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The Black Maternal Health Crisis: How to Right a Harrowing History Through Judicial and Legislative Reform

Melia Thompson-Dudiak

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**THE BLACK MATERNAL HEALTH CRISIS:
HOW TO RIGHT A HARROWING HISTORY THROUGH
JUDICIAL AND LEGISLATIVE REFORM**

MELIA THOMPSON-DUDIAK*

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I. INTRODUCTION

For centuries, Black Americans have existed as second-class citizens. With glaring disparities in nearly every facet of society, Black Americans consistently fare worse than their fellow countrymen.¹ Now, amidst a global pandemic and race revolution, Black people find themselves in even more dire situations.²

¹ Angela Hanks, et. al., *Systemic Inequality*, CTR. FOR AM. PROGRESS (Feb. 21, 2018), <https://www.americanprogress.org/issues/race/reports/2018/02/21/447051/systemic-inequality/>.

² Richard A. Oppel Jr., et. al., *The Fullest Look Yet at the Racial Inequity of Coronavirus*, NY TIMES (July 5, 2020), <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos->

Currently, Black mothers are 243 percent more likely to die from pregnancy or childbirth related causes than white women.³ The emotional, medical, communal, and spiritual costs of these deaths and near deaths are compounded by the enormous financial burdens they bring.⁴ In fact, available data suggests the costs of maternal morbidity in America amounts to billions of dollars every year.⁵

The financial loss of these tragedies is spread across private and state insurance companies, individuals, families, taxpayers, and communities.⁶ Worse, many medical professionals admit the majority of these deaths, and near deaths, are preventable through adequate monitoring, early intervention, and appropriate medical treatment.⁷ Yet, despite the social, moral, and financial considerations, which affect the entire country, the current Black maternal health crisis embodies the all too familiar narrative of how Black Americans continue to be victims of failed systems.

The failure of the American jurisprudence system to reckon with racism, as it exists today, eschews the opportunity for legal safeguards to protect against discrimination.⁸ Moreover, it restricts the law's ability to create equity and redress systems that historically disenfranchised Black Americans. Structural racism is a societal web of "social, economic, and governmental practices, systems, and policies," that advantages people classified as white and disadvantages those classified as "people of color."⁹ As such, it functions irrespective of the individual actor's intent and requires a comprehensive and contextualized perspective to understand.¹⁰

african-americans-cdc-data.html; Wenei Philimon, *Black Americans Report Hate Crimes, Violence in Wake of George Floyd Protests and Black Lives Matter Gains*, USA TODAY (July 7, 2020).

³ See also Nina Martin & Renee Montagne, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 17, 2017), <https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why>.

⁴ Katherine Ellison & Nina Martin, *Nearly Dying in Childbirth: Why Preventable Complications are Growing in U.S.*, NPR KQED (Dec. 22, 2017), <https://www.npr.org/2017/12/22/572298802/nearly-dying-in-childbirth-why-preventable-complications-are-growing-in-u-s>.

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ Doron Samuel-Siegel et. al., *Reckoning with Structural Racism: A Restorative Jurisprudence of Equal Protection*, 23 RICH. PUB. INT. L. REV. 137, 138 (2020).

⁹ *Id.* at 138.

¹⁰ *Id.*

Distinct from individual racism, which arises from prejudiced attitudes and behaviors, structural racism stems from self-replicating, societal systems.¹¹ Examples of structural racism are aggressive street crime and quality of life law enforcement policies in poor communities.¹² Even though that type of law may be enacted with no discriminatory intent, it results in racial disparities.¹³ Though not as obvious as a prejudiced individual, those laws could be equally damaging and even more far-reaching in scope. Accordingly, both structural and individual racism are contributing to the ongoing Black maternal health crisis. By ignoring the existence of structural racism, jurists interpreting the Equal Protection Clause dilute the Fourteenth Amendment's ability to "combat the oppressive race-based gaps in life chances produced by structural racism."¹⁴

To begin the arduous and complicated process of dismantling structural racism, this article suggests jurists apply existing laws in a way that revitalizes the safeguards intended to be checks against discrimination. That is, the Fourteenth Amendment's Equal Protection Clause has the potential to contribute to undoing structural racism through: (1) considering the discriminatory effects of government action, rather than solely focusing on the actor's intent, and (2) contextualizing policies within a societal and historical context.¹⁵ Once adopted, these shifts in perception and application would not only justify, but would necessitate, new legislation to combat structural and individual racism and corresponding implicit racial biases.

To best posture this comment's prescription, Part II provides a brief overview of the history and current state of maternal health in America. With this foundation, Part III addresses how restoring anti-discriminatory legal safeguards, by revitalizing the Equal Protection Doctrine and creating targeted legislation, can have significant positive impacts as the country navigates this crisis. The comment concludes with Part IV, which analyzes and critiques current proposed legislation aimed at curbing the Black maternal health crisis.

Namely, the Black Maternal Health Momnibus Act of 2020, which establishes task forces to address "social determinants of health, maternal mental and behavioral health, and other topics."¹⁶ It also awards grants for committees to

¹¹ *Id.*

¹² See THE ASPEN INST., DISMANTLING STRUCTURAL RACISM: A RACIAL EQUITY THEORY OF CHANGE 1–2, <https://www.racialequitytools.org/resourcefiles/aspeninst1.pdf> (last visited Oct. 20, 2020).

¹³ *Id.*

¹⁴ Doron Samuel-Siegel et. al., *supra* note 8, at 138 (2020).

¹⁵ *Id.*

¹⁶ Black Maternal Health Momnibus Act of 2020, H.R. 6142, 116th Cong. (2020) [hereinafter BMHMA].

review maternal mortality, to develop innovative maternity care models, as well as other purposes. As a whole the Act is a promising step in the right direction, yet improvements in feasibility and impact are required. For instance, failure to include a national maternity leave proposal dilutes the Act's ability to effectuate change. Likewise, task forces must be designed to foster optimal participation and yield results. To improve the Act, lessons from other countries can provide blueprints for an effective starting point, while properly leveraging the benefits of technology can increase transparency and establish accountability among providers. With all of the potential good that could emanate from the Act, ultimately, making maternity care safe, affordable, and accessible requires a complete value shift and systemic overhaul.

II. AN OVERVIEW OF MATERNAL HEALTH IN AMERICA

The following section provides an overview of maternal health in America, including critical information regarding the history of maternal health and its current state. This section concludes by highlighting the tragic and lingering effects of systemic inequities, implicit bias, and individualized racism on Black mothers.

A. THE HISTORY OF MATERNAL HEALTH IN AMERICA

Understanding the integral and historic roles of Black women in the development of maternal health in America provides an insightful context to better understand current maternal health disparities. This history is twofold and involves Black women's: (1) involuntary sacrifices that advanced reproductive science and sustained slavery; and (2) their fundamental function as midwives. Black slave women's bodies were exploited to further slave production and advance reproductive medicine.¹⁷ Logically, they brought immense worth through their reproductive capabilities.¹⁸ However, treating these women according to their value would have upended the strategically propagandized narrative of the inhuman slave. Instead, this chasm facilitated severe dehumanization by way of medical experiments, field treatments, and legal precedents. For example, the practice of digging a hole for expecting mothers to position their abdomens in

¹⁷ Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology*, 43 (2017).

¹⁸ *Id.*

before being lashed illustrates the dichotomy of abusing Black slave mothers' bodies while protecting the value of their fetuses.¹⁹

Although a prevailing belief at the time was that Black women were inferior, white doctors seemed fascinated by Black women's bodies.²⁰ This fascination helped perpetuate myths that Black women had "medical superbodies" and could not feel pain.²¹ As a consequence of this misguided notion, enslaved Black women often became subjects of medical experiments.²² For instance, in 1835, four doctors performed an experimental ovarian surgery on a 35-year-old Black slave to remove an ovarian tumor.²³ The woman screamed and struggled during the experimental surgery, which reportedly left her sterile.²⁴ The doctors, however, preserved the ovary and studied it, enabling them to further their medical research and understanding of the female reproductive system.²⁵

The findings from many of these medical experiments were published and presented with medical hypotheses, which were later used to substantiate legal precedent to combat slave deviance.²⁶ This dehumanization of Black slave women furthered economic, moral, legal, and physical motives and eventually became engrained in the systems that sustained the institution of slavery. The side effects of normalizing these beliefs are the harmful and medically incorrect perceptions about Black women, such as their ability to withstand pain and their inability to accurately assert agency over their bodies.²⁷

¹⁹ *Id.*

²⁰ *Id.* at 44

²¹ *Id.*

²² *Id.*

²³ *Id.* at 46-47.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.* See e.g., OWENS, *supra* note 17, at 50. The case of *Lightner ads. Martin* exemplifies how a slave woman who was examined and prodded because of a venereal disease. A court determined the woman was a threat to the health of other slaves, even after she was healed. In its opinion, the court included explicit language about how devious behavior was "mapped onto [B]lack women's bodies." In addition to medical journals, judicial cases expose how nineteenth-century Americans struggled to define Blackness within the realm of reproductive labor and even go as far as establishing enslaved people's sanity.

²⁷ Black Americans are systematically undertreated for pain relative to white Americans. Moreover, participants who endorsed these beliefs rated black (vs. white) patient's pain as lower and made less accurate treatment recommendations. These findings suggest that individuals with at least some medical training hold and may use false beliefs about biological differences between Blacks and whites to inform medical judgments, which may contribute to racial disparities in pain assessment and treatment. Kelly M. Hoffman, et. al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences Between Blacks and Whites*, 113 PNAS 4296-4301 (Apr. 19, 2016).

On the other end of the historical spectrum concerning maternal health in America, Black women served integral roles as birth workers—for both white and Black mothers—well into the twentieth century.²⁸ A by-product of the slave trade were the predominately West African midwives, known as “granny midwives.”²⁹ Midwifery encompasses the care of women “during pregnancy, labor, and the postpartum period, as well as care of the newborn.”³⁰ Granny midwives employed African traditional medicine, which espoused holistic, compassionate, and spiritual care for mothers.³¹ Indeed, for many Black mothers, home births attended by midwives were preferable to hospital deliveries because they shielded mothers from the prejudice and discrimination they often experienced in white society.³²

In the colonial era, granny midwives attended most births, effectively relegating physicians to only the most complicated cases.³³ At that time, this symbiotic relationship was often described as being “relatively peaceful,” existing in a “system of cooperation” and “professional courtesy.”³⁴ The custom at the time was to pay midwives “two or three dollars per delivery,” though midwives would sometimes be given “a chicken as payment or not be paid at all.”³⁵

At the turn of the century, evolution in the medical field prompted a shift in how health care professionals dealt with childbirth.³⁶ As a way to promote their services and eliminate competition, physicians “waged systematic and virulent propaganda campaigns” against midwives.³⁷ In fact, doctors portrayed midwives as “dirty, illiterate, ignorant, and irresponsible,” when compared to hospital physicians who were depicted as “clean . . . [and] educated.”³⁸ Doctors further perpetuated myths of racial superiority aimed to convince white women that

²⁸ *Rural South* (Mar. 19, 2018), <https://www.rootmama.co/blog/granny-midwives-of-the-rural-south>. *But see* Radical Doula, *Remembering the Work of Black Midwives of the South* (Mar. 19, 2015), <https://radicaldoula.com/2015/03/19/remembering-the-work-of-black-midwives-of-the-south/> (“Granny Midwives” had a meeting about 20 years ago and proclaimed they no longer wanted to be called “Granny.” They requested they be referred to as “Grand Midwives.”)

²⁹ Root Mama, *supra* note 28.

³⁰ *Midwifery*, WORLD HEALTH ORG. (Aug. 12, 2020), <https://www.who.int/topics/midwifery/en/>.

³¹ Root Mama, *supra* note 28.

³² Sheena M. Morrison, MPH & Elizabeth Fee, PhD, *Nothing to Work With but Cleanliness: The Training of African American Traditional Midwives in the South*, 100 AM. J. PUB. HEALTH 238 (Feb. 2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804652/>.

³³ Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 BERKELEY J. GENDER L. & JUST. 241, 250 (2016).

³⁴ *Id.*

³⁵ Morrison, *supra* note 30.

³⁶ Kukura, *supra* note 33, at 251.

³⁷ *Id.*

³⁸ *Id.*

Black midwives were “filthy and ignorant and not far removed from the jungles of Africa,” portraying “a relic of barbarism.”³⁹

This barbaric depiction was far from the truth. Midwives were often members of midwifery clubs, which were not only regulated but functioned by using uniform standards of care in the profession.⁴⁰ Midwives were instructed to maintain standards related to cleanliness and sterility, while also expected to be “clean in person, home, and equipment.”⁴¹ Though most midwives lacked formal training, they learned the skill through “demonstrations, role playing, and songs.”⁴² Midwives stood at the center of science, social work, and health, even before these domains were recognized. Their roles went beyond delivering babies—as community health educators, they “encouraged women to seek prenatal and postnatal care, accompanied them to clinics as needed, and explained the nature and significance of the visits.”⁴³ They also actively promoted health by “sponsoring child immunization clinics in their homes, providing nutrition education, and notifying public health nurses of bedridden residents in their communities.”⁴⁴

Akin to how the law could justify exploiting and experimenting on enslaved Black women, physicians availed themselves of discriminatory legal processes to exclude granny midwives from the field of maternal health.⁴⁵ For instance, physicians who served on the state medical board often initiated criminal prosecutions against midwives, accusing them of practicing unauthorized medicine.⁴⁶ Of course, such accusations erased the extensive experiential knowledge of granny midwives, which enabled midwives to successfully aid women through pregnancy and childbirth.⁴⁷ In turn, these allegations facilitated courts to continuously disregard the safe and affordable maternity care midwives provided, sometimes as little as one-third the cost of local physician rates.⁴⁸ Also, by failing to acknowledge the extreme tactics levied on Black people, which prevented them from gaining an education in a traditional sense, courts rejected midwives’ expertise as a means of establishing professional and legal standing.⁴⁹

³⁹ *Id.* at 252.

⁴⁰ Morrison, *supra* note 32, at 238.

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.* at 239.

⁴⁴ Kukura, *supra* note 33, at 252.

⁴⁵ *Id.* at 253.

⁴⁶ *Id.* at 253.

⁴⁷ *Id.* at 252.

⁴⁸ *Id.* at 252.

⁴⁹ *Id.*

Paradoxically, during that time, most new physicians lacked clinical training or experience with childbirth, due in large part to prevailing norms of modesty, which precluded physician-trainees from observing women in labor.⁵⁰ Through misconception and manipulation, doctors managed to marginalize granny midwives from maternal health.

Once the narrative of physician superiority to midwives fell on receptive judicial ears, the notion that childbirth was an “abnormal, pathogenic process[,] which required routine medical assistance to prevent disaster,” all but extinguished the prevalence of midwifery.⁵¹ Judicial opinions about midwifery refused to recognize midwives’ skills and corresponding positive outcomes.⁵² By discounting granny midwives’ practical abilities and exaggerating physicians’ limited knowledge about childbirth, courts justified rejecting defendant midwives on the grounds of no professional or legal standing.⁵³ Together, the law and the medical field supplanted the reality that childbirth is a healthy and completely natural event, demonized midwives, and instituted a new standard for maternal health care. All of these concepts flourished on the basis that Black women were stupid, inferior, and unable to understand maternal health better than doctors.

Today, these stigmas continue to affect the quality of maternal health care. A look into the current landscape of midwifery provides ample evidence of the lingering effects of these beliefs. Despite midwiferies’ “woman-centered philosophical approach to childbirth—or perhaps because of it—midwives have been restricted in their ability to practice.”⁵⁴ In several states, midwives are still targeted for criminal prosecution.⁵⁵ This marginalization translates into limited, and in extreme cases, severely restricted options for some pregnant women with respect to having a midwife as their primary care provider during pregnancy and childbirth.⁵⁶ Depending on where they live, many women are forced to join the 80

⁵⁰ Kukura, *supra* note 33, at 251.

⁵¹ *Id.* at 252.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.* at 255.

⁵⁵ *Id.* See e.g., Noah Berlatsky, *When Midwives are Considered Criminals*, VICE (Sept. 13, 2015), <https://www.vice.com/en/article/a3wvmz/when-midwives-are-considered-criminals> (Certified Professional Midwives are licensed to practice in 28 states, yet, in 22 other states home birth midwifery remains largely illegal. For instance, while North Carolina and Alabama have particularly restrictive environments, other states like Massachusetts and North Carolina don’t license midwives.); *Legal Status of U.S. Midwives*, MIDWIVES ALLIANCE NORTH AM., <https://mana.org/about-midwives/legal-status-of-us-midwives> (last visited Oct. 20, 2020).

⁵⁶ Kukura, *supra* note 33, at 255. See e.g., Berlatsky, *supra* note 55 (When Midwifery is not sanctioned by the state mothers: may not be eligible for reimbursement for midwifery services from insurance companies; may not know whether their midwife will be there the next day

percent of American women who rely solely on obstetric specialists, trained in pathology and surgery.⁵⁷ With reduced options, women who would stand to benefit from the individualized care of a midwife, are restricted to a system with known shortcomings that affect their ability to receive optimal and dignified care.

This foundational lens sets forth the historical basis of how Black women have been, and continue to be, at the center of maternal health in this country. While sustaining the slave population, and fronting slavery's most valuable physical commodities, their bodies were subjected to torturous experiments that facilitated the very medical technology that eventually replaced their central role in maternal health. Consequently, the discriminatory legal and medical paradigms that first sought to exploit and remove Black women from maternal health have contributed to the structural impediments that have created the dire situation Black women face. In turn, these structural inequities fuel individual racism and reinforce destructive implicit biases about Black women by promoting medically inaccurate beliefs about Black women and failing to recognize the expertise Black women possess with regard to their bodies. This comment now turns to examine the current state of maternal health in America.

B. THE CURRENT STATE OF MATERNAL HEALTH IN AMERICA

With approximately four million babies born every year, childbirth is currently the leading reason for hospitalization in the American health care system.⁵⁸ Correspondingly, hospital charges for childbirth “exceed expenditures for any other condition, totaling \$111 billion each year.”⁵⁹ Contrary to the expensive costs

because she may be getting arrested; and when hired, mothers may not definitively know whether their midwife is properly certified with the required education and credentials).

⁵⁷ Kukura, *supra* note 33, at 255.

⁵⁸ Carol Sakala & Maureen P. Corry, *CHILDBIRTH CONNECTION, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE* 2, 26 (2008), https://www.milbank.org/wp-content/files/documents/0809MaternityCare/0809MaternityCare.html?gclid=CjwKCAiAz4b_BRBbEiwA5XIVVvRyIviEPQnO2-_iJ1OyCE6RVRx3TWsmCD0vgyONxqLd_zOC9yDtrxoCck8QAvD_BwE (noting that 83 percent of women have low-risk pregnancies in the U.S.).

⁵⁹ CHILDBIRTH CONNECTION, NAT'L P'SHIP FOR WOMEN & FAMILIES, UNITED STATES MATERNITY CARE FACTS AND FIGURES (2012) [hereinafter *MATERNITY CARE FACTS AND FIGURES*], *archived at* <http://perma.unl.edu/W3ZT-WZMC>. Significantly, the U.S. spends almost twice as much per capita on health care as any other nation. *See* Carmen Denavas-Walt et al., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2012, at 22–25 (2013), *archived at* <https://www.census.gov/prod/2013pubs/p60-245.pdf>; *see also* ORG. FOR ECON. CO-OPERATION & DEV., HEALTH AT A GLANCE 2013: OECD INDICATORS 24–25, 64–65, 88–89, 155–56 (2013), *archived at* <http://perma.unl.edu/XH47-HEU7>.

associated with maternity care, U.S. birth outcomes are markedly inferior to those of other industrialized nations.⁶⁰ In fact, according to the World Health Organization's ("WHO") most recent maternal mortality ranking, the U.S. sits at number 55.⁶¹ Lower rates of maternal death lead to a higher ranking on the list, meaning the country ranked first has the lowest maternal death rate in the world. When compared to nine other similarly wealthy nations, the U.S. ranks last on the list.⁶²

Within the last twenty-five years, maternal mortality rates fell 44 percent globally, but maternal mortality in the U.S. increased by 16.7 percent, putting the U.S. alongside Afghanistan and Sudan as the only countries with rising mortality rates.⁶³ The Center for Disease Control and Prevention ("CDC") reported nearly 700 deaths from complications related to pregnancy or childbirth every year.⁶⁴ Of that number, Black women die between 3 and 12 times more often than white women, depending on their location, making the maternal deaths among Black women a driving factor in the maternal health crisis.⁶⁵ For instance, in Washington, D.C., where fifty percent of the population is Black, the rate of maternal morbidity among Black women is 41.6 per every 100,000 deaths.⁶⁶ Similarly, in Fulton County, Georgia, the rate is 94 maternal deaths per 100,000 live births among Black women.⁶⁷ Most startling, Chickasaw County, Mississippi, reported a rate of 595 deaths per 100,000 live births, positioning that county

⁶⁰ Denavas-Walt, *supra* note 59.

⁶¹ WORLD HEALTH ORG., TRENDS IN MATERNAL MORTALITY 2000 TO 2017: EXECUTIVE SUMMARY, 77,98 (2019) [hereinafter WORLD HEALTH ORG. EXEC. SUMM.], <https://apps.who.int/iris/bitstream/handle/10665/327596/WHO-RHR-19.23-eng.pdf?ua=1>. See also Julia Belluz, *We Finally Have a New US Maternal Mortality Estimate. It's Still Terrible*, VOX (Jan. 30, 2020), <https://www.vox.com/2020/1/30/21113782/pregnancy-deaths-us-maternal-mortality-rate>.

⁶² WORLD HEALTH ORG. EXEC. SUMM., *supra* note 61.

⁶³ Alma Adams & Lauren Underwood, *About Black Maternal Health*, BLACK MATERNAL HEALTH CAUCUS, <https://blackmaternalhealthcaucus-underwood.house.gov/about-black-maternal-health> (last visited Aug. 4, 2020).

⁶⁴ Maternal mortality is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes." *Health Statics and Information Systems*, WORLD HEALTH ORG., <https://www.who.int/healthinfo/statistics/indmaternalmortality/en/> (last visited Aug. 4, 2020); Elizabeth Chuck, *The U.S. Finally Has Better Maternal Mortality Data. Black Mothers Still Fare the Worst*, NBC NEWS (Jan. 29, 2020 9:01 P.M.) <https://www.nbcnews.com/health/womens-health/u-s-finally-has-better-maternal-mortality-data-black-mothers-n1125896>.

⁶⁵ Chuck, *supra* note 64.

⁶⁶ Belluz, *supra* note 61.

⁶⁷ *Id.*

below countries such as Kenya and Rwanda.⁶⁸ Worse, CDC-approved experts on the subject have affirmed that 60 percent of these fatalities are preventable.⁶⁹ This bears repeating—60 percent of maternal fatalities are preventable.

Given these statistics, it is important to note the growing recognition that it is scientifically “untenable to view race as capturing biological divisions within human populations.”⁷⁰ In other words, the idea that physiological differences account for worse maternal health outcomes in Black women is being discounted by the scientific community because it is not biologically plausible for genetic differences alone to play a major role in racial/ethnic differences in health.⁷¹

As one of the few health measures included in the United Nations Sustainable Health Goals, “[m]aternal mortality is a sentinel public health indicator,”⁷² but until recently, the extent of the maternal health crisis was unknown. It would be reasonable to assume that data on the subject would be a primary concern and would be collected regularly to use as a benchmark of the nation’s public health. However, the United States failed to release maternal health data for a period of twelve years, spanning from 2006 and 2018.⁷³ Notably, the 2018 data revealed that the maternal death rate for Black women more than doubled that of white women: 37.1 deaths per 100,000 live births compared to 14.7.⁷⁴ Native American and Native Alaskan women account for the second highest maternal mortality rate, which is more than double the rate of their white counterparts.⁷⁵ While the abysmal statistics should incite a sense of national embarrassment, they also provide a starting point for addressing the issue. With deliberate action and power of the law, the Black maternal health crisis is not beyond repair.

The first step in this process is recognizing these racial disparity gaps, which have existed for decades, and in some places, continue to grow. On a broad scale, researchers attribute the existence of these disparities to a variety of structural

⁶⁸ *Id.*

⁶⁹ Samantha Vincenty, *Kamala Harris Is Fighting to Protect Black Mothers from Medical Bias*, THE OPRAH MAG. (Aug. 14, 2020), <https://www.oprahmag.com/entertainment/a33577853/kamala-harris-black-maternal-health-care-crisis/>.

⁷⁰ David R. Williams, *Racial/Ethnic Variations in Women’s Health: The Social Embeddedness of Health*, 92 AM J. PUB. HEALTH 558, 597 (Apr. 2002).

⁷¹ *Id.*

⁷² Chuck, *supra* note 64.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ Gabrielle Frank & Rheana Murray, *Black. Pregnant. And COVID 19 positive.*, TODAY.COM, <https://www.today.com/health/how-coronavirus-affects-black-pregnant-women-t185645> (Sept. 1, 2020).

factors, including: “access to healthy food and safe drinking water, safe neighborhoods, good schools, decent jobs, and reliable transportation.”⁷⁶ These inequities affect Black women’s health, before, during, and after pregnancy.⁷⁷ In particular, poverty, lack of access to quality health care, location, and preexisting conditions are considered prime culprits.⁷⁸ However, research also reveals that structural inequities do not provide a full explanation of racial disparities in maternal mortality.⁷⁹ That is, elevated maternal mortality rates among Black women “span income and educational levels, as well as socioeconomic status,” indicating that in addition to structural racism, individual racism, or rather implicit bias, are also at play.⁸⁰ As such, even when Black women have access to health care, live in middle to upper middle-class neighborhoods, have financial security, and know the benefits of availing themselves to healthy diets, they are still far more likely to die as a result of childbirth or pregnancy.⁸¹

What was once pervasive racist propaganda in the medical field is now more commonly expressed through, perhaps unintended, implicit biases and/or micro-aggressions, in both medical school and in practice.⁸² Studies reveal that the effects of prolonged exposure to these ingrained beliefs and systems can “result[] in conditions . . . including hypertension and pre-eclampsia,” two leading causes contributing to the high maternal mortality rate in Black women.⁸³

C. THE TRAGIC EFFECTS OF SYSTEMIC INEQUITIES, IMPLICIT BIASES, AND INDIVIDUALIZED RACISM ON BLACK MOTHERS

Four accounts of Black mothers who received hospital care make the dangers of giving birth in America as a Black woman abundantly clear. Take, for example, the story of Shalon Irving, an epidemiologist at the CDC, whose life work sought to expose how people’s limited access to health care leads to poor health

⁷⁶ Chuck, *supra* note 64.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ Maternal CARE Act, H.R. 2902, 116th Cong. (2019) <https://www.congress.gov/bill/116th-congress/house-bill/2902/text> [hereinafter Maternal CARE Act]; Implicit Bias exists when people unconsciously hold attitudes toward others or associate stereotypes with them. *Implicit Bias*, STAN. ENCYCLOPEDIA OF PHIL. (revised on July 31, 2019).

⁸⁰ Maternal CARE Act, *supra* note 79.

⁸¹ *Id.*

⁸² STAN. ENCYCLOPEDIA OF PHIL., *supra* note 79.

⁸³ Maternal CARE Act, *supra* note 79.

outcomes.⁸⁴ When Irving conceived, she did not take her pregnancy lightly.⁸⁵ Between the acknowledged risks of postpartum hypertension and peripartum heart failure among Black mothers, along with Irving's own complicated journey to pregnancy, one might think her doctors would have anticipated the need to closely monitor and follow-up with her postpartum.⁸⁶ Predictably, three weeks after giving birth, Irving suffered complications from high blood pressure.⁸⁷ When Irving informed her doctor that she felt unwell and had dramatic swelling in her leg, she was prescribed medication for high blood pressure and sent home without any further monitoring.⁸⁸ That night, she collapsed in her home from cardiac arrest, which ultimately led to her untimely death.⁸⁹

The irony of a researcher working to eradicate disparities in health access and outcomes becoming a symbol of one of the most troublesome health disparities currently facing Black women is patent. It proves that you "cannot simply educate or health care access your way out of this crisis."⁹⁰ Irving's mother believes that had the doctors taken Irving's symptoms and complaints of pain more seriously, potentially life-saving treatment could have been rendered, and Irving would still be alive today.⁹¹

The birth experience of Olympic tennis player, Serena Williams, further depicts how neither status nor money can fully shield Black women from the detriments arising from structural racism, individual racism, and implicit biases. Williams detailed how her doctor and nurses initially dismissed her concerns of potentially fatal blood clots, ultimately jeopardizing her life.⁹² Instead of conducting a CT scan to identify potential clots and administer blood thinners intravenously, as Williams had requested, doctors performed an ultrasound, delaying treatment and putting Williams's life further in danger.⁹³

Finally, the medical team obeyed Williams's diagnostic requests, found that she was suffering from several blood clots, and commenced appropriate treatment.⁹⁴ Perhaps lingering and even subconscious perceptions, which equate

⁸⁴ Nina Martin & Renee Montagne, *Nothing Protects Black Women From Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 17, 2017), <https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth>.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ Martin and Montagne, *supra* note 84.

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

Black bodies to being “super bodies,” or implicit biases regarding Black women’s abilities to correctly identify and communicate issues within their bodies, are responsible for situations like the one Williams experienced. Whatever the culprit, her story highlights that even with the best medical care money can buy, valid and urgent concerns regarding a Black woman’s health were questioned and disregarded.

The story of twenty-six-year-old Amber Isaac also shows how even when Black women advocate on their own behalf, their efforts fall on deaf ears. During the final days of her pregnancy, Isaac tweeted that she would write an exposé on “dealing with incompetent doctors,” who neglected her and administered “rude and unprofessional” care during her pregnancy.⁹⁵ After feeling overlooked at her treating hospital, Isaac insisted on additional blood work from outside the facility.⁹⁶ The results revealed that Isaac’s platelet count was low and that she would require more specialized care to prevent her risk of internal bleeding.⁹⁷ Isaac made repeated attempts to alert her medical team to her condition, but her efforts were futile.⁹⁸ It was not until the day of her delivery that doctors realized she had HELLP syndrome, a disorder of the liver and blood that can be fatal if left untreated.⁹⁹ In fact, the acronym “HELLP” stands for the three major abnormalities seen on the initial lab analysis, including low platelet count.¹⁰⁰ Unfortunately, this revelation proved to be too shortsighted.¹⁰¹ Isaac died after being induced more than a month early into an emergency Cesarean section.¹⁰²

When advocating for oneself is not a viable method to receive proper medical care, it seems logical that having a close family member advocate on one’s behalf could make a difference. However, that is not the case either. In 2016, Kira Johnson was admitted to the hospital after going into labor.¹⁰³ After noticing

⁹⁵ Alexandra Villarreal, *New York Mother Dies After Raising Alarm on Hospital Neglect*, THE GUARDIAN (May 2, 2020), <https://www.theguardian.com/us-news/2020/may/02/amber-rose-isaac-new-york-childbirth-death>.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ Tanya A. Christian, *New York Woman Dies During Childbirth Days After Tweeting Concerns About Hospital Care*, ESSENCE (Apr. 29, 2020), <https://www.essence.com/news/amber-isaac-dies-childbirth-bronx-hospital-tweet/>.

¹⁰⁰ *Id.*

¹⁰¹ Euna Chi, *HELLP Syndrome*, HEALTHLINE PARENTHOOD (Sept. 12, 2018), <https://www.healthline.com/health/hellp-syndrome>.

¹⁰² Villarreal, *supra* note 95.

¹⁰³ Angela Helm, *Kira Johnson Spoke 5 Languages, Raced Cars, Was Daughter in Law of Judge Glenda Hatchett. She Still Died in Childbirth*, THE ROOT (Oct. 19, 2018), <https://www.theroot.com/kira-johnson-spoke-5-languages-raced-cars-was-daughte-1829862323>.

blood in Johnson’s catheter, her husband immediately notified nurses and doctors, who quickly determined a CT scan was in order.¹⁰⁴ Until that moment, Johnson, who speaks five languages, races cars, and was the daughter-in-law of famed Black American Judge Hatchett, was in “excellent health” and had experienced a normal pregnancy.¹⁰⁵ Despite repeated requests to perform the necessary CT scan, the medical team failed to do so and after seven hours had passed, Johnson tragically died.¹⁰⁶ After finding three liters of blood in Johnson’s stomach, doctors discovered that Johnson hemorrhaged, ultimately causing her heart to stop.¹⁰⁷ Johnson received care in a world-renowned hospital and had no preexisting conditions, but she died because medical professionals failed to heed the repeated warnings and requests from her husband.

While there are many additional and similar stories, these anecdotes highlight how status, education, fame, ample resources, and echoed advocacy from Black pregnant women and their families still fall short of securing required and often lifesaving treatment. The suboptimal clinical treatment, implicit biases, and individual racism, coupled with more deeply entrenched issues such as stifled access to quality care and limited access to feasible health insurance, make these narratives all too common within maternal health conversations.

The relative dearth of comparable experiences for white women indirectly reveals how this is most certainly a crisis involving race. To strengthen the racial argument, a report from Amnesty International confirms how a woman’s birthing experience was affected by her being Black.¹⁰⁸ One doctor reportedly took her aside after her delivery and told her, “[w]e don’t get many Black patients. They’re just not used to your personality, asking the questions that you’re asking, saying what you’re saying. Challenging and holding them to their diagnoses.”¹⁰⁹

Additionally, limited Medicaid coverage in many states with already large health disparities creates added impediments for Black women to secure long-term health insurance.¹¹⁰ The result is that women who are thought to be uninsured or on public health assistance report being treated “horribly by medical

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ AMNESTY INTERNATIONAL, *DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 23* (2009) [hereinafter *DEADLY DELIVERY*], <https://www.amnestyusa.org/files/pdfs/deadlydelivery.pdf>.

¹⁰⁹ *Id.*

¹¹⁰ Gabrielle T. Wynn, *The Impact of Racism on Maternal Health Outcomes for Black Women*, 10 U. MIAMI RACE & SOC. JUST. L. REV. 85, 93 (2019).

staff at hospitals.”¹¹¹ They are subject to unreasonably long delays, and are often ignored or treated with indifference by staff.¹¹²

To this point, according to the 2017 National Healthcare Disparities Report, Black patients received worse care than white patients on 40 percent of quality measures.¹¹³ Furthermore, Black women received worse access to care compared to white patients on 52 percent of the measures.¹¹⁴ Though general standards of care and best practices for obstetric emergencies exist, the success of these practices depends greatly on clinical performance, i.e., how the treatment or intervention is carried out.¹¹⁵ When physicians are individually racist, implicitly biased, or hold inaccurate perceptions of Black women, clinical care and what should be standard treatments may vary greatly when executed. Perhaps, not surprisingly, the fact that “three-quarters of Black women in the United States deliver their babies in only one-quarter of the U.S. hospitals” reveals how clinical underperformance is disproportionately situated within a limited geographic scope.¹¹⁶ In other words, according to data, Black women receive care in a concentrated set of hospitals and these hospitals appear to provide a lower quality of care.¹¹⁷

III. PRESCRIPTION

The following section provides a detailed framework for how existing legal doctrines can facilitate the implementation of Restorative Justice and ultimately improve the status of Black mothers. The section concludes with an in-depth analysis of the Black Maternal Health Momnibus Act of 2020 and suggestions to improve the Act’s capacity to effectuate meaningful change.

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ), 2017 NATIONAL HEALTHCARE DISPARITIES REPORT 1, 14 (Sept. 2018) [hereinafter AHRQ REPORT], <https://www.ahrq.gov/research/findings/nhqdr/nhqdr17/index.html>.

¹¹⁴ *Id.*

¹¹⁵ Wynn, *supra* note 110, at 92.

¹¹⁶ Elizabeth Howell, et. al., *Black-white Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OBSTETRICS & GYNECOLOGY 122.e1, 122.e1 (2016).

¹¹⁷ *Id.*

A. REVITALIZING THE FOURTEENTH AMENDMENT’S EQUAL PROTECTION DOCTRINE THROUGH RESTORATIVE JUSTICE CAN IMPROVE THE STATE OF BLACK MOTHERS IN AMERICA

Distinct from prejudiced beliefs that manifest through individual bad acts or implicit biases, structural racism results from a set of “reciprocal and mutual interactions within and between institutions.”¹¹⁸ The product of these interactions is inequality through a set of “cumulative effects of discrimination ‘over time and across domains.’”¹¹⁹ Unfortunately, health care, and more specifically, maternal health care, is one of the many casualties of structural racism. But despite the daunting nature of deeply engrained structural racism, addressing it has the ability to reshape society in ways that deemphasize unequal pathways.¹²⁰

One of the most effective ways to commence the process of dismantling structural racism is through restorative justice focused on the Equal Protection Doctrine. As it currently exists, the Equal Protection Doctrine “misconceives of race discrimination as the product of a strictly individual type of racism.”¹²¹ This is why reframing the doctrine to account for a more accurate and structural conception of racism could provide a better framework to achieve equity. Currently, the Court applies the Equal Protection Doctrine in a way that harbors structural racism as a result of two barriers embedded in the doctrine.¹²² First, is the prioritization of discriminatory intent over discriminatory effect and second, the decontextualization of facts concerning race.¹²³

As applied, these barriers present a “glaring mismatch” between the doctrine and the needs of people whose fates rely on it.¹²⁴ This is due to the Court’s current application of the doctrine, which enables the creation of a legal standard, thereby preventing racial minorities from receiving equal treatment.¹²⁵ It is important to note, however, that restorative justice does not seek to supplant the doctrine; rather, it encourages jurists to reframe the doctrine by prioritizing intent and contextualizing relevant facts. To better understand this approach, it is necessary

¹¹⁸ Rebecca M. Blank, *Tracing the Economic Impact of Cumulative Discrimination*, 95 AM. ECON. REV. 99, 100 (May 2005).

¹¹⁹ Doron Samuel-Siegel et. al., *Reckoning with Structural Racism: A Restorative Jurisprudence of Equal Protection*, 23 RICH. PUB. INT. L. REV. 137, 150 (2020).

¹²⁰ *Id.* at 152.

¹²¹ *Id.* at 141.

¹²² *Id.* at 152.

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ Samuel-Siegel et. al, *supra* note 119, at 152.

to examine the Equal Protection Doctrine and the inherent problems with its current interpretation and application.

The Equal Protection Doctrine is two-fold. On one end, it facilitates cases to challenge facially neutral policies that create disparate harm to people in marginalized groups.¹²⁶ On the other end, it allows plaintiffs to challenge government policies designed to remediate the harms of discrimination against members of marginalized groups.¹²⁷ Under the Fourteenth Amendment, if a law confers a burden or benefit based on a particular group of people, and not to others, then the law may be unconstitutional.¹²⁸ The court must apply the appropriate degree of scrutiny when reviewing the law, based on the group classification. The degree of scrutiny is the level of skepticism the court holds as to the motive and purpose underlying the government's action.¹²⁹ Strict scrutiny applies when the law's classification burdens a group of people based on their race.¹³⁰ For such laws to be constitutional, they must be narrowly tailored to further a compelling government interest.¹³¹

With regard to the second prong of the Equal Protection Doctrine, strict scrutiny is always applied to policies that explicitly use racial classifications, "even when race is being used to remedy the effects of discrimination."¹³² The result of this is that people of color face insurmountable barriers when trying to remedy racial inequality.¹³³

¹²⁶ U.S. Const. amend. XIV, § 2.

¹²⁷ *Id.*

¹²⁸ Doron Samuel-Siegel et. al., *supra* note 119, at 154.

¹²⁹ *Id.* at 153-54.

¹³⁰ Suspect classes include race, ethnicity, and nationality. See Sonu Bedi, *Collapsing Suspect Class with Suspect Classification: Why Strict Scrutiny is Too Strict and Maybe Not Strict Enough*, 47 GA. L. REV. 301, 308 (2013).

¹³¹ *Id.* See, e.g., *Williams-Yulee v. Fla. Bar*, 575 U.S. 433, 435 (2015) (Canon of judicial ethics prohibiting judicial candidates from personally soliciting campaign contributions serves compelling state interests in preserving the integrity of its judiciary and maintaining the public's confidence in an impartial judiciary). *But see*, *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 508 (1989) (A city's plan requiring prime contractors awarded city construction contracts to subcontract at least 30 percent of the dollar amount of each contract to one or more "Minority Business Enterprises" was not narrowly tailored to remedy prior discrimination; there did not appear to have been any consideration of the use of race-neutral means to increase minority business participation in city contracting, and the 30 percent quota could not be said to be narrowly tailored to any goal, except perhaps outright racial balancing.)

¹³² Samuel-Siegel et. al., *supra* note 119, at 141.

¹³³ *Id.* at 154.

B. SHIFTING THE FOCUS OF THE EQUAL PROTECTION DOCTRINE FROM DISCRIMINATORY INTENT TO DISCRIMINATORY PURPOSE IS NECESSARY TO ACHIEVE RESTORATIVE JUSTICE AND COMBAT THE BLACK MATERNAL HEALTH CRISIS

The Court addressed the first prong of the doctrine, which focuses on intent versus effect, in *Washington v. Davis*.¹³⁴ There it established that a showing of racially “discriminatory purpose” was necessary to apply strict scrutiny, regardless of discriminatory effects.¹³⁵ The Court went on to solidify the “intent doctrine” in *Massachusetts v. Feeny*, where it clarified the definitional framework, stating:

discriminatory purpose . . . implies more than intent as violation or intent as awareness of consequences. It implies that the decision maker . . . selected or reaffirmed a particular course of action at least in part “because of,” not merely “in spite of,” its adverse effects upon an identifiable group.¹³⁶

But in reality, even absent racist intent, people of color still suffer the effects of racial inequality.¹³⁷ As such, the effect of the intent doctrine is that it insulates structural racism from constitutional scrutiny by failing to acknowledge the effects of seemingly race-neutral policies.¹³⁸

Absent evidence of intentional discrimination by identifiable actors in a given setting, “the doctrine maintains that the Fourteenth Amendment’s strongest protection is not available to help remedy the effects of structural racism.”¹³⁹ To

¹³⁴ *Washington v. Davis*, 426 U.S. 229, 242, 267 (1976).

¹³⁵ *Id.* at 240 (rejecting the discrimination claim of black city employee applicants who were denied jobs because of failure to pass a test that whites passed at disproportionate rates); To pass strict scrutiny, the legislature must have passed the law to further a “compelling governmental interest,” and must have narrowly tailored the law to achieve that interest. Strict scrutiny is the highest standard of review, which a court will use to evaluate the constitutionality of governmental discrimination.

¹³⁶ *Pers. Adm’r of Mass. v. Feeny*, 442 U.S. 256, 277 (1979).

¹³⁷ Doron Samuel-Siegel et. al., *supra* note 101, at 157.

¹³⁸ *Id.*

¹³⁹ See, e.g., Mark Dorosin, *A Civil Rights Act for the 21st Century: The Privileges and Immunities Clause and a Constitutional Guarantee to be Free From Discriminatory Impact*, 6 WAKE FOREST J.L. & POL’Y 35, 36 (2016) (“Our current equal protection jurisprudence fails to address the reality of race discrimination in the twenty-first century. The entrenchment of racial inequities caused by the disparate discriminatory impacts of ostensibly facially-neutral policies and practices of government officials. While these policy decisions are often made with full knowledge and

this end, the Court has explicitly refused to consider discriminatory effects in scenarios where discriminatory intent is not readily identifiable, “opining that the ‘Fourteenth Amendment guarantees equal laws, not equal results.’”¹⁴⁰

For instance, in *McCleskey v. Kemp*, by prioritizing individual intent, the Court glossed over empirical evidence suggesting the law’s racially disparate effects.¹⁴¹ There the Court addressed Georgia’s death sentencing laws and determined the evidence presented was insufficient because it lacked proof that decision makers in the case intended any discrimination.¹⁴² The evidence presented was a statistical study that exposed disparities in the imposition of the death sentence, which correlated with race.¹⁴³ Among its findings, the study revealed defendants charged with killing white victims were 4.3 times more likely to be sentenced to death than those charged with killing Black victims.¹⁴⁴

Furthermore, the study found that “prosecutors pursued the death penalty for 70% of Black defendants with white victims, but only for 15% of Black defendants with black victims, and only 19% of white defendants with black victims.”¹⁴⁵ Although the Court accepted the study’s validity and findings, it denied the plaintiff’s petition claiming he did not offer specific evidence to support an inference that racial considerations prejudiced his sentencing.¹⁴⁶ By failing to consider the unequal outcomes Black people in Georgia experienced as a result of the law, the Court ignored the actual effect the law was having on Black people in the state.

The reasoning in *McCleskey* highlights how the constitutional guarantee of “equal protection” defends the racial status quo instead of promoting reform.¹⁴⁷

foreseeability of the adverse consequences for communities of color, current constitutional jurisprudence demands that unless those decisions are made *because of* those impacts, and not merely *in spite of them*, they are not actionable.”)

¹⁴⁰ Feeney, 442 U.S. at 277.

¹⁴¹ See *McCleskey v. Kemp*, 481 U.S. 279 (1987). Other examples abound. See, e.g., *Pers. Adm’r of Mass. v. Feeney*, 442 U.S. 256, 278 (1979) (where the Court made clear it was not concerned with the inevitable, unequal effects of the law, no matter how obvious or predictable the discriminatory effects will be). For further discussion, see Ian F. Haney-López, *Intentional Blindness*, 81 N.Y.U.L. REV. 1779, 1834 (2012) (stating that the Feeney majority “imposed an exacting definition of discriminatory purpose: [o]nly a conscious intent to harm, not simply an awareness of harmful consequences, would qualify. The immediate payoff of this definitional constriction was to exonerate Massachusetts. The long-term impact was a major step toward closing courthouse doors to contextual evidence of discrimination against vulnerable groups.”)

¹⁴² *Kemp*, 481 U.S. at 279.

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 287.

¹⁴⁵ *Id.*

¹⁴⁶ *Id.* at 279-80.

¹⁴⁷ Ian F. Haney-López, *Intentional Blindness*, 87 N.Y.U. L. REV. 1779, 1781 (Dec. 2012).

Insisting that a blameworthy perpetrator be identified to acknowledge the existence of racial discrimination creates an alternative reality where discrimination only exists if it is consciously intended.¹⁴⁸ It is through this type of willful ignorance that the Court can be credited for contributing to racial inequality, while sustaining both racial oppression and structural inequalities. Still, the Court is equipped to address and remedy this misguided approach with a relatively simple but fundamentally revitalized approach—using restorative jurisprudence would offer a forward-looking conception of equal protection by prioritizing the “*effects* of wrongdoing over questions about potential wrongdoers’ intent.”¹⁴⁹

Specifically, within the context of Black maternal health, a restorative justice approach looks like reprioritizing the Supreme Court’s analytical approach to prompt jurists to acknowledge and search for discriminatory effects and remedies. One example of how this can be achieved is by reckoning with the ways in which structural racism distresses low-income Black women. Although economics fail to fully account for the disproportionate deaths among Black pregnant mothers, income is certainly a factor that can be attributed, in part, to structural racism.

Consider the case of Texas, where lawmakers gutted Title X funding and caused reproductive health clinics to close.¹⁵⁰ As a result, maternal mortality rates skyrocketed and not surprisingly, Black women bore the brunt of the decision.¹⁵¹ Instead, lawmakers could have considered the effects of defunding reproductive health providers, while reasonably anticipating that low-income women—predominantly Black women—would be impacted most severely. That type of foreshadowing could inform legal and legislative decisions to mitigate the negative effects they have on suspect classes, even when those effects are unintentional.

Under a restorative justice setting, states’ abilities to remove funding, or to allow Black-serving hospitals to continuously underperform, would be abolished because under no circumstance would such actions evade discriminatory effects on Black women. This reframed approach would then facilitate the process of recalibrating the current crisis by adding a check to the system that currently

¹⁴⁸ Doron Samuel-Siegel et. al., *supra*, note 119, at 161.

¹⁴⁹ *Id.* at 171.

¹⁵⁰ Nina Martin, *Texas Is One of the Most Dangerous Places in The Developed World To Have a Baby*, PAC. STANDARD (Sept. 1, 2016), <http://psmag.com/news/texas-is-one-of-the-most-dangerous-places-in-the-developed-world-to-have-a-baby> [<http://perma.cc/MCP7-Y7YW>].

¹⁵¹ Kristy Johansen & Zachary Green, *The Fight to End Texas’ High Maternal Mortality Rate* (May 25, 2019), <https://www.pbs.org/newshour/show/the-fight-to-end-texas-high-maternal-mortality-rate#:~:text=Texas%20has%20one%20of%20the,birth%20in%202012%20to%20Klaire>.

disregards the practical reality that Black women suffer at the hands of laws imposing discriminatory effects.

C. THE EQUAL PROTECTION DOCTRINE MUST TAKE INTO ACCOUNT THE SPECIFIC AND HISTORICAL CONTEXT OF LAWS TO EMBODY ITS FULL POTENTIAL

The second barrier to interpreting structural racism under the Equal Protection Doctrine arises from the Court's acontextual approach in applying the law. The Court has admitted that context is essential, explaining that the meaning of a statutory provision must be construed not in isolation but in context.¹⁵² However, the Court's routine decontextualization in race discrimination claims treats the backdrop of governmental racial oppression as inoperative.¹⁵³ Coupled with the Equal Protection Doctrine's second prong, which always involves strict scrutiny, any projected effect or context of a law becomes irrelevant.¹⁵⁴ Meaning, the Court has interpreted the Equal Protection Clause to subject race-based policies, designed to help people of color, to the same standards as policies that hurt people of color because of their race.¹⁵⁵

For instance, in *City of Richmond v. J.A. Croson, Co.*, the Court established "strict scrutiny applies whenever race is used on the face of a law or policy, regardless of which racial group is singled out or why."¹⁵⁶ Taken together with the decision in *Regents of Univ. of Cal. v. Bakke*, where the Court significantly limited the constitutionality of affirmative action,¹⁵⁷ the Court essentially announced "compelling state interests do not include an interest in remedying the

¹⁵² *FTC v. Mandel Brothers, Inc.*, 359 U.S. 385, 389 (1959) ("The meaning—or ambiguity—of certain words or phrases may only become evident when placed in context . . . A court must therefore interpret the statute 'as a symmetrical and coherent regulatory scheme,' and 'fit, if possible, all parts into a harmonious whole.'")

¹⁵³ See, e.g., William M. Wiecek & Judy L. Hamilton, *Beyond the Civil Rights Act of 1946: Confronting Structural Racism in the Workplace*, 74 LA. L. REV. 1095, 1101 (2014) (observing that the "Court approaches racial controversies in ways that remove them from their social and historical context . . . mandat[ing] instead an abstract and formalistic resolution of race-related issues").

¹⁵⁴ Doron Samuel-Siegel et. al., *supra* note 119.

¹⁵⁵ *Id.* at 154.

¹⁵⁶ *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 521 (1989).

¹⁵⁷ "'Affirmative action' means positive steps taken to increase the representation of women and minorities in areas of employment, education, and culture from which they have been historically excluded." Stanford Encyclopedia of Philosophy, *Affirmative Action*, <https://plato.stanford.edu/entries/affirmative-action/> (last visited Oct. 21, 2020).

effects of ‘societal discrimination.’”¹⁵⁸ In both cases, the Court failed to recognize the tangible injuries arising from structural racism and how affirmative action could serve to remedy these injuries. The effect of requiring race neutral remedies further entrenches structural racism by ignoring the lived experiences of people of color and preventing the government from addressing root causes of racial inequality.

Other Supreme Court decisions, including *Maier v. Roe*, *Beal v. Doe*, and *Harris v. McRae*, exemplify how context is essential to understanding and deciding legal issues. Those cases all imprudently suggest that indigent women forged their social and socioeconomic conditions entirely on their own—thereby denying the state’s share of responsibility or, at the very least, complicity in their indigence.¹⁵⁹ To carry on as if Black women’s economic and social statuses were developed in a vacuum disregards the extensive history of state-manufactured conditions, including those that denied Black women political access, control over their reproductive health, economic opportunities, and the full realization of their constitutional rights.¹⁶⁰ Presently, the state has made minimal efforts, if any, to disrupt the poverty cycle that haunts the children and grandchildren of Black Americans who lived under decades of state-sponsored terror.¹⁶¹ In fact, the Court’s decisions in *Beal*, *Maier*, and *Harris* work to perpetuate these poverty cycles by forcing underprivileged women to seek care at under-resourced facilities that provide exceptionally limited options.

Failing to take into account the multi-generational oppression Black women have experienced at the hands of the state allows the law to be used as a vehicle to perpetuate systemic racism. In fact, proponents of restorative justice believe it is impossible to achieve justice without taking into account the backdrop against which societal relations occur.¹⁶² Thus, restorative jurisprudence provides the appropriate context to allow Justices and jurists to recalibrate the Equal Protection Doctrine to acknowledge that remedying “societal discrimination” is a compelling government interest, and that using race-based measures to do so might be an essential component to achieving that interest.¹⁶³ To illustrate by way of example, the Indian Child Welfare Act (“ICWA”) seeks to protect Indian children’s best

¹⁵⁸ *City of Richmond*, 488 U.S. at 521.

¹⁵⁹ Michele Goodwin & Erwin Chemerinsky, *Pregnancy, Poverty, and the State the Poverty of Privacy Rights* by Khiara M. Bridges Stanford University Press, 2017, 127 YALE L.J. 1270, 1307 (Mar. 2018).

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² William M. Wiecek, *Structural Racism and the Law in America Today: An Introduction*, 100 KY. L.J. 1, 7 (2011).

¹⁶³ 25. U.S.C. §§ 1901 et seq. (2010).

interests and promotes stable and secure Indian households and tribes by establishing standards for the process of placing Indian children in homes.¹⁶⁴ This Act is in response to the horrific and traumatizing experiences to which Indian children were subjected which resulted in the erasure of their language and culture. Presently the Act provides additional minimum standards for Indian children in the welfare system, requiring they be placed in homes that will reflect the “unique value of Indian culture.”¹⁶⁵ While other children in the welfare system are not afforded these additional protections, these safeguards are necessary to redress the irreparable harm that ensued prior to the Act.¹⁶⁶

While the notion of restorative justice may initially seem fantastical, these restorative values are not in any sense “extra-legal.”¹⁶⁷ In fact, they have “ample basis in Supreme Court precedent.”¹⁶⁸ That is, this suggestion is not a “wholesale transformation, but rather a perspective-taking and a reprioritization for jurists engaging in equal protection analysis.”¹⁶⁹

As of 2016, at least thirty-two states had enacted some form of legislation related to interpersonal restorative justice.¹⁷⁰ Among these policies, victim-offender mediation is the most common form of restorative justice employed.¹⁷¹

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ Doron Samuel-Siegel et. al., *supra* note 119, at 177.

¹⁶⁸ *Id.*

¹⁶⁹ Needs more information we couldn't access this source. Correction using the information available to us: Shannon M. Sliva & Carolyn G. Lambert, *Restorative Justice Legislation in the American States*, 14 J. POL'Y PRACT. 77, 85 (2015). Among them are, for example, Colorado, Delaware, Florida, Maine, Minnesota, Missouri, Montana, South Carolina, Vermont, Virginia, and West Virginia. Sandra Pavelka, *Restorative Justice in the States: An Analysis of Statutory Legislation and Policy*, 2 JUST. POL. J. 1, 17–23 (2016). Montana, for example, has made a particularly strong and permanent investment in restorative infrastructure through the creation of the Office of Restorative Justice, reinforced by statute. *Id.* at 20. Other states such as Colorado, Maine, and Vermont have fashioned statutory schemes to provide funding and organization for more localized restorative structures such as community reparative and accountability boards. ME. STAT. 17-A, § 1204-A (1997); VT. STAT. tit. 28, § 910 (1999) (amended in 2011); COLO. REV. STAT. § 19-2-309.5 (2016). Fourteen states, ranging from politically liberal states such as California and Oregon to conservative strongholds such as Arkansas, Louisiana, and Georgia, subscribe to the infusion of quasi-restorative practices into their state law, including VOMs and avenues to facilitate dialogue between victim and offender. Sandra Pavelka, *Restorative Justice in the States: An Analysis of Statutory Legislation and Policy*, 2 JUST. POL. J. 1, 7 (2016).

¹⁷⁰ Sliva, *supra* note 169, at 78-79.

¹⁷¹ Sandra Pavelka, *Restorative Justice in the States: An Analysis of Statutory Legislation and Policy*, 2 JUST. POL. J. 1, 17–23 (2016). The statutory guidelines for restorative justice are further affirmed by some increased or prioritized funding for schools utilizing a restorative justice punishment framework.

School discipline involving restorative practices is also becoming more common, with some states even enacting supporting legislation.¹⁷² These alternative forms of justice make evident the purpose behind restorative justice, which seeks not to punish wrongdoers but instead, focuses on how to heal the harms created by the wrongdoing.¹⁷³ This requires a context-specific and forward-looking approach focused on real-world effects of legislation.

In sum, reframing the current application of the Equal Protection Doctrine provides a fulsome, values-based framework for striving toward equality.¹⁷⁴ Specifically, restorative justice has the potential to first, reveal the existence of structural racism and the ways in which the doctrine, as currently applied, falls short of addressing it. Second, restorative justice can equip jurists to grapple with the complexity of structural racism by refocusing their priorities on the effects of laws while resituating them within relevant contexts. Finally, restorative justice can open the Equal Protection Doctrine to the remedies that are capable of interrupting structural racism, through new and existing legislation.

With a foundation of restorative justice, the ease and acceptance of targeted legislation not only becomes more conventional, but also necessary to combat discriminatory effects and navigate the historical context that has contributed to the Black maternal health crisis. Specific legislation serves two purposes: (1) it provides the incremental changes necessary to erode structural racism, and (2) it attempts to contain the individualized aspects of racism that the law is best equipped to condemn. It is with this vision that this comment turns to examine current forms of legislation aimed at generating equity within Black maternal health. The purpose of the following section is to acknowledge existing laws attempting to address the Black maternal health crisis, examine laws and practices from other countries to see how those ideas may lend to a solution in America, and identify new ways in which the law can aid in realizing equilibrium for Black mothers.

IV. UNDER A REVITALIZED SYSTEM, TARGETED LEGISLATION CAN CONTRIBUTE TO SUCCESSFULLY REVERSING THE CRISIS

Addressing structural change to improve the birth outcomes and lives of Black mothers means new laws and policies. A beacon of hope comes in the form of the

¹⁷² Jennifer J. Llewellyn & Robert Howse, *Restorative Justice: A Conceptual Framework*, PREPARED FOR THE LAW COMMISSION OF CANADA (1999), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2114291.

¹⁷³ *Id.* at 199.

¹⁷⁴ BMHMA, *supra* note 16.

2020 proposed legislation that Senator Kamala Harris, Congresswoman Lauren Underwood, and Congresswoman Alma Adams introduced, S. 3424—the Black Maternal Health Momnibus Act of 2020 (“BMHMA”).¹⁷⁵ The purpose of this act is to “end preventable maternal mortality and severe maternal morbidity in the United States and close disparities in maternal health outcomes.”¹⁷⁶

To achieve its goal, the Act consists of nine individual bills sponsored by Black Maternal Health Caucus Members. The bills range from making critical investments in social determinants of health, providing funding to community-based organizations, growing and diversifying the perinatal workforce, improving data collection processes and quality measures, supporting maternal mental health, humanizing conditions for incarcerated women, investing in digital tools to track data and treatment, and promoting innovative payment methods to sustain high-quality maternity care and continuity of health insurance coverage.¹⁷⁷

Since March 2020, all nine of the proposed bills have been assigned to subcommittees and are awaiting further action.¹⁷⁸ Given the targeted focus of these bills, without a revitalized system, the legislature and courts may be hard pressed to accept their seemingly radical ideas. One reason for potential pushback is that the bills could be interpreted as affirmative action, and therefore, not race neutral. However, if the legislature and courts interpreted the Act as a means to redress and equalize the effects of historically inequitable maternal health, within the current and past contexts of maternal health as explained herein, the Act’s relevance would be obvious. That is, under restorative jurisprudence, the bills would have a better chance of success, given jurists would be better equipped to appreciate and justify the need for such policies.

A. ADDRESSING SOCIAL DETERMINANTS AFFECTING THE BLACK MATERNAL HEALTH CRISIS

One of the bill’s strengths is that it employs a holistic approach to address the current maternal health crisis. Targeting more than maternal health alone can achieve equilibrium in many of the societal facets that indirectly contribute to the crisis. Accordingly, the bill engages various sectors to improve the overall state of women’s health, including: the Departments of Health, Transportation, and Agriculture, in addition to the national academics environmental studies.¹⁷⁹ This

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ Belluz, *supra* note 61.

provides a realistic framework for change, which begins with “valuing women’s health itself, whether or not a woman happens to be pregnant. That way, women will begin their pregnancies in a healthier state and be well supported after they have had their baby.”¹⁸⁰

The first bill of the Act seeks to ensure women in prenatal and postpartum periods have “safe, stable, affordable, and adequate housing for themselves and their other children.”¹⁸¹ It also proposes improvements to transportation systems to reduce barriers preventing women from attending medical appointments, accessing maternal health services, and obtaining services that provide healthy and nutritious foods.¹⁸² Additionally, the bill focuses on the “impacts of water and air quality, exposure to extreme temperatures,¹⁸³ and pollution levels on maternal and infant health outcomes.”¹⁸⁴ Collectively, the bill identifies these areas for improvement as “social determinants.”¹⁸⁵

To improve the social determinants of maternal health, the bill appropriates fifteen million dollars in grant allocations for each fiscal year between 2021 and 2025. For instance, the bill proposes to award grants to state, local, and tribal public health departments that will act to reduce or eliminate “racial and ethnic disparities in maternal health outcomes.”¹⁸⁶ Specifically, these grants will be utilized to: build capacity to hire staff and coordinate efforts, develop and provide resource lists of available social services for women in prenatal and postpartum periods, directly address particular social determinants,¹⁸⁷ and/or develop a “one-stop” resources center that provides coordinated services.¹⁸⁸

¹⁸⁰ BMHMA, *supra* note 16, at 9.

¹⁸¹ *Id.* at 10.

¹⁸² Black women experience greater health effects from heat exposure. In addition, research shows that people of color and low-income people are less likely to have access to air conditioning. As such, rising global temperatures may exacerbate the already large racial gap in maternal health. Meera Jagannathan, *How Climate Change Could Contribute to Racial Maternal-Health Disparities*, MARKETWATCH (Oct. 21, 2020), <https://www.marketwatch.com/story/how-climate-change-could-contribute-to-racial-maternal-health-disparities-2019-10-21>.

¹⁸³ BMHMA, *supra* note 16, at 14.

¹⁸⁴ Title I-Social Determinants for Moms identifies the following as dispositive social determinants for moms: housing, transportation, nutrition, lactation and other infant feeding options, lead testing and abatement, air and water quality, car seat installation, child care access, and wellness and stress management programs. BMHMA, *supra* note 16, at 8.

¹⁸⁵ *Id.* at 18.

¹⁸⁶ *Id.* at 18-19.

¹⁸⁷ *Id.* at 19.

¹⁸⁸ *Id.* at 22.

B. CENTERING THE COMMUNITY AS A RESOURCE IS ESSENTIAL FOR IMPROVING THE QUALITY OF CARE FOR BLACK MOTHERS

Title II of BHMHA awards grants to community-based organizations “offering programs and resources aligned with evidence-based practices for improving maternal health outcomes for Black women.”¹⁸⁹ Under this section, grants will be designated for organizations to: provide culturally congruent training and support to perinatal health workers such as doulas, community health workers, peer supporters, certified lactation consultants, nutritionists and dietitians, social workers, home visitors, and navigators; to conduct or support research on Black maternal health issues; address community specific needs for women in prenatal and post-partum periods; and contribute technical assistance to target these programs.

This section also plans to award grants to accredited hospitals, health systems, and other maternity care delivery settings to establish a respectful maternity care compliance office.¹⁹⁰ The duties of the office would include: institutionalizing mechanisms to allow patients (and their relatives or advocates) receiving maternity care services to report grievances and allowing representatives to respond; and preparing a publicly available, system-wide strategy to reduce racial and ethnic biases, and provide an annual report to the Secretary on the progress and findings.¹⁹¹

This bill appears particularly valuable, given its encouragement of grantees to develop all-encompassing programs to reduce and prevent bias, racism, and discrimination through ongoing training.¹⁹² Grantees awarded funds under this bill would be expected to provide these types of trainings and programs to: front desk employees, sonographers, schedulers, health care professionals, security staff, and hospital or health system administrators.¹⁹³

The two, perhaps, most important aspects of the bill are recommendations to: (1) include a service-learning component that sends providers to work in underserved communities to better understand patients’ lived experiences, and (2) to deliver cultural competence education in undergraduate programs that funnel into medical schools.¹⁹⁴

This section appropriates 5 million dollars to carry out the community initiatives for each fiscal year from 2021 to 2025 and “sums as may be necessary

¹⁸⁹ *Id.* at 32.

¹⁹⁰ BMHMA, *supra* note 16, at 33-34.

¹⁹¹ *Id.* at 28.

¹⁹² *Id.*

¹⁹³ *Id.* at 29.

¹⁹⁴ *Id.* at 31, 36.

for fiscal years 2021 through 2026.”¹⁹⁵ It also provides guidance for strategies and reporting requirements, as well as a preview of the application process and eligibility criteria. Moreover, it proposes an academic study involving a disinterested academic institution to evaluate disrespect and racial bias within the maternal health field and propose potential solutions.

C. CREATING A CULTURALLY AND ETHNICALLY REFLECTIVE PERINATAL WORKFORCE IS A MAJOR COMPONENT IN ADDRESSING THE CRISIS

Title IV of the Act sets forth guidance for states to educate providers and managed care entities about the value and process of delivering respectful maternal health treatment through diverse care provider models.¹⁹⁶ The bill outlines how states can “encourage and incentivize hospitals, health systems, free standing birth centers,” and other maternity care provider groups and managed care entities to: “recruit racially and ethnically diverse staff; with experience practicing in racially and ethnically diverse communities; and who have undergone training on racism and implicit and explicit bias.”¹⁹⁷

Significantly, the bill suggests policies to incorporate midwives into maternal care by providing individuals enrolled in accredited midwifery education programs with opportunities to participate in job shadowing with maternity care teams, health systems, and freestanding birth centers.¹⁹⁸ There is also a component intended to identify and study the current barriers of entry to starting a career in the maternity care field.¹⁹⁹ The proposed grants in this bill are: to establish schools and programs that provide training and licensing in maternal and perinatal health, to expand the capacity of existing schools through scholarships to minority students, and to grow and diversify the nursing workforce in maternal and perinatal care.²⁰⁰

¹⁹⁵ *Id.* at 44.

¹⁹⁶ BMHMA, *supra* note 16, at 44-45.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.* at 56.

¹⁹⁹ *Id.* at 47-48

²⁰⁰ Connor Maxwell & Danyelle Solomon, *Mass Incarceration, Stress, and Black Infant Mortality*, CTR. FOR AM. PROGRESS (June 5, 2018), <https://www.americanprogress.org/issues/race/reports/2018/06/05/451647/mass-incarceration-stress-black-infant-mortality/>.

D. ADDRESSING INCARCERATED MOTHERS HELPS TARGET A DRIVING FORCE OF THE CRISIS

According to an American Public Health Association study, Black women are incarcerated at twice the rate of white women.²⁰¹ This, taken with the fact that mothers define the carceral landscape of women in the U.S.,²⁰² makes it clear that dedicating resources to improve under equipped penal systems will also contribute to improving the Black maternal health crisis. Title VII of the Act seeks to ensure justice for incarcerated mothers.²⁰³ The main highlights of this bill include: ending the shackling of pregnant individuals, creating model programs to care for incarcerated mothers during prenatal and postpartum periods, and improving maternal health outcomes for women in state prisons, local prisons, and jails through grant funds.²⁰⁴

The bill seeks to achieve these goals through a variety of comprehensive services supported by grants totaling 10 million dollars for each fiscal year between 2021 and 2025.²⁰⁵ Services include: counseling and treatment for trauma and substance abuse, access to healthy foods, access to doulas and other perinatal health workers, education and training, and opportunities for postpartum mothers to maintain contact with their newborns.²⁰⁶ By dedicating services to incarcerated mothers, the risk of their pregnancies can be significantly reduced, which translates to better outcomes for Black maternal health overall.

E. TECHNOLOGY CAN LEVERAGE THE AGENCY OF BLACK MOTHERS AND IMPROVE THE MATERNAL CARE THEY RECEIVE

Title VIII of the bill focuses on technology advances to save mothers.²⁰⁷ These technological initiatives include: CMI modeling of integrated telehealth models in maternity care services, grants to promote equity in maternal health outcomes by increasing access to digital tools, grants to expand the use of technology enabled collaborative learning, and capacity models that provide care to pregnant and postpartum women.²⁰⁸

²⁰¹ *Id.*

²⁰² BMHMA, *supra* note 16, at 100.

²⁰³ *Id.* at 101-108.

²⁰⁴ *Id.* at 115.

²⁰⁵ *Id.* at 103-104.

²⁰⁶ *Id.* at 120.

²⁰⁷ BMHMA, *supra* note 16, at 122.

²⁰⁸ *Id.* at 122.

These grants are intended to facilitate the development and acquisition of instructional programming and the training of maternal health care providers (and other professionals who provide or assist in the provision of services), to promote equity in maternal health outcomes by increasing access to digital tools, and to create a report on the use of technology to reduce both maternal mortality and severe maternal morbidity, and to close racial and ethnic disparities in outcomes.²⁰⁹

F. REVAMPING THE COST OF MATERNAL CARE IS ALSO AN ESSENTIAL COMPONENT OF COMBATING THE CRISIS

The final bill in the BMHMA promotes innovative payment models to incentivize high-quality maternity care and continuity of health insurance coverage from pregnancy through labor and delivery and up to one year after delivery.²¹⁰ Specifically, the bill sets forth parameters to establish a “Perinatal Care Alternative Payment Model Demonstration Project,” (“The Demonstration”) to allow states to test payment models under title XIX of their state’s plans of the Social Security Act, and State child health plans under title XXI of the Act.²¹¹ As a follow-up measure, the bill requires a report containing the results of any evaluations and recommendations as to whether the project should continue beyond fiscal year 2026.²¹² It also requests a report from the Medicaid and CHIP Payment and Access Commission on issues related to the continuity of coverage under state plans.²¹³

Notably, the bill calls for relevant entities to examine alternative payment models that include consideration of non-hospital birth settings such as freestanding birth centers, and for the inclusion of non-clinical perinatal health workers such as doulas.²¹⁴

V. CRITIQUE AND SUGGESTIONS FOR THE BMHMA

The BMHMA is the most promising legislation that has been introduced on this topic, but it is not without faults. The following section will critique components of the BMHMA and suggest ways to strengthen the roll-out of its goals.

²⁰⁹ *Id.* at 130-131.

²¹⁰ *Id.* at 137.

²¹¹ *Id.*

²¹² BMHMA, *supra* note 16.

²¹³ *Id.* at 138.

²¹⁴ *Id.*

A. FAILURE TO INCLUDE A NATIONALIZED MATERNITY LEAVE PROPOSAL DILUTES THE ACT’S ABILITY TO EFFECTUATE CHANGE

On a structural level, more overarching legislative change is necessary to facilitate the most feasible access to resources like those proposed in the Act—such as the one-stop homes. It seems the most obvious omission from the BMHMA is its failure to mention the need for a nationalized maternity leave policy.

According to a 2019 report by UNICEF on how nations fare in terms of “family friendliness” among the world’s wealthiest countries, the U.S. was once again at the bottom of the list.²¹⁵ While Estonia topped the list with 85 weeks of maternity leave at full pay, the U.S. trailed all developed nations with a “grand total of zero weeks,” of maternity leave.²¹⁶ Paid-leave policies in the U.S. often create a two-tiered system in which those with higher incomes can afford to stay at home, while lower-income women must continue working.²¹⁷ Studies reveal that new parents with paid medical leave of twelve weeks or greater are more likely to be in better mental and physical shape compared to those who receive less paid leave.²¹⁸ The U.S. was the only country in the analysis, offering absolutely no national paid leave.²¹⁹

Paid maternity leave also ensures babies are less likely to die, have better odds of secure maternal attachment, and are more likely to be breastfed and receive timely vaccinations.²²⁰ Notably, researchers suggest paid maternity leave could help the economy by “substantial individual and societal benefits,” including “labor force attachment, wage stability and decreased use of public assistance.”²²¹

It seems a logical precursor to the innovative and targeted measures the Act proposes that there be a foundational landscape through which women can

²¹⁵ *How Does UNICEF maternity leave compare with EU and OECD countries?*, UNICEF (2016), <https://www.unicef-irc.org/family-friendly>.

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ Steven Reinberg, *12 Weeks of Paid Maternity Leave Benefits Everyone: Study*, U.S. NEWS (Mar. 12, 2020), <https://www.usnews.com/news/health-news/articles/2020-03-12/12-weeks-of-paid-maternity-leave-benefits-everyone-study>.

²¹⁹ Miranda Bryant, *Maternity Leave: U.S. Policy is Worst on List of the World’s Richest Countries*, THE GUARDIAN (Jan. 27, 2020), <https://www.theguardian.com/us-news/2020/jan/27/maternity-leave-us-policy-worst-worlds-richest-countries>.

²²⁰ Suzanne Leigh, *National Paid Maternity Leave Makes Sense for Mothers, Babies and Maybe the Economy: Moms Who Stay Home Longer Less Susceptible to Depression, Domestic Violence, Poor Attachment to Offspring*, UNIVERSITY OF CALIFORNIA SAN FRANCISCO (Mar. 9, 2020), <https://www.ucsf.edu/news/2020/03/416831/national-paid-maternity-leave-makes-sense-mothers-babies-and-maybe-economy>.

²²¹ *Id.*

actually avail themselves of the proposed benefits. A nationalized paid maternity leave would help establish such a foundation. Without alleviating some of the financial burdens women confront as they navigate through pregnancies and motherhood, it seems the Act's suggestions serve more as symbolic recommendations rather than an actionable blueprint for change.

Acknowledging that a nationalized paid maternity leave is unlikely to materialize in the near future, perhaps exploring alternative options to subsidize low-income pregnant women is appropriate. A recent pilot program in San Francisco provides a hopeful approach to coping with the lack of paid maternity privileges.²²² A desperate response to the “lasting health disparities in the Black and Pacific Islander communities,” the city introduced the “Abundant Birth Project.”²²³ The initiative was born from a partnership between the city's Department of Public Health, the University of California at San Francisco, and the Hellman Foundation.²²⁴ The project will provide guaranteed income support of a monthly \$1000 supplement to Black and Pacific Islander mothers during pregnancy and for up to two years post-pregnancy.²²⁵ The purpose of this project is to ease some of the financial stress “that all too often keeps women from being able to put their health first.”²²⁶

The Abundant Birth Project is the exact type of radical racial justice that the restorative jurisprudence approach supports. The project recognizes how Black and Pacific Islander mothers suffer disparate health impacts, in part because of the persistent wealth and income gaps.²²⁷ By contextualizing the issue and focusing on the effects of how this project could aid in equalizing disparities, it offers a prospect of real change. Supplemental income for low-income mothers will undoubtedly improve mothers' abilities to: access and attend important prenatal appointments, access healthy food, take required time from work to prioritize their health, avoid housing insecurity, pay copays for insurance and medical bills, and generally reduce stress associated with unstable finances.

Perhaps similar efforts aimed specifically at those geographic regions identified as having the worst maternal health disparities in the country could be replicated and piloted. This type of relief could potentially come in the form of grants supported by the BMHMA. Such a direct and deliberate form of relief is

²²² Bay City News, *San Francisco Launches New Pilot Program Giving Some Pregnant Women \$1,000 a Month*, ABC7 (Sept. 15, 2020), <https://abc7news.com/abundant-birth-project-1000-pregnant-women-sf-san-francisco-pregnancy-money-to-pay-woman/6424373/>.

²²³ *Id.*

²²⁴ *Id.*

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.*

likely to have significant and immediate positive impacts on maternal health. Yet, to ensure monies are best allocated to mothers' needs, perhaps a component of the supplemental income programs could be a mandatory financial literacy and/or counseling course. Of course, the goal of this kind of education would be to inform and suggest, rather than dictate, how to most effectively budget and perhaps provide resources to help with financial planning.

B. ADDRESSING IMPLICIT BIAS IN MEDICAL SCHOOLS AND IN PRACTICE IS AN INTEGRAL COMPONENT OF IMPROVING BLACK MATERNAL HEALTH

Addressing racial biases as early as possible appears to be the best way to eliminate bias in the medical profession. Currently, medical school curricula leave little room for nuanced discussions about the impact of race and racism on health.²²⁸ In fact, many students undergo rigorous course studies aided by lectures, textbooks, and scientific journal articles that divide patients by racial categories, thereby reinforcing the idea that race is biological.²²⁹ Once introduced, that belief can lead to misdiagnoses, such as treating sickle cell anemia as a largely “Black disease.”²³⁰ Or, the fact that nearly half of dermatologists report that their medical schools did not prepare them to identify or diagnose cancer on Black skin.²³¹ These beliefs then become fundamental aspects of medical teachings, which are subsequently reflected in board examinations and later, the medical profession. Patients bear the consequences of this unfortunate cycle. For example, Black patients in the emergency department are 22 to 30 percent less likely to receive medication for the same level of pain as white patients,²³² indicating that racial bias leads to less effective pain management for Black patients.

Fortunately, medical schools are introducing new ways of understanding race, presenting it as a system of social stratification, rather than a biologically valid category.²³³ Medical schools are also making commitments to diversity, which in addition to racially and ethnically varied incoming classes, include education about race to reflect biological and social understandings as opposed to inherited

²²⁸ Ike Swetlitz, *Teaching Medical Students to Challenge ‘Unscientific’ Racial Categories*, STAT (Mar. 10, 2016), <https://www.statnews.com/2016/03/10/medical-schools-teaching-race/>.

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ *Id.*

²³² *Id.*

²³³ Cameron Nutt, et. al., *Medical Schools Must Play a Role in Addressing Racial Disparities*, STAT (July 25, 2016), <https://www.statnews.com/2016/07/25/medical-schools-racial-disparities/>.

prejudice.²³⁴ Yet, undoing these systems starts long before students enter medical school—it begins at birth. Babies born of Black mothers are more likely to lose their mothers as a result of their birth. And Black babies that are fortunate enough to have their mothers may be subject to any one or all of the social determinants that create societal disparities in nearly every facet of life. In this way, targeting implicit biases becomes a cycle. Still, the best way to address implicit bias in the medical field is to provide real opportunities to ensure a diverse study body, dismantle destructive beliefs and medically incorrect ideas about race, and encourage medical school deans and leaders to speak honestly about how social forces like racism jeopardize patients’ health and well-being.

C. TASK FORCES MUST BE DESIGNED TO FOSTER OPTIMAL PARTICIPATION AND YIELD RESULTS

The BMHMA purports to establish several task forces to coordinate and carry out efforts to address: social determinants of health, maternal health data and quality measures, and maternal mental and behavioral health.²³⁵ These task forces will be comprised of various leaders and community members ranging from women who experienced severe maternal morbidity, to family members of women who experienced pregnancy related deaths, researchers, experts, non-medical maternal support providers, leaders of community based organizations, and Black women.²³⁶ Addressing this crisis through this type of collaborative and holistic approach is a step in the right direction. This is because, in many ways, this crisis was facilitated through a “failure to include community members and advocacy groups in the decision-making process regarding what constitutes appropriate, quality maternal care,” in the first place.²³⁷

However, while these task forces will certainly be integral, long-term components of combating the crisis, they do not seem best suited to provide expeditious results. Key objectives for the task forces include gathering data, evaluating current processes, identifying strengths and weaknesses of existing maternity care quality measures, determining whether professionals performing reviews of maternal mortality participate in trainings on bias and racism, as well as other related duties.²³⁸

²³⁴ *Id.*

²³⁵ *See generally* BMHMA, *supra* note 16.

²³⁶ *Id.*

²³⁷ Wynn, *supra* note 110, at 149.

²³⁸ *See generally* BMHMA, *supra* note 16.

Notably, these task forces are not intended to create immediate intervention services. In fact, some are set to be established 180 days after the Act becomes effective, which has been awaiting subcommittee attention in the House since March. When established, each task force is expected to carry out its function over a three to five-year period.²³⁹ Much of the heavy lifting towards change comes in the form of grants, which in theory will be informed by these task forces.

Additionally, all members of the task forces are expected to serve on a volunteer basis.²⁴⁰ This could be a potential barrier for accessing valuable insight from the people most affected by this crisis because those affected often are unable to dedicate time without being compensated and/or having options for childcare. Perhaps a modest honorarium and vouchers for childcare would afford people who would otherwise be interested in serving on these various task forces an opportunity to participate. This type of support could be offered on an as-needed basis for members of the force who demonstrate need.

D. LESSONS FROM ABROAD CAN HELP ACHIEVE MANY OF THE MEASURES SET FORTH IN THE BMHMA

Based on its effectiveness abroad, the idea of a “one-stop” resource center in communities could prove promising. Analogous to this concept is the maternal health system Cuba employs to maintain high quality maternal care. With a maternal mortality rate of 36 deaths per 100,000 live births, Cuba ranks as the number one developing country for mothers.²⁴¹ According to these statistics, having a baby in Cuba is safer than having a baby in certain places in the U.S.²⁴² Ironically, despite relatively low per capita health expenditures compared to similar expenditures in “resource-rich” nations like the United States, Cuba, a “resource-poor” country, prioritizes providing high quality, free maternal care.²⁴³

Implementing community-based regional maternity health homes to provide comprehensive care for women with high-risk pregnancies has also been wholly effective.²⁴⁴ In Cuba, if your pregnancy is considered high-risk, you may be referred for housing in a home for expecting mothers, all paid for by the

²³⁹ *Id.*

²⁴⁰ *Id.*

²⁴¹ Temma Ehrenfeld, *Cuba Does It. Why Can't the U.S. Provide Healthcare for its Poor?*, HEALTHLINE (Oct. 16, 2017), <https://www.healthline.com/health-news/why-cant-us-provide-healthcare-for-poor>.

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ *Id.*

government.²⁴⁵ Rather than embed these facilities in traditional health care settings, existing houses were re-purposed and re-conditioned to create a familiar, home-like environment where the health and wellbeing of mothers and their fetuses can be closely monitored.²⁴⁶ Currently, each of the 327 maternity homes across the country follow uniform practice guidelines designed by the Ministry of Public Health’s Maternal-Child Health Program, in collaboration with UNICEF.²⁴⁷ The homes provide a range of multidisciplinary services, including: daily visits with doctors, meals prepared by a nutritionist, mental health services (e.g., psychological counseling and stress management), pre-natal education (e.g., breastfeeding), genetic testing for maternal and fetal abnormalities, fetal surveillance, lab services, dental services, nutritional counseling, contraception (e.g., family planning services), access to legal resources and social workers, and fitness training.²⁴⁸

Lessons from the Cuban system could prove immensely valuable in rolling out “one-stop” maternal community centers in the United States. Admittedly, the concept would have to be tweaked to effectively address the nuances of the American maternal health crisis. For instance, given the pervasive racial biases contributing to the vast disparities in Black maternal health, the U.S. would need to deliberately include in one-stop homes, both racially and ethnically reflective workers. Providing these workers with racial bias and racial sensitivity training would also be useful. Furthermore, because BMHMA recognizes post-partum services as crucial, given that most maternal and infant deaths occur in the first six weeks after delivery,²⁴⁹ incorporating post-partum services in these one-stop homes would serve as another useful function.

Perhaps instead of designating these one-stop homes exclusively for women with high-risk pregnancies (as is the custom in Cuba), the concept can be modified to make these homes accessible to all women living in areas identified as high-risk zones for maternal morbidity and mortality. When considering that three-quarters of Black women deliver their babies in one-quarter of the hospitals in America, identifying and targeting high-risk areas should be relatively straight forward. This system would then allow women whose pregnancies do not meet

²⁴⁵ Conner Gorry, *Cuban Maternity Homes: A Model to Address At-Risk Pregnancy*, 13 MEDICC REV. [PAGE #] (July 12, 2011), http://mediccreview.medicc.org/articles/mr_203.pdf.

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ *Id.*

²⁴⁹ Roosa Tikkanen, et. al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, THE COMMONWEALTH FUND (Nov. 18, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>.

the definition of “high-risk,” but who are still in need of additional support, to increase their chances of experiencing a healthy pregnancy.

To achieve a paramount commitment to diversity and access, these one-stop homes could also incorporate more midwifery and doula services. According to research, both midwives and doulas are associated with improved maternal health outcomes and lower rates of medical intervention at birth.²⁵⁰ Furthermore, these services are leading the way in providing “access to culturally competent prenatal, birth, and postpartum care and support for their communities.”²⁵¹ Involving midwives and doulas into these one-stop home settings can “significantly improve the health and birthing outcomes and experiences of people of color and LGBTQ people.”²⁵² Incorporation of midwives and doulas would not only reframe the narrative that these services are out of reach for low-income women but also re-instill the cultural roots that were ripped away when Black midwives were systematically excluded from maternal care.

In addition to the benefits outlined above regarding culturally and ethnically diverse midwives and doulas, a recent study exposed how racially congruent providers lead to better outcomes for newborns and their mothers.²⁵³ That is, Black newborn babies in the U.S. are more likely to survive childbirth if they are cared for by Black doctors but “three times more likely than white babies to die when looked after by white doctors.”²⁵⁴ This study provides the first evidence lending support to research “examining the importance of racial concordance in addressing health care inequities.”²⁵⁵ The inference the study provides is that Black physicians outperform their white counterparts when caring for Black newborns.²⁵⁶ Thus, in the context of this reasoning, improving the Black maternal health crisis will not be possible without also generating and including more Black providers. As such, the BMHMA’s recommendation to facilitate a more

²⁵⁰ Nora Ellman, *Community-Based Doulas and Midwives*, CTR. FOR AM. PROGRESS (Apr. 14, 2020), <https://www.americanprogress.org/issues/women/reports/2020/04/14/483114/community-based-doulas-midwives/>.

²⁵¹ *Id.*

²⁵² *Id.*

²⁵³ Brad N. Greenwood, et. al., *Physician–patient Racial Concordance and Disparities in Birthing Mortality for Newborns*, 117 PNAS 21194, 21200 (Aug. 17, 2020), <https://www.pnas.org/content/117/35/21194>. See also, Rob Picheta, *Black Newborns More Likely to Die When Looked After by White Doctors*, CNN (Aug. 20, 2020), <https://www.cnn.com/2020/08/18/health/black-babies-mortality-rate-doctors-study-wellness-scli-intl/index.html>.

²⁵⁴ *Id.*

²⁵⁵ *Id.*

²⁵⁶ *Id.*

diverse workforce by developing a larger pool of qualified birth workers is absolutely essential.

E. TECHNOLOGY CAN CREATE REAL TIME AND ANONYMOUS PLATFORMS TO PROMOTE TRANSPARENCY BETWEEN PROVIDERS AND PATIENTS AND ESTABLISH ACCOUNTABILITY AMONG PROVIDERS

Given the pervasive function of technology and social media in our world today, the drafters of the BMHMA would be remiss if they fail to explore the extensive advantages technology could offer. For example, mobile health has the potential to improve health knowledge by increasing access to physicians and providers, while making health education more readily available. In turn, this can equip women with the knowledge necessary to recognize and demand quality maternity care. Additionally, the added sense of anonymity afforded through online platforms could be used to leverage and in some cases pressure medical providers.

The combination of women having a clear concept of what quality maternity care looks like and the opportunity to anonymously rate and provide feedback will result in medical providers being held to higher standards. By making the feedback available to other women through a digital platform, providers will be subject to a structured demand for improving failing systems. On the other hand, providers will gain direct insight on how to improve the quality of their care. Coupled with other aspects of the BMHMA, such as establishing a compliance office, technology offers fast and efficient digital innovations to carry out such improvements.

F. MAKING MATERNITY CARE MORE ACCESSIBLE AND AFFORDABLE REQUIRES A COMPLETE VALUE SHIFT AND SYSTEMIC OVERHAUL

In the maternity care context, improving outcomes and reducing costs require addressing the “deeply rooted paradigm of pathology and achieving structural and systemic change in the provision of care.”²⁵⁷ Fortunately, an alternative model where birth is a normal, physiologic process allowed to “unfold free of outside pressure or mediation,” with specialized medical care available when necessary, is viable.²⁵⁸ Replacing the current birth narrative with one more conducive for optimal cost and access involves: (1) restructuring current payments to eliminate misaligned incentives, and (2) developing and promoting evidence-based

²⁵⁷ Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care*, 94 Neb. L. Rev. 799, 840 (2016).

²⁵⁸ *Id.*

medicine in the maternity health field, and (3) elevating the midwifery model for the majority of low-risk women, while reserving complicated medical birth needs for obstetricians.²⁵⁹

First, without altering America's current insurance system, the BMHMA will encounter great difficulty in discovering a differential payment model. Typically, insurers' payment practices encourage a "procedure-intensive approach to maternity care."²⁶⁰ This is because rather than being reimbursed based on the quality of care provided, physicians are reimbursed for every order they write and procedure they perform.²⁶¹ In turn, the idea that medically managing childbirth is not only the optimal, but rather the only option, is reinforced.²⁶² As discussed in section B, maternity care constitutes big business in America.²⁶³ For example, higher reimbursements for cesareans, along with longer hospitalization and higher hospital charges, incentivize doctors to recommend cesareans over natural births.²⁶⁴ Moreover, under scheduled circumstances, cesarean procedures facilitate increased hospital planning and require additional hospital services such as administering intravenous drips and performing episiotomies; meanwhile, anesthesiology, radiology, and lab services are all billed separately.²⁶⁵

Existing payment systems fuel the high cost of childbirth by failing to link the amount of payments to the quality and value of care rendered.²⁶⁶ Accordingly, "aligning incentives for providers [] to adhere to evidence-based practices that improve outcomes," while decreasing the mounting costs of maternity care services, is the best way to improve existing payment models.²⁶⁷ One way to achieve this is through a system whereby insurers can set a single price for all services; that is, operate under a one risk-adjusted price for all maternal care.²⁶⁸ This payment model could encourage evidence-based decisions aimed at reducing complications throughout pregnancy and after delivery. In turn, this scheme could eliminate the need for services outside of the reimbursement bundle. Perhaps an annual or quarterly incentive rewards system to recompense the top hospitals with the best quality services and the most successful deliveries could also ensure doctors do not cut corners to save money under this type of plan.

²⁵⁹ *Id.*

²⁶⁰ *Id.* at 837.

²⁶¹ *See generally id.*

²⁶² *Id.* at 860.

²⁶³ *Id.* at 841.

²⁶⁴ *Id.* at 842.

²⁶⁵ *Id.* at 842-843.

²⁶⁶ *Id.* at 843.

²⁶⁷ *Id.*

²⁶⁸ *Id.* at 844.

Second, maternity care research identifies a “widespread and continuing underuse of beneficial practices, overuse of harmful or ineffective practices, and uncertainty about the effects of inadequately assessed practices.”²⁶⁹ In other words, research does not support the use of common maternity care practices, including “continuous electronic fetal monitoring, rupturing membranes during labor, and episiotom[ies].”²⁷⁰ Subsequently, the current maternal health system functions on traditional practices, many of which are no longer supported by the evidence. Adopting evidence-based care, that is, care proven to be most effective, would logically lead to more affordable care, and thus, greater access.

The BMHMA’s attempt to create a unified collection of data about maternity care practices will enable efforts to advance maternal health outcomes by improving the quality of care through evidence-based practices. If done correctly, BMHMA’s data solutions could provide a comprehensive system for capturing, analyzing, and interpreting data on maternal mortality and obstetrics. This level of continuity will allow experts to better identify and promote best practices. For example, a revision of maternity related billing codes would lead to better data to track the quality of prenatal care and various medical interventions associated with such. The BMHMA’s efforts to improve technology could also assist in developing unified and connected data tracking systems, which would allow researchers to identify trends and emerging vulnerabilities in maternal health.

Third, promoting midwifery over current maternal care, which remains deeply rooted in obstetrics and complicated medicine, would promote access and affordability for expecting mothers. To become a midwife, students must complete a Master’s level nursing program and meet rigorous certification standards set by the American Midwifery Certification Board. Thus, midwives are skilled in nursing, midwifery and women’s health issues, and function under an evidenced-based model.²⁷¹

With roughly 83 percent of pregnant women having low-risk pregnancies, modern midwifery is a safer and cheaper form of care for most women.²⁷² In fact, in most developed nations, midwives are the first-line providers for healthy pregnant women and lead to better health outcomes and lower maternal costs in those countries.²⁷³ In general, midwives and obstetricians within these countries

²⁶⁹ *Id.* at 847.

²⁷⁰ *Id.*

²⁷¹ *How to Become A Certified Nurse Midwife (CNM)*, MIDWIFESCHOOLING.COM, <https://www.midwifeschooling.com/> (last visited Sept. 19, 2020).

²⁷² Kukura, *supra* note 258 at 851.

²⁷³ *Id.*

collaborate as autonomous providers to ease any transitions that may become necessary to ensure the mother's safety during the course of prenatal care.²⁷⁴

Additionally, the American Congress of Obstetricians and Gynecologists project that by 2030, the U.S. will experience a 25 percent shortage of OB-GYNs, labeling this decrease as an imminent threat to maternal health care.²⁷⁵ As such, increasing the number of certified midwives presents a viable solution for this impending healthcare crisis. Remarkably, a recent study encompassing nearly 17,000 midwife-led births, “confirmed the safety of home births, with low rates of interventions and high rates or positive health outcomes”—this was the largest analysis of planned home births in the U.S. to date.²⁷⁶ Still, despite midwives' documented success, they face many hurdles maneuvering with respect to various state laws restricting or regulating their practice.²⁷⁷

The BMHMA will need to recreate the contemporary narrative through neutralizing more than a century of rhetoric depicting midwives as “untrained, unskilled, and providers of inferior care.”²⁷⁸ To facilitate this rebranding of maternal care, the BMHMA could encourage collaborative relationships between midwives and physicians with the purpose of equalizing the share of professional turf, while establishing mutual respect for each provider's childbirth expertise.²⁷⁹ Perhaps the BMHMA could also incorporate legislative agendas in each state aimed at unifying regulations surrounding midwifery and paving the way for national standards.²⁸⁰ Additionally, the BMHMA could push for an alternative payment system that would equalize reimbursements for midwifery services, alleviating some of the burdens for midwives who rely on government insurance only.²⁸¹ This would allow midwives to seek reimbursements from private insurance companies, thus, enabling a stable, complete scope of services for more mothers.

Admittedly, this comment acknowledges the heavy lifting required to effectuate a cultural shift that would place midwives on the same footing as physicians. Indeed, it would require near universal policies for sufficient data collection and interpretation, a consensus for states concerning threshold legislation impacting midwifery throughout the nation, and receptiveness towards redefining the complex authority dynamics between physicians and patients, by

²⁷⁴ *Id.*

²⁷⁵ *How to Become A Certified Nurse Midwife (CNM)*, *supra* note 272.

²⁷⁶ Kukura, *supra* note 258, at 855.

²⁷⁷ *Id.*

²⁷⁸ *Id.* at 855.

²⁷⁹ *Id.*

²⁸⁰ *Id.*

²⁸¹ *Id.*

recognizing patient autonomy through the concept that women are the experts of their own bodies.²⁸² However, the BMHMA's best chance at making maternal care more accessible and affordable requires radical attempts to wholly redefine the current paradigm of maternal health.

VI. CONCLUSION

This comment recognizes that governmental policies alone will not dismantle structural racism. It purports to provide suggestions for legal revitalizations that could serve as useful guideposts, while catalyzing similarly meaningful changes in other segments of the population. Additionally, by revamping the current maternal health system and the underpinnings of the philosophy on which it functions, targeted and effective legislation can facilitate progress. Moreover, the legal shifts suggested herein have the potential to uproot entire systemic shortfalls that perpetuate a deeply engrained racial hierarchy in America. Indeed, the same system that continues to enable the killing of Black bodies by law enforcement,²⁸³ imprisons Black people at disproportionate rates,²⁸⁴ and puts Black lives in greater peril at the hands of Covid-19,²⁸⁵ is the same system under which Black mothers are dying at unprecedented rates.

A restorative jurisprudence system is more amenable to the notions of reframing maternal health values, leveraging technology and traditional wisdom, and centering communities as invaluable resources. In turn, this new approach better aligns the maternal health care system's current and exorbitant expenditures with the high quality that should come as a result of such a grandiose investment.

Because local, state, and federal governments are not the only creators and sustainers of structural racism, non-governmental entities and individuals must also adjust their beliefs, values, and actions to effectively undergo the multi-generational and intense process of eliminating the pervasive racial lens that plagues health care and nearly every other facet of American life.²⁸⁶ The right combination of attitudes, perspective, measurable and actionable steps, and sound policies can indeed repair the system. The truth is, once maternal health becomes

²⁸² *Id.*

²⁸³ Alia Chughtai, *Know their Names Black People Killed by the Police in the US*, AL JAZEERA, <https://interactive.aljazeera.com/aje/2020/know-their-names/index.html> (last visited Aug. 30, 2020).

²⁸⁴ See, e.g., The Sentencing Project, *Report to the United Nations on Racial Disparities in the U.S. Criminal Justice System* (Apr. 19, 2018), <https://www.sentencingproject.org/publications/un-report-on-racial-disparities/>.

²⁸⁵ Oppel, *supra* note 2.

²⁸⁶ *Id.*

a priority, the maternal health crisis will be solved. There is no question as to whether the United States is capable or equipped to prioritize the importance of Black American women, the real question is, will it? The Black maternal health crisis affects all of us in some way, whether economic, social, moral, or personal—maternal health is in fact a societal issue. After all, we all fall into one of two categories, if not both, we either are mothers or have one.