, the pragmatist certainly has a point.³⁵² The racialization, and consequent politiciza-

³⁴⁹ See 9to5, National Association of Working Women et al., *supra* note 339, at 1 (requesting “that the Office of Justice Programs . . . condition federal criminal justice grants on data collection and reporting on police-community encounters”).

³⁵⁰ See Brucato, *supra* note 316, at 2 (“In 2011, FBI spokesperson William Carr claimed . . . that budgetary and practical factors would prohibit police officers and agencies from collecting the data.”); McCarthy, *supra* note 315 (stating that Georgia, Montana, and Maryland refused to participate in the BJS's data collection program because participation “could mean extra work and compliance headaches” and stating that “Washington DC dropped out of the program as resources and willpower dwindled”).

³⁵¹ It is worth noting that the death of George Floyd, and the mobilization it has inspired, has resulted in an unprecedented focus on police use of force by both political parties. See JOANNA R. LAMPE, CONG. RESEARCH SERV.: LEGAL SIDEBAR, COMPARING POLICE REFORM BILLS: THE JUSTICE IN POLICING ACT AND THE JUSTICE ACT 1, 2, 4 (2020), <https://crsreports.congress.gov/product/pdf/LSB/LSB10498> (describing subjects covered by both Democratic and Republican bills as including, among others, “[l]imitations on chokeholds and other uses of force” and “[r]eporting on use of force”).

³⁵² Officer-involved homicides and maternal mortality share another similarity: As noted below, there are compelling arguments that we already know how to prevent pregnancy-related deaths. See *infra* Section IV.C. Similarly, there are compelling arguments that we *already know* how to prevent officer-involved homicides. Indeed, scholars have devoted much time and effort to examining the legal determinants of police violence—that is, how the laws concerning when and how police can engage with citizens enable deadly police encounters. See, e.g., Devon W. Carbado, *Blue-on-Black Violence: A Provisional Model of Some of the Causes*, 104 GEO. L.J. 1479 (2016) (advancing a multipart model that accounts for how social and legal forces enable and perpetuate police violence against black people); Devon W. Carbado, *From Stopping Black People to Killing Black*

tion, of an issue may be the equivalent of a death knell for congressional action. To the extent that attempting to erase race from the fact of maternal mortality in the United States achieved its depoliticization, then this racial erasure breathed life into the Preventing Maternal Deaths Act. However, as argued above, there is a compelling argument to be made that the Act's racial erasure will function to make it an ineffectual tool in the effort to eliminate *racial disparities* in maternal mortality. Again, the inability to speak about racism oftentimes makes attempts to address the effects of racism ineffective.

Further, there is a compelling argument to be made, and critical race theorists have made it often, that the nation's refusal to name race functions to perpetuate racial inequities and injustices in the post-Civil Rights present.³⁵³ If so, then we should expect that the racial un-naming that the Preventing Maternal Deaths Act performs will function to maintain existing racial stratification.

People: The Fourth Amendment Pathways to Police Violence, 105 CALIF. L. REV. 125 (2017) (explaining how Fourth Amendment doctrine creates preconditions for police violence against, and police killings, of black Americans); Stephen Rushin, *Federal Enforcement of Police Reform*, 82 FORDHAM L. REV. 3189, 3192–94 (2014) (examining how the DOJ has underenforced a federal regime for promoting structural police reform through pattern-or-practice litigation). Scholars have also explored how the failure to hold police accountable for injuring and killing citizens—inasmuch as the federal government does not monitor police departments' use of force and juries very rarely hold individual officers legally responsible for the force they use—allows for the status quo to continue. See, e.g., Joseph B. Richardson, Christopher St. Vil & Carnell Cooper, *Who Shot Ya? How Emergency Departments Can Collect Reliable Police Shooting Data*, 93 J. URB. HEALTH S8, S10 (2015) (“[T]he Department of Justice keeps no comprehensive database or record of police shootings from the roughly 18,000 law enforcement departments in [sic]USA.”); Kate Levine, *Who Shouldn't Prosecute the Police*, 101 IOWA L. REV. 1447, 1464–65 (2016) (describing the “already-existing statutory and credibility barriers” that contribute to “why so few officers are indicted, let alone convicted, of criminal acts”). Just as we might argue in the context of maternal deaths that the problem is not one of knowledge, but rather the *will* to organize society differently, we might make the same argument in the context of police killings. In light of recent officer-involved homicides, like those of George Floyd, Breonna Taylor, Tony McDade, Rayshard Brooks, and countless others, this argument becomes all the more cogent.

³⁵³ Khiara M. Bridges, *Class-Based Affirmative Action, or the Lies that We Tell About the Insignificance of Race*, 96 B.U. L. REV. 55, 58–60, 94–97 (2016) (discussing the use of class-based affirmative action to deny the reality of continued racial inequity). In the context of admissions to colleges and universities, for example, critical race theorists have observed that aversion to naming race functions to perpetuate racial inequity in that process. See *Introduction to CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT*, at xiii, xiv–xvi, xxix (Kimberlé Crenshaw, Neil Gotanda, Gary Peller & Kendall Thomas eds., 1995). (“[C]ertain conceptions of merit function not as a neutral basis for distributing resources and opportunity, but rather as a repository of hidden, race-specific preferences for those who have the power to determine the meaning and consequences of ‘merit.’”). Furthermore, the failure to address race bolsters the popular conception that the “current distribution of access, power, privilege, and disadvantage is just the way things are.” Kimberlé Crenshaw, *The Court's Denial of Racial Societal Debt*, 40 HUM. RTS. 12, 12–13 (2013).

B. The Political Agnosticism of the Preventing Maternal Deaths Act and the Variable Political Commitments of State MMRCs

That a state has an MMRC should not be taken as unimpeachable evidence that the state has pregnant women's best interests at heart. If the state directs the MMRC that it establishes to engage in a wide-ranging investigation into how social structures and institutions interacted with individual behavior to produce a maternal death, then the MMRC will do the work that advocates for better maternal health outcomes believe needs to be done to bring the United States' MMR down to defensible levels. If, however, the state provides limited direction to its MMRC, it leaves the political commitments of those who staff the committee to inform the work that the committee does. In that case, there are no assurances that the MMRC will do the critical work that will preserve women's lives. Notably, there is nothing in the Preventing Maternal Deaths Act demanding that the state MMRCs that the Act funds do this critical work.

The Congress that passed the Preventing Maternal Deaths Act knew perfectly well how to direct MMRCs to pay attention to the things that it thought important. Consider the issue of confidentiality. The Act takes care to require that MMRCs that participate in the program establish guidelines for the confidentiality of the review process.³⁵⁴ It requires MMRCs to "develop a process" that allows for healthcare providers, medical examiners, family members, and other affected persons to confidentially report the deaths of women from a pregnancy-related cause.³⁵⁵ Additionally, it obligates states to "establish confidentiality protections" that ensure that identifying information about women who died from pregnancy-related causes and "information from committee proceedings" are not made public.³⁵⁶ These provisions were likely included because the authors of the Act understood that confidentiality is essential to the process of reviewing maternal deaths. Individuals and institutions who provide obstetrical care to pregnant women may not be supportive or responsive to the requests of MMRCs if they fear that an MMRC review might open them up to litigation and liability.³⁵⁷ A confidential review process may provide the assurance that many need if they are to back the work that an MMRC does in a state and to comply with an investiga-

³⁵⁴ See Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, sec. 2(5), § 317K(d)(2), 132 Stat. 5047, 5049 (codified at 42 U.S.C. § 247b-12(d)(2) (2018)).

³⁵⁵ *Id.* sec. 2(5), § 317K(d)(2)(A)–(B), 132 Stat. at 5049.

³⁵⁶ *Id.* sec. 2(5), § 317K(d)(4), 132 Stat. at 5050.

³⁵⁷ See AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 89 (acknowledging this risk).

tion that an MMRC conducts.³⁵⁸ Prior to the Preventing Maternal Deaths Act, some states with MMRCs had no such confidentiality protections.³⁵⁹ Congress took aim at this flaw, making explicit its understanding that confidentiality is an essential aspect of an effective maternal mortality review process.

With this in mind, what are we to make of the fact that the Act simply tells state MMRCs, in the vaguest and most general of terms, “to identify adverse outcomes that may contribute to . . . pregnancy-related death, and to identify trends, patterns, and disparities in such adverse outcomes to allow the [government] to make recommendations . . . to improve maternal care and reduce . . . pregnancy-related death”?³⁶⁰ What are we to make of the fact that the Act says nothing about institutions, structures, or systems that make pregnancy and childbirth unsafe for women in the United States? Congress was convinced that confidentiality was an essential component of an effective maternal death review process. In contrast, Congress appears unconvinced that institutional, structural, or systemic transformation is an essential component of an effective response to maternal deaths in the United States.

The importance of MMRCs’ taking a critical approach to the issue of maternal mortality and committing themselves to investigating structural causes of the United States’ elevated ratios of maternal death is laid bare when one considers Louisiana’s MMRC. In its earlier iterations, the commission seemed interested in laying the blame for maternal deaths at the feet of the women dying during pregnancy³⁶¹—a problem that Section II.C identified as a feature of the general discourse around maternal mortality in the United States.³⁶² The committee paid very little attention to the conditions under which women lived.³⁶³ It did not inquire about women’s ability

³⁵⁸ *But see id.* at 90 (“[E]ven in those states [with confidential review processes] providers apparently remain concerned that the protections are not sufficient to shield them from litigation.”).

³⁵⁹ *See id.* at 89–90 (noting that three of the twenty-one states with MMRCs at the time of publication did not “have legal or administrative protections for the confidentiality of information disclosed for public health investigations”).

³⁶⁰ *See* Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, sec. 2(5), § 317K(d)(3)(B), 132 Stat. 5047, 5049.

³⁶¹ *See* LA. DEP’T OF HEALTH & HOSPS., *supra* note 217, at 10–11 (suggesting intensive monitoring of, or attention to, several conditions and comorbidities that the commission found were linked to maternal death).

³⁶² *See supra* Section II.C (discussing researchers’ and experts’ misguided focus on explanations for high maternal mortality that center exclusively on the role of mothers’ compromised health).

³⁶³ *See* LA. DEP’T OF HEALTH & HOSPS., *supra* note 217 (failing to discuss structural factors in its causal analysis).

to access healthcare. It did not interrogate whether lives might have been saved if hospitals and physicians altered the way that they delivered care. Were hospitals responding to emergencies in the most effective way possible? Were practices in place for identifying the development or worsening of life-threatening conditions, like high blood pressure or excessive blood loss? Were women given information about signs that they should look out for—signs that, when present, mean that a woman should go immediately to her healthcare provider? Were providers listening to the symptoms that women reported?

Instead of asking these questions, the earlier iteration of Louisiana's MMRC asked what *women* were doing that led to pregnancy complications. Accordingly, the report that the commission issued noted that if the state was going to lower its MMR, women needed to stop smoking and lose weight.³⁶⁴ Louisiana's MMRC was willing to look in many places to find ways to reduce the number of women who die during pregnancy and yet largely overlooked the healthcare delivery system in the state.³⁶⁵ The MMRCs in Georgia, Michigan, Minnesota, Missouri, and Virginia have taken a similarly narrow view by focusing on what women are doing to cause pregnancy complications.³⁶⁶

³⁶⁴ See *id.* at 10 (identifying “smoking” and “obesity” as the “principle [sic] modifiable clinical risk indicators”—which assumes that other risk indicators are not modifiable); see also Ungar, *supra* note 185 (“In Louisiana—the deadliest state in America for pregnant women and new mothers—the state’s 2012 report on maternal deaths emphasized suicide, domestic violence and car crashes. It dedicated pages of charts and recommendations to those issues.”).

³⁶⁵ Louisiana's MMRC recommended that, because many pregnancy-associated deaths are due to interpersonal violence, law enforcement should be represented on the committee that reviews maternal deaths. See LA. DEP'T OF HEALTH & HOSPS., *supra* note 217, at 10 (“Due to the large number of pregnancy-associated homicide deaths . . . the committee recommended the incorporation of law enforcement/criminal justice system representatives as key stakeholders and participants in the [pregnancy-associated mortality] review process.”). Inasmuch as most MMRCs do not involve police officers, the Louisiana MMRC was capable of imagining creative interventions to save women's lives. (Of course, responding to interpersonal violence with law enforcement and the criminal legal system is not creative at all.) However, the MMRC never looked to the healthcare delivery system, apart from its suggestion of increased clinical monitoring of certain conditions. It refused to engage its creativity to imagine ways to improve the health-compromising environments in which so many women in the state live. *Id.* at 10–11.

³⁶⁶ See VENKATA PS GARIKAPATY, MO. DEP'T OF HEALTH & SENIOR SERVS., PREGNANCY ASSOCIATED MATERNAL MORTALITY REVIEW (PAMR) IN MISSOURI 31 (2015), <https://nurturekc.org/wp-content/uploads/2015/01/Missouri-Maternal-Mortality-System.pdf> (identifying, among other things, “maternal age” and “smoking during pregnancy” as important factors that have contributed to maternal deaths in the state); YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 14 (criticizing Georgia's MMRC for using “a narrow medical lens” and failing to “consider the impact of social determinants of health on mortality [or] the drivers of the racial disparities in maternal

Notably, the lens through which Louisiana's MMRC views maternal mortality transformed over time. Ten years after concluding that smoking and obesity were the "principle [sic] modifiable clinical risk indicators,"³⁶⁷ the commission was willing to look more broadly for modifiable causes of maternal death.³⁶⁸ This broadened focus led the commission to recommend structural, systemic changes.³⁶⁹ Indeed, when the commission identified individual behavior as problematic and a likely contributor to maternal deaths, it was *healthcare providers'* behavior—not pregnant women's behavior. Remarkably, the commission concluded that the contributing factors most commonly identified in maternal deaths were "[p]rovider and facility-level factors"—like the failure to adequately assess risk and the failure to implement standardized policies and procedures.³⁷⁰ Where, earlier, the Louisiana MMRC seemed capable of only viewing maternal deaths through the narrowest of clinical lenses,³⁷¹ it now wrote:

Racial disparities in maternal mortality are complex and multifactorial. Mortality is influenced by a wide range of economic, social, and clinical determinants. In addition to health status prior to pregnancy and consistent access to quality healthcare during pregnancy and throughout the life course, social determinants of health such as racial bias and discrimination, lack of transportation or childcare, poverty, and racism in policies, practices and systems can contribute to adverse outcomes, including maternal death.³⁷²

The lesson here is that not all MMRCs are created equal. Some will do work that is in the service of undoing the structures that make the United States deadly for pregnant women—especially pregnant black women. Others will not share that same commitment. Accordingly, the work that they do will not be transformative. It may not even be effective. Importantly, there is nothing in the Preventing Maternal

death"); Ungar, *supra* note 185 ("Virginia published entire reports about cancer, opioid abuse and motor vehicle crashes among moms who died. Minnesota's team recommended more education for pregnant women on seat belt use and guns in the home. Michigan's team urged landlords to make sure pregnant women's homes have smoke detectors.").

³⁶⁷ LA. DEP'T OF HEALTH & HOSPS., *supra* note 217, at 9.

³⁶⁸ See KIELTYKA ET AL., *supra* note 227, at 4.

³⁶⁹ See *id.* at 4–5 (recommending, among other things, the "[i]ncorporat[ion of] strategies into quality improvement activities to reduce racial bias and modify policies, practices, and systems to support equity in outcomes" and "[a]ddress[ing] inequities in social determinants of health to improve women's preconception health").

³⁷⁰ *Id.* at 20 (identifying contributing factors present in forty-seven deaths and finding that "[p]rovider and facility-level factors" were present in more deaths than "patient-level" factors).

³⁷¹ Cf. YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 14.

³⁷² KIELTYKA ET AL., *supra* note 227, at 22 (citing Bryant et al., *supra* note 115; Gadson et al., *supra* note 116).

Deaths Act that demands that MMRCs take the former path over the latter.

C. *Data Fetishization*

As discussed above, the Preventing Maternal Deaths Act commits the federal government to spending twelve million dollars annually for five years to fund state maternal mortality review commissions. Proponents of the Act justified its approach with the claim that we need to improve the data that we have about maternal deaths. Legislators, in effect, asserted that without adequate information about maternal deaths, it would be impossible to prevent deaths in the future.³⁷³ Many affirmed that improving the quality of our data about maternal mortality was a necessary “first step” in bringing our ratios down to levels that are comparable to those of other developed nations.³⁷⁴ Indeed, the hearing that preceded the passage of the Act was titled “Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.”³⁷⁵—underscoring that the chosen way to improve outcomes was through generating “better” information.

Of course, there is truth in this position: If we do not know what is causing the problem, we will not know how to solve the problem. However, there is a compelling argument to be made that we *already* know how to save women. Initiatives to demonstrably improve maternal health outcomes include:

- the implementation of toolkits and safety bundles, which are protocols for managing specific emergent events, like hemorrhage, hypertension, and blood clots;³⁷⁶

³⁷³ See, e.g., 164 CONG. REC. H10,060 (daily ed. Dec. 11, 2018) (statement of Rep. Burgess) (“This is a problem we cannot address without accurate data.”); *id.* (statement of Rep. Green) (“[I]n order to reverse this unconscionable trend, we must have the necessary data so providers can monitor their practices and improve their care delivery.”).

³⁷⁴ Chuck, *supra* note 258 (“‘This is an amazing first step,’ said Dr. Lisa Hollier, president of the American College of Obstetricians and Gynecologists. ‘Having high-quality data that is comparable across jurisdictions is going to be so very valuable to our prevention efforts.’”).

³⁷⁵ *Hearing on H.R. 1318, supra* note 264, at 1 (2018).

³⁷⁶ See Ozimek & Kilpatrick, *supra* note 28, at 182 (discussing California’s implementation of initiatives to combat maternal mortality). California recently lowered its ratios of maternal mortality by implementing safety bundles at hospitals. See Tanya H. Lee, *How California Reduced Its Maternal Deaths: A Q&A with Dr. Elliott Main*, REWIRE.NEWS (Nov. 30, 2017, 3:50 PM), <https://rewire.news/article/2017/11/30/maternal-deaths-qa-elliott-main>. After hospitals across the state implemented these safety bundles, California became one of the safest places to be pregnant and give birth. See Laura Ungar & Caroline Simon, *Which States Have the Worst Maternal Mortality?*, USA TODAY (Nov. 1, 2018, 2:26 PM), <https://www.usatoday.com/list/news/investigations/maternal-mortality-by-state/7b6a2a48-0b79-40c2-a44d-8111879a8336/?block=California> (ranking California safest out of all states analyzed).

- requiring providers to use checklists, which help to ensure the same quality of care for every patient;³⁷⁷
- engaging in simulation trainings in hospitals, which can improve providers' skills and knowledge when responding to a severe pregnancy complication;³⁷⁸ and
- the “[i]mplementation of a disparities dashboard, which stratifies quality metrics by race and ethnicity” and “allows hospitals and healthcare systems to become aware of disparities within their hospitals and to monitor their performance on quality metrics for groups with higher risks of poor outcomes.”³⁷⁹

Additionally, it is well-established that doula support during pregnancy and childbirth improves maternal outcomes.³⁸⁰ In Minnesota, which is one of four states that currently covers doula services through its Medicaid program,³⁸¹ Medicaid beneficiaries with doula support were fifty-six percent less likely to give birth via a cesarean section³⁸²—a procedure that is both a risk factor for, and an effect of, pregnancy complications.³⁸³ Because of the demonstrated

³⁷⁷ Kavita Shah Arora, Larry E. Shields, William A. Grobman, Mary E. D’Alton, Justin R. Lappen & Brian M. Mercer, *Triggers, Bundles, Protocols, and Checklists—What Every Maternal Care Provider Needs to Know*, 214 AM. J. OBSTETRICS & GYNECOLOGY 444, 447–48 (2016) (discussing support both within and outside of obstetrics for checklists). See Howell & Zeitlin, *supra* note 167, at 270 (mentioning checklists as part of a series of recommended practices).

³⁷⁸ Howell & Zeitlin, *supra* note 167, at 270 (referring specifically to simulations training health care providers to respond to shoulder dystocia, a severe childbirth complication).

³⁷⁹ *Id.*

³⁸⁰ Kenneth J. Gruber, Susan H. Cupito & Christina F. Dobson, *Impact of Doulas on Healthy Birth Outcomes*, 22 J. PERINATAL EDUC. 49, 49–50, 54–56 (2013) (reviewing various findings of doulas’ positive effects on women’s experiences and discussing data showing better outcomes with doulas than without).

³⁸¹ Those states are Indiana, Minnesota, Oregon, and New York. Note, however, that Indiana’s program has yet to be funded, and New York’s is a pilot program limited to a few counties. Christina Gebel & Sara Hodin, *Expanding Access to Doula Care: State of the Union*, MATERNAL HEALTH TASK FORCE (Jan. 8, 2020), <https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care>. See also Corrinne Hess, *Milwaukee Plans to Provide Doulas to 100 Women*, WIS. PUB. RADIO (Mar. 20, 2019, 6:00 AM), <https://www.wpr.org/milwaukee-plans-provide-doulas-100-women> (explaining that Wisconsin’s governor has proposed covering doula services through Medicaid); Mattie Quinn, *To Reduce Fatal Pregnancies, Some States Look to Doulas*, GOVERNING (Dec. 21, 2018), <https://www.governing.com/topics/health-human-services/gov-doula-medicaid-new-york-2019-pregnant.html>.

³⁸² Quinn, *supra* note 381.

³⁸³ As noted in Section I.A.2, women who undergo cesarean sections are at greater risk of developing severe, life-threatening complications—caused by the cesarean section itself or the condition that made the cesarean section medically indicated. Moaddab et al., *supra* note 40, at 710 (noting that the correlation between cesarean delivery and maternal mortality is largely due to the indication for cesarean delivery); see also Stephanie A. Leonard, Elliott K. Main & Suzan L. Carmichael, *The Contribution of Maternal*

effectiveness of doula support in improving maternal outcomes, the State of New York elected to introduce a pilot program for covering these services through the state's Medicaid program.³⁸⁴ Scholars have noted that providing Medicaid coverage of doula services could function to ameliorate the impact of the closure of obstetrics units in hospitals that serve high numbers of low-income patients—a phenomenon that both threatens the health of pregnant low-income women and has become more pronounced due to the low reimbursement rates that Medicaid offers for obstetrics care.³⁸⁵ As one scholar argues in the context of hospitals in Washington, D.C., “Medicaid coverage of doulas would also function to alleviate the impact of reduced access to hospitalized prenatal care by creating an alternative to hospital care.”³⁸⁶ The Preventing Maternal Deaths Act might have provided funds to states to adequately and generously cover doula support through their Medicaid programs.³⁸⁷ The architects of the Act elected not to make this concrete, effective intervention.

In the face of all that we already know about why pregnant and recently postpartum women are dying—and in the face of all of the knowledge that we already have accumulated about the concrete practices and policies that help women survive pregnancy and childbirth—

Characteristics and Cesarean Delivery to an Increasing Trend of Severe Maternal Morbidity, 19 BMC PREGNANCY & CHILDBIRTH 1, 2, 5–7 (2019) (finding a strong association between cesarean sections and severe maternal morbidity but noting that cesarean sections did not explain increased severe maternal morbidity).

³⁸⁴ Renee Mehra, Shayna D. Cunningham, Jessica B. Lewis, Jordan L. Thomas & Jeannette R. Ickovics, *Recommendations for the Pilot Expansion of Medicaid Coverage for Doulas in New York State*, 109 AM. J. PUB. HEALTH 217, 217 (2019) (noting that, in 2018, the governor of New York, Andrew M. Cuomo, “announced a comprehensive initiative to address maternal mortality and racial disparities in health outcomes” and that the “plan includes increasing access to prenatal and perinatal care through a pilot expansion of Medicaid coverage for doulas”).

³⁸⁵ See Wilson, *supra* note 128, at 222–23, 226, 229–30, 233–34 (discussing the impact on low-income communities of the closure of, and limited access to, obstetrics units in Washington, D.C.).

³⁸⁶ *Id.* at 234.

³⁸⁷ While Oregon and Minnesota cover doula services through the states' Medicaid programs, observers contend that they cover these valuable services at insufficient rates: “Oregon reimburses doulas \$350 per mother for four maternity support visits and the day of delivery. Minnesota reimburses doulas \$411 per mother for seven visits, one of which is for labor and delivery.” Mehra et al., *supra* note 384, at 217. Analysts argue that the low levels of these rates explain why doula care remains inaccessible to many low-income women: The rates are below the costs to doulas of providing the services to women, and low-income women cannot afford to supplement the reimbursements that doulas receive from Medicaid with their own funds. See *id.* (noting that out-of-pocket fees for doulas in New York City can be between \$400 and \$2000). Advocates in Minnesota wanted the state to raise the reimbursement rates from \$411 to \$770. See Quinn, *supra* note 381. Although legislators included raised rates in the budget, the governor at the time vetoed the bill. See *id.*

the Preventing Maternal Deaths Act does no more than fund state MMRCs. The Act may be read as pretending that the causes of maternal deaths are an utter mystery. In this way, the Act is not a commitment. It is a pretension. One need not be overly pessimistic to believe that, in the absence of a clear, full-throated commitment to saving the lives of women—especially, black women—the Act will fail to lead to a meaningful reduction in the frequency of maternal deaths, let alone the elimination of racial disparities in maternal mortality.

Further, there is an abundance of evidence demonstrating that the mere existence of a state MMRC that reviews every maternal death in a state is no guarantor of safe pregnancies and childbirths for women. The clearest indication of this is the fact that *nearly every state currently has an MMRC*.³⁸⁸ Nevertheless, the maternal death ratios in the United States remain the highest in the industrialized world. Indeed, some of the states with the highest maternal death ratios—including Maryland, Michigan, Louisiana, and New York—have MMRCs.³⁸⁹ Again, the mere existence of these committees has not managed to save women. The commitment to review each maternal death has to be wedded to a commitment to actually implement the policies and practices that have been proven to save lives.³⁹⁰ Nevertheless, the Preventing Maternal Deaths Act does no more than to fund MMRCs.

This critique should not be read as arguing that information is bad. Rather, the critique here is that if there is a limited pot of money, and that money can either be spent gathering information about a problem or making concrete interventions that are known to be effective ways to address the problem, it is a fascinating political choice to pursue the former over the latter.

We might compare the Act's attempt to address maternal mortality with New York City's effort to address the same. In July 2018, the city announced that it would be dedicating \$12.8 million over the course of three years to reduce the frequency of maternal deaths and severe maternal morbidity in the city—specifically, and explicitly,

³⁸⁸ See Ungar, *supra* note 185 (noting that only seven states—Arkansas, Idaho, Montana, Nevada, Rhode Island, South Dakota, and Wyoming—do not have an MMRC).

³⁸⁹ See AMNESTY INT'L, DEADLY DELIVERY, *supra* note 71, at 104 app. A.

³⁹⁰ See BLACK MAMAS MATTER, *supra* note 40, at 63 (“Gathering the information is *only* step one. We must also demand that this nation make the needless loss of women, especially black women, a priority that the community invests in together to eliminate[; said] Dr. Joia Crear-Perry, Founder of National Birth Equity Collaborative.”) (emphasis added); YALE GLOB. HEALTH JUSTICE P'SHIP, *supra* note 40, at 60 (“[I]solated collection of data . . . alone will not alleviate systemic barriers around access to and quality of care.”).

among women of color.³⁹¹ In dramatic contrast to the Preventing Maternal Death Act's single-pronged approach to saving lives through information gathering, New York City's approach is multifaceted. Certainly, the city acknowledges the need to improve data about maternal deaths: A component of the plan focuses on the city's existing MMRC, charging the committee to review cases of severe maternal morbidity in addition to cases of maternal deaths.³⁹² Additionally, the plan endeavors to remedy the problem of the years-long delay in the release of annual data, providing that the Health Department will release preliminary estimates of mortality events every year.³⁹³ However, unlike the Preventing Maternal Deaths Act, New York City's effort goes well beyond the mode of information-as-intervention. The plan provides that:

- hospitals will engage in “simulation training” in which staff must identify and respond to emergent obstetric events, specifically postpartum bleeding and blood clots;³⁹⁴
- the city will enlist “maternal care coordinators” to ensure that “high-risk” patients, among other things, keep their appointments and are able to access the medications that providers prescribe to them;
- women will receive healthcare *before* they become pregnant, and providers will assess them for their risk of developing complications should they become pregnant;³⁹⁵ and
- women will have access to a variety of programs that will offer them disease management or doula support, including a “Nurse-Family Partnership program,” a “Newborn Home Visiting Program,” and “the By My Side program, which provides doula support services.”³⁹⁶

³⁹¹ See *De Blasio Administration Launches Comprehensive Plan to Reduce Maternal Deaths and Life-Threatening Complications from Childbirth Among Women of Color*, NYC (July 20, 2018), <https://www1.nyc.gov/office-of-the-mayor/news/365-18/de-blasio-administration-launches-comprehensive-plan-reduce-maternal-deaths-life-threatening> (“The five-year plan aims to eliminate disparities in maternal mortality between Black and White women—where the widest disparity exists . . .”).

³⁹² See *id.* (providing that the plan will “support[] private and public hospitals to enhance data tracking and analysis of severe maternal mortality and maternal morbidity events”).

³⁹³ See *id.*

³⁹⁴ The plan focuses on these two events because they are “the two top causes of pregnancy-related deaths for women of color.” *Id.*

³⁹⁵ *Id.* (stating that the plan includes the “hir[ing] of maternal care coordinators to assist an estimated 2,000 high-risk women in the prenatal and postpartum periods to keep appointments, procure prescriptions, and connect women to eligible benefits”).

³⁹⁶ *Id.*

Simply put, New York City does not fetishize data. The city's plan to address maternal mortality does not pretend that information alone will prevent deaths. It links the necessity of gathering data on maternal mortality and morbidity with concrete initiatives that history has shown to improve maternal outcomes.

There is a danger that with the passage of the Preventing Maternal Deaths Act, the country will rest on its laurels—satisfied that it has done *something* about the problem of maternal mortality in the United States. That is, there is a danger that the creation of state MMRCs and the collection of data on maternal deaths will be taken to be an end in itself—as opposed to a means to the ultimate end of reducing the frequency of maternal deaths in the country. It is imperative to underscore that *data will not save women*. Information about why women are dying—without a political and financial commitment to intervene in the complex processes that make pregnancy and childbirth deadly events in the United States—will not make pregnancy and childbirth any safer for women, especially black women, in the United States.³⁹⁷

CONCLUSION

The foregoing discussion leaves us with a question: Is *something* sometimes worse than *nothing*? The Preventing Maternal Deaths Act presents the puzzle of whether black women might actually be worse off after the Act's passage. If there is a modicum of truth in the preceding analysis, the Act will fail to address black women's needs. It ignores the reality that black women are more frequently felled on the path to motherhood, refuses to charge state MMRCs with the task of investigating the large-scale, macro processes that make the United States a dangerous place for women (and black women, specifically) to be pregnant and give birth, and pretends that more and better data

³⁹⁷ See, e.g., REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES, *supra* note 41, at 55 (noting that “[s]tate- and local-level MMRCs are poised to be the gold standard for understanding why maternal deaths continue to occur and make recommendations for action,” but stating that they must “connect MMRC data to action”).

Similarly to how the Preventing Maternal Deaths Act pretends that the problem of maternal mortality is a problem of information, politicians have only been willing to “study” the possibility of reparations. See Sheryl Gay Stolberg, *House Democrats, with Pelosi's Support, Will Consider a Commission on Reparations*, N.Y. TIMES (June 18, 2019) (discussing a “House bill, titled the ‘Commission to Study and Develop Reparation Proposals for African-Americans Act,’” that would fund a commission that “would study the effects of slavery and racial discrimination, hold hearings across the country and recommend ‘appropriate remedies’ to Congress”). In the contexts of both maternal mortality and reparations, there is a lack of a political will to make actual material interventions that will produce change. Politicians have been able to punt on both issues by framing them as ones about which we just need more data.

(as opposed to concrete interventions) will save pregnant women and new mothers. While being woefully unresponsive to the actual, material needs of black women, the Act may take up the political, legal, and cultural space for more effective, responsive interventions—leaving black women in a worse position than they were before.

Time will tell whether black women are actually served by Congress's colorblind foray into a problem that race and racism have produced.