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Emily Siron

University of Richmond School of Law

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THIS IS NOT NEW: ADDRESSING AMERICA'S MATERNAL
MORTALITY CRISIS

*Emily Siron**

* J.D. Candidate, Class of 2022 at the University of Richmond School of Law. Emily Siron serves as the Executive Editor for the University of Richmond Public Interest Law Review. Throughout law school, Emily has interned with Pro-Choice Virginia, the Honorable Chief Judge Marla Graff Decker of the Virginia Court of Appeals, and the American Civil Liberties Union of Virginia. Emily graduated from the University of South Carolina in 2019 with a B.A. in Political Science.

ABSTRACT

This article utilizes an intersectional approach to examine the causes and realities of the dismal state of pregnancy-related healthcare in the United States, highlighting the disparate impact on Black pregnant people. The enslavement and brutalization of Black women in the U.S. demonstrates how American society systematically devalues Black health, especially reproductive health. The impacts of this horrific history persist today, resulting in the American healthcare system utterly failing Black mothers and pregnant people of all gender identities. This article surveys this history and presents policy solutions to improve maternal health outcomes for all, but especially Black individuals, including proposed pieces of legislation, implicit bias training, and stricter standards for data collection.

INTRODUCTION

The United States is experiencing a maternal health crisis. It is not a new crisis, but it is worsening. In 2018, approximately 658 pregnant people died from conditions caused or exacerbated by pregnancy, making for a maternal mortality ratio of 17.4 deaths per 100,000 live births.¹ Not only is 658 a staggering number of deaths, but the United States stands alone among developed countries as the only such nation to have seen an increase in maternal death rates between 2000 and 2014.² Among those who died, Black pregnant people fared the worst: in 2018, 37.1 Black women died per 100,000 births as a result of pregnancy-related factors compared to 14.7 per 100,000 births among white women.³

This disparity raises the question as to why, in the world's richest nation, pregnant people are dying of causes that are approximately 60% preventable and why Black people die almost two and a half times more frequently than their white counterparts.⁴ This paper argues that as a result of long-standing, deeply entrenched racial stereotypes about Black people generally, Black women and pregnant individuals of other gender identities are disproportionately more likely to experience death or serious complications due to not being taken seriously about their experiences during pregnancy or childbirth than white pregnant people, regardless of socioeconomic status or level of

¹ Elizabeth Chuck, *The U.S. Finally Has Better Maternal Mortality Data. Black Mothers Still Fare the Worst*, NBC NEWS (Jan. 30, 2020), <https://www.nbcnews.com/health/womens-health/u-s-finally-has-better-maternal-mortality-data-black-mothers-n1125896>.

² Jaime H. Beutler, et al., *Alone Among Developed Nations, the US Maternal Mortality Rate is Rising. Here's How We Can Fix That*, THE HILL (July 26, 2018), <https://thehill.com/blogs/congress-blog/healthcare/398860-alone-among-developed-nations-the-us-maternal-mortality-rate>.

³ Chuck, *supra* note 1.

⁴ *Id.*; *Pregnancy Related Deaths*, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 7, 2019), <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html>.

education. Section I will define the crisis itself and presents data. Section II will analyze the history of racist stereotyping in regard to Black health and how that history has led to the current maternal mortality crisis. Section III will present legislative and policy solutions to ameliorate the crisis. This analysis will conclude with recommendations as to how to address America's failure to protect its Black mothers.

I. AMERICA'S MATERNAL MORTALITY CRISIS

A. *Pregnancy and Gender Identity*

In a conscientious analysis of the American maternal mortality crisis, it is important to note that pregnant people do not always identify as women. Individuals with a uterus who may identify as transgender men or as nonbinary can get pregnant and should therefore not be referred to as "mothers." Consequently, this paper will, when possible, refer to pregnant people using gender-neutral language. However, much terminology in the relevant literature is not gender-neutral, such as the phrase "maternal mortality" itself. Therefore, when it is necessary to use appropriate terminology, which includes the words "maternal" or "mother," gender-neutral language is impossible. This paper still recognizes the incredible gender diversity among pregnant people and that inclusive language is critical to fully and holistically addressing America's maternal mortality crisis.

B. *Defining the Problem*

Maternal mortality rates have historically been an important indicator of the health standards of a nation as a whole.⁵ Because maternal deaths are approximately 60% preventable, the data is particularly useful in determining how effective a nation's healthcare system is, because a robust healthcare system should be able to protect against preventable deaths.⁶ Two of the most common causes for maternal death, preeclampsia and obstetric hemorrhage, are serious but preventable with diligent pre and postnatal healthcare.⁷ Early response to high blood pressure can prevent preeclampsia, while having hemorrhage carts present at a hospital birth can prevent deaths as a result of obstetric bleeding.⁸ Worldwide maternal mortality rates are highest in low-income countries, primarily in Sub-Saharan Africa and Southern Asia, where

⁵ Chuck, *supra* note 1.

⁶ Beutler, *supra* note 2.

⁷ *Id.*

⁸ *Id.*; Preeclampsia, MAYO CLINIC (Mar. 19, 2020), <https://www.mayoclinic.org/diseases-conditions/preeclampsia/symptoms-causes/syc-20355745>.

86% of estimated global maternal deaths occurred in 2017.⁹ This shocking figure reflects inequalities in access to high-quality healthcare services and the necessary diligent providers.¹⁰

The United States, the wealthiest country in the world, also spends more than twice the average amount of money of developed countries on healthcare: approximately \$3.5 trillion in 2017, which is 18% of the United States gross domestic product (“GDP”).¹¹ Such a staggering number would seem to indicate that the United States healthcare system would be far more robust than those of the low-income nations, which account for the majority of worldwide maternal deaths, resulting in lower rates of maternal mortality. However, this is not the case.

Maternal mortality is a “critical statistic to get right”, and standardized data is necessary to “make . . . sense of trend[s] at the national level.”¹² In early 2020, for the first time in United States history, standardized data for the maternal mortality rate in all fifty states was made available.¹³ States diligently track data related to infant mortality, teenage pregnancy, transplant operations, cancer treatments, and countless other public health statistics, but have not had any form of standardized data collection for maternal mortality rates.¹⁴ Despite the recognized importance of maternal mortality as a measure of the success of a nation’s healthcare, the United States did not have any reliable way to collect national data due to the inconsistencies among state data collection.¹⁵

Some measures have been taken to try to improve data collection.¹⁶ In 2003, the federal government added a pregnancy checkbox to the standard death certificate, which asked whether the person who died was pregnant or had recently given birth.¹⁷ States, however, were not required to use the

⁹ *Maternal Mortality*, WHO (Sept. 19, 2019), <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>.

¹⁰ *Id.*

¹¹ *American Health Care: Health Spending and the Federal Budget*, COMM. FOR A RESPONSIBLE FED. BUDGET (May 16, 2018), <https://www.crfb.org/papers/american-health-care-health-spending-and-federal-budget>; Caleb Silver, *The Top 20 Economies in the World*, INVESTOPEDIA (Mar. 18, 2020), <https://www.investopedia.com/insights/worlds-top-economies/>; *American Health Care: Health Spending and the Federal Budget*, COMMITTEE FOR A RESPONSIBLE FEDERAL BUDGET (May 16, 2018), <https://www.crfb.org/papers/american-health-care-health-spending-and-federal-budget>.

¹² Chuck, *supra* note 1.

¹³ *Id.*

¹⁴ Robin Fields and Joe Sexton, *How Many American Women Die From Causes Related to Pregnancy or Childbirth? No One Knows*, PROPUBLICA (Oct. 23, 2017), <https://www.propublica.org/article/how-many-american-women-die-from-causes-related-to-pregnancy-or-childbirth>.

¹⁵ Julia Belluz, *We Finally Have a 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>.

¹⁶ *Id.*

¹⁷ *Id.*

checkbox, and some did not adopt the change quickly.¹⁸ Further, it was common for deaths that did not result from pregnancy complications to be nonetheless attributed to them because the box would be checked regardless of whether the pregnancy contributed to the pregnant person's death.¹⁹ Consequently, maternal death data was inconsistent and unreliable.²⁰ As a result, the National Center for Health Statistics ceased any publication of data relating to maternal mortality rates until new data was released in January 2020.²¹ This new data is based on a new method of coding to limit past inconsistencies, representing the first time that every state has had a consistent pregnancy checkbox on official death certificates.²²

In the newly published data, the National Center for Health Statistics and its umbrella agency, the Centers for Disease Control and Prevention, found that 658 pregnant people died from complications related to pregnancy or delivery in 2018.²³ With a pregnancy-related mortality ratio ("PRMR") of 17.4 maternal deaths per 100,000, the United States ranks last among all developed nations.²⁴ Among the top ten wealthiest countries, the United States ranks tenth.²⁵ Further, global maternal death rates fell by more than a third from 2000 to 2015, while the United States was one of the few countries which experienced an increase.²⁶ Among all countries worldwide, the United States ranks 55th, just behind Russia.²⁷

While these data alone are dismal, the disparities that exist within them are even more astounding.²⁸ Black pregnant people die due to childbirth or complications thereof at staggeringly disproportionate rates compared to other groups.²⁹ In 2018, non-Hispanic Black pregnant people in the United States experienced a PRMR of 37.1 pregnancy-related deaths per 100,000 live births.³⁰ This is approximately three times higher than the same rate for white

¹⁸ *Id.*

¹⁹ Fields & Sexton, *supra* note 14.

²⁰ *Id.*

²¹ Belluz, *supra* note 15.

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ Sabrina Tavernise, *Maternal Mortality Rate in U.S. Rises, Defying Global Trend, Study Finds*, N.Y. TIMES (Sept. 21, 2016), <https://www.nytimes.com/2016/09/22/health/maternal-mortality.html>.

²⁷ Belluz, *supra* note 15.

²⁸ Press Release, Ctrs. for Disease Control and Prevention, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019), <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparitiespregnancy-deaths.html>.

²⁹ *Id.*

³⁰ Eugene Declercq & Laurie Zephyrin, *Maternal Mortality in the United States: A Primer*, COMMONWEALTH FUND (Dec. 16, 2020), <https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer>.

pregnant people.³¹ The risk of death among Black pregnant people increases significantly with age.³² The PRMR for Black pregnant people over the age of 30 is four to five times higher than that of white pregnant people.³³ Further, the disparity does not seem to discriminate based on the level of education.³⁴ The Centers for Disease Control and Prevention found that the PRMR for Black pregnant people with at least a college degree was 5.2 times that of their white counterparts.³⁵

C. Rates of Medical Mistreatment During Childbirth

Women of color in America are disproportionately more likely to experience mistreatment by healthcare providers during childbirth.³⁶ Global health experts agree that both the quality of care and the general treatment received during childbirth significantly impact the health outcomes of both the pregnant person and the child.³⁷ Consequently, the more mistreatment from healthcare providers a pregnant person receives during childbirth in particular, the poorer the outcome is for maternal health and maternal mortality.³⁸ Not only did 17%, or one in six, of the women surveyed report experiencing one or more types of mistreatment, but that number was even higher for Black women: 23%, as compared to 14% for white women.³⁹

Common types of mistreatment include being shouted at or scolded, having requests for help ignored or refused, care providers not responding to requests for help quickly enough, violations of physical privacy, threats to withhold treatments, and being forced into unwanted treatment.⁴⁰ People of color were twice as likely to have their requests for help ignored or refused compared to their white counterparts.⁴¹ For example, a Black participant in the study reported being denied a test for an amniotic fluid leak, a pregnancy complication that causes high rates of maternal death.⁴² The doctor instead

³¹ Chuck, *supra* note 1.

³² Press Release, *supra* note 28.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ Saraswathi Vedam, et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD. HEALTH 1, 2 (2019).

³⁸ *Id.* at 14.

³⁹ Julia Belluz, *A Shocking Number of Women are Harassed, Ignored, or Mistreated During Childbirth*, VOX (Jun. 20, 2019), <https://www.vox.com/2019/6/10/18628073/maternal-mistreatment-women-of-color>.

⁴⁰ *Id.*

⁴¹ Oluwatobi Alliyu, *Maternal Mistreatment*, PUB. HEALTH POST (Mar. 27, 2020), <https://www.publichealthpost.org/research/maternal-mistreatment/>.

⁴² Vedam, *supra* note 37 at 2; *Amniotic Fluid Embolism*, MAYO CLINIC (Aug. 18, 2020), <https://www.mayoclinic.org/diseases-conditions/amniotic-fluid-embolism/symptoms-causes/syc-20369324>.

insisted on testing her for a sexually transmitted disease, while the suspected fluid leak was occurring and went undetected.⁴³ Although this particular participant survived, the leaking she experienced continued for approximately a week after childbirth before she was able to receive treatment.⁴⁴ The study found that women of color were twice as likely to be ignored by healthcare providers or to have their requests for help refused than white women.⁴⁵ This disparity is particularly alarming because delayed response to early warning signs is the leading cause of maternal mortality in the United States, especially for Black mothers.⁴⁶

D. Transcending Socioeconomic Lines

Kimberlé Williams Crenshaw, a feminist legal scholar, coined the term intersectionality to describe how different aspects of an individual's identity combine to create unique and varying experiences of oppression or privilege.⁴⁷ For example, a wealthy, educated, cisgender white woman will experience significantly more privilege than a poor, uneducated, transgender Black woman.⁴⁸ Individuals with the same racial and gender identity can experience differing levels of privilege or oppression within that identity group: a wealthy Black woman with a high level of education will generally experience higher levels of privilege than a poor Black woman with a low level of education.⁴⁹

Because of this particular example of intersectionality, one may assume that a Black expecting parent with a high level of education and a high socioeconomic status would have access to superior healthcare and would therefore have better maternal health outcomes. However, although high poverty rates are associated with high maternal mortality rates, rates are similarly severe among Black pregnant individuals of all socioeconomic statuses and educational backgrounds.⁵⁰ A study from 2008 to 2012 of women in New York found that not only did non-Latina Black women experience the highest rates of maternal mortality, but that regardless of their wealth, Black women

⁴³ Vedam, *supra* note 37 at 9.

⁴⁴ *Id.*

⁴⁵ Alliyu, *supra* note 41.

⁴⁶ *Id.*

⁴⁷ Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. OF CHI. LEGAL F. 139, 140; see also Anne Sisson Runyan, *What Is Intersectionality and Why Is It Important?*, AM. ASSOC. OF UNIV. PROFESSORS (2018), <https://www.aaup.org/article/what-intersectionality-and-why-it-important#.YTVsJN8pA2w>.

⁴⁸ Crenshaw, *supra* note 47 at 149.

⁴⁹ *Id.*

⁵⁰ *Maternal Mortality Fact Sheet*, WORLD HEALTH ORG. (Sept. 19, 2019), <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>.

remained the group with the highest rates of death.⁵¹ Further, the study found that the disparity persisted regardless of education: Black women with a college degree had higher maternal mortality rates than women of other races who never graduated high school.⁵² High rates of maternal death among Black women regardless of wealth or education indicate that the issue is not one of money, but racism.

The stories of real women help to illustrate the problem. During pregnancy, professional tennis player Serena Williams was mistreated when she was experiencing childbirth complications.⁵³ Williams, who has a history of blood clots, suffered a pulmonary embolism following the delivery of her daughter via an emergency C-section, meaning that blood clots had blocked at least one artery in her lungs.⁵⁴ She experienced intense coughing caused by the embolism, leading her to rip her C-section wound, after which she was taken into surgery where doctors discovered a hematoma in her abdomen, which almost killed Williams.⁵⁵ Between gasps for air, Williams told a nurse that she needed a CT scan and a blood thinner, but the nurse did not believe her.⁵⁶ She thought that Williams was just confused due to her pain medication.⁵⁷ Williams insisted that she receive what she had requested, but a doctor performed an unnecessary ultrasound of her legs instead delaying her requested CT scan.⁵⁸ The scan revealed what Williams knew was wrong: there were “several small blood clots in her lungs, and soon she was receiving blood-thinning medication on a drip.”⁵⁹

Shalon Irving’s story shows what happens when a patient’s mistreatment results in death. Irving was an epidemiologist at the Centers for Disease Control and Prevention with a B.A. in Sociology, two Master’s degrees, a dual-subject Ph.D., and excellent health insurance.⁶⁰ About a week after a relatively unremarkable C-section birth, Shalon found a painful lump on her

⁵¹ N.Y.C. DEPT. OF HEALTH AND MENTAL HYGIENE, SEVERE MATERNAL MORBIDITY, 2008-2012 20 (2016), <https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf>.

⁵² *Id.* at 15.

⁵³ Allyson Chiu, *Beyoncé, Serena Williams open up about potentially fatal childbirths, a problem especially for Black mothers*, WASH. POST (Aug. 7, 2018), <https://www.washingtonpost.com/news/morning-mix/wp/2018/08/07/beyonce-serena-williams-open-up-about-potentially-fatal-childbirths-a-problem-especially-for-black-mothers/>.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ Renee Montagne, *Black Mothers Keep Dying After Giving Birth. Shalon Irving’s Story Explains Why*, NPR (Dec. 7, 2017), <https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why>.

incision, which her doctor said was nothing to be concerned about.⁶¹ However, a second doctor, Shalon's regular OB/GYN, trusted Shalon and found she had a hematoma.⁶² She arranged for a nurse to visit Shalon every other day to change the hematoma's dressings.⁶³ This nurse noted on more than one occasion that Shalon had an abnormally high blood pressure and appeared to show some symptoms of preeclampsia, a pregnancy complication resulting from high blood pressure and organ damage which can result in seizures, strokes, and death.⁶⁴

Shalon then went back to her regular OB/GYN.⁶⁵ Her OB/GYN noted that she had "no symptoms concerning for postpartum [pre-eclampsia]" and that her jumps in blood pressure were likely related to "poor pain control."⁶⁶ She continued to experience headaches and swelling in her legs, but she was again told that there was nothing that could be done and that Shalon just needed to wait.⁶⁷ Shalon collapsed and died three weeks later from complications of high blood pressure.⁶⁸

II. RACISM AS THE CAUSE

Racialized pseudoscience has long been used to perpetuate the idea of white racial superiority, particularly in Western culture.⁶⁹ For example, the Great Chain of Being, combined religion and pseudoscience to depict the races as separate, with Black people at the bottom of the chain and white people at the top.⁷⁰ The Chain of Being originated among ancient Greek philosophers and persisted through the Middle Ages.⁷¹ The theory surfaced periodically throughout history, but reappeared most prominently in the eighteenth century as part of the growth of science.⁷² Self-asserted scholars like Edward Long, a jurist and planter, cited the Great Chain theory to justify racist rankings.⁷³ In 1774, Long wrote a treatise justifying slavery titled *History of Jamaica*, arguing that "[African Americans] are void of genius, and

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ Gabrielle T. Wynn, *The Impact of Racism on Maternal Health Outcomes for Black Women*, 10 U. MIAMI RACE & SOC. JUST. L. REV. 85, 86 (2019).

⁷⁰ AUDREY SMEDLEY & BRIAN D. SMEDLEY, RACE IN NORTH AMERICA: ORIGIN AND EVOLUTION OF A WORLDVIEW 164–65 (Westview Press, 4th ed. 2012).

⁷¹ *Id.* at 165.

⁷² *Id.*

⁷³ *Id.* at 168.

seem almost incapable of making any progress in civility or science.”⁷⁴ He ranked Black people alongside orangutans on the Chain somewhere between humans and the lower primates: “That the oran-outang and some races of black men are very nearly allied, is, I think more than probable.”⁷⁵ Long’s hierarchy proceeded from monkeys and apes to orangutans, to the “Guinea Negros,” and ascending to “the lighter casts, until we mark its utmost limit of perfection in the pure White.”⁷⁶

The ranking of races allowed for a new approach to ethnocentrism, providing fabricated evidence that Black people are simply naturally inferior.⁷⁷ The conflation of the idea of race and natural, biological differences between the races allowed for the continuation of white ethnocentrism which “constructed and maintained social barriers and economic equalities” and “create[d] social stratification based on these visible differences.”⁷⁸ This section will discuss the myths of physical differences between white and Black people, particularly that Black people have higher pain tolerances, the justification of medical experimentation on Black women using these myths, and myths specifically regarding Black fertility.

A. The Myth of Pain Tolerance

One of the most pervasive, long-standing, and harmful racist stereotypes perpetuated about Black people on the basis of racist pseudoscience is that they have an incredibly high pain tolerance and do not experience physical pain as severely as white people.⁷⁹ To help justify slavery, white physicians and non-physicians alike perpetuated myths about Black physicality.⁸⁰ Such stereotypes included that Black people had thicker skin than other races, large sex organs and small skulls, increased immunity or susceptibility to particular diseases, weak lung capacity which could be strengthened through hard work, and that they were generally impervious to pain.⁸¹

Benjamin Moseley, a British doctor, wrote in his 1787 “A Treatise on Tropical Diseases; and on The Climate of the West-Indies” that Black people could bear the pain of surgical operations in a way that white people could not.⁸² “What would be the cause of insupportable pain to a white man, a

⁷⁴ *Id.* at 169.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.* at 21.

⁷⁹ Linda Villarosa, *Myths About Physical Racial Differences Were Used to Justify Slavery — And Are Still Believed by Doctors Today*, N.Y. TIMES (Aug. 14, 2019), <https://www.nytimes.com/interactive/2019/08/14/magazine/racial-differences-doctors.html>.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

Negro would almost disregard.”⁸³ To justify this argument, Moseley cited his own experience, writing that he had “amputated the legs of many Negroes who have held the upper part of the limb themselves.”⁸⁴ Thomas Jefferson also perpetuated these racist stereotypes in his widely revered *Notes on the State of Virginia*.⁸⁵ In addressing “the real distinctions which nature has made” between Black and white people, Jefferson wrote that Black individuals were more tolerant of heat than white people because of a difference in how they perspire.⁸⁶ He also hypothesized that they require less sleep and that they “secrete less by the kidnies [sic], and more by the glands of the skin, which gives them a very strong and disagreeable odour.”⁸⁷

Ideas like Moseley’s and Jefferson’s persisted throughout the nineteenth century.⁸⁸ For example, in 1851, Dr. Samuel Cartwright the pamphlet “Diseases and Peculiarities of the Negro Race,” which was published and made popular by *The New Orleans Medical and Surgical Journal*.⁸⁹ Cartwright wrote that Black people suffer from a “Negro disease [making them] insensible to pain when subjected to punishment.”⁹⁰ Further, Black people had lower lung capacity, which could conveniently be remedied by forced labor to “vitalize” the blood.⁹¹ Cartwright also claimed that Black people suffered from a “disease of the mind” called “drapetomania,” which caused them to run away from their slaveowners.⁹² His solution to this particular ailment was “whipping the devil out of them.”⁹³ These ideas that Black people were biologically different and inferior to white people eventually led to the utilization and exploitation of enslaved Black women as guinea pigs for medical advancement.⁹⁴

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Robert P. Forbes, *Notes on the State of Virginia (1785)*, ENCYCLOPEDIA VA. (May 6, 2016), https://www.encyclopediavirginia.org/Notes_on_the_State_of_Virginia_1785#itsTL.

⁸⁶ THOMAS JEFFERSON, NOTES ON THE STATE OF VIRGINIA 148 (Prichard and Hall, 1787).

⁸⁷ *Id.*

⁸⁸ Villarosa, *supra* note 79.

⁸⁹ *Id.*

⁹⁰ Kelly M. Hoffman, et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT’L ACAD. SCI. U.S. 4296, 4297 (Apr. 19, 2016).

⁹¹ Villarosa, *supra* note 79.

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *See id.*

B. Black Women and Medical Experimentation

Enslaved Black women became the target of a particularly nefarious manifestation of racist stereotypes of Black pain.⁹⁵ While all enslaved Black people were subjected to the idea that they experienced less pain than white people, enslaved Black women dealt with specific stereotypes relating to their reproductive health.⁹⁶ For example, enslaved women were thought to experience relatively little pain during childbirth.⁹⁷ A report published in an 1817 edition of the *London Medical and Chirurgical Review* stated that “Negresses ... will bear cutting with nearly, if not quite, as much impunity as dogs and rabbits.”⁹⁸ Ideas such as this, which served to dehumanize the enslaved, inspired individuals such as J. Marion Sims, known as the “father of modern gynecology” to begin conducting research on women they deemed subhuman.⁹⁹

An 1808 federal ban on the importation of slaves from other countries accelerated this issue.¹⁰⁰ Slaveowners now had to obtain new slaves through reproduction.¹⁰¹ This placed an intense financial value on enslaved women’s reproductive systems, introducing a relationship between the economic interests of slaveowners and the professional interests of doctors trying to enter the new field of gynecology.¹⁰² Due to poor conditions and a lack of any reproductive healthcare, countless enslaved Black women experienced debilitating complications after childbirth, prompting slaveowners to seek medical attention in order to keep their slaves in a condition to continue reproducing.¹⁰³ Slaveowners would often send their female slaves to doctors like Sims, who would then perform medical experimentation on them.¹⁰⁴

Sims is credited with several developments in the field of gynecology, namely the invention of the speculum and a treatment for vesicovaginal

⁹⁵ *See id.*

⁹⁶ *Id.*

⁹⁷ Wynn, *supra* note 69 at 95–96.

⁹⁸ *Id.* at 96.

⁹⁹ Kathleen Bachynski, *American Medicine Was Built on the Backs of Slaves. And it Still Affects How Doctors Treat Patients Today*, WASH. POST (Jun. 4, 2018), <https://www.washingtonpost.com/news/made-by-history/wp/2018/06/04/american-medicine-was-built-on-the-backs-of-slaves-and-it-still-affects-how-doctors-treat-patients-today/>.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ Wynn, *supra* note 69 at 96.

¹⁰⁴ Brynn Holland, *The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Enslaved Women*, HISTORY (Dec. 4, 2018), <https://www.history.com/news/the-father-of-modern-gynecology-performed-shocking-experiments-on-slaves>.

fistula (“VVF”).¹⁰⁵ These developments, however, came at the expense of unwilling enslaved women whose consent to the procedures was immaterial to their owners or Sims.¹⁰⁶ If the women’s owners provided clothing and paid taxes, Sims was essentially given temporary ownership of the women until he had completed their treatments.¹⁰⁷ Sims wrote that there was “never a time that [he] could not, at any day, have had a subject for operation,” and records list three known women who were the subjects of Sims’ VVF experiments: Lucy, Anarcha, and Betsey.¹⁰⁸

Lucy, who was only eighteen years old, had given birth just a few months earlier and had been unable to control her bladder ever since.¹⁰⁹ Without giving her anesthesia, Sims forced Lucy to endure an hour-long surgery as she screamed and cried out in pain while a dozen other doctors watched.¹¹⁰ Sims later wrote that “Lucy’s agony was extreme.”¹¹¹ Lucy eventually developed blood poisoning as a result of Sims’ decision to use a sponge to draw urine away from the bladder during surgery.¹¹² “I thought she was going to die ... It took Lucy two or three months to recover entirely from the effects of the operation,” Sims wrote.¹¹³

In the four years during which Sims was developing his VVF surgical techniques, he continued experimenting on enslaved women, conducting thirty experiments on one woman, Anarcha.¹¹⁴ After he was satisfied with the amount of experimentation, Sims began utilizing his new techniques on white women – using anesthesia.¹¹⁵ Sims continued his experimentation through the 1850s, opening the country’s first Woman’s Hospital in New York.¹¹⁶ He never blamed himself when any of his patients died, instead placing blame on “the sloth and ignorance of [the] mothers and the Black midwives who attended them.”¹¹⁷

¹⁰⁵ Meagan Flynn, *Statue of ‘Father of Gynecology,’ Who Experimented on Enslaved Women, Removed From Central Park*, WASH. POST (Apr. 18, 2018), <https://www.washingtonpost.com/news/morning-mix/wp/2018/04/18/statue-of-father-of-gynecology-who-experimented-on-enslaved-women-removed-from-central-park/>. VVF is a condition often caused by complications during childbirth in which a hole develops between the bladder and vagina, causing extreme pain and incontinence.

¹⁰⁶ Holland, *supra* note 104.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ Bachynski, *supra* note 99.

¹¹⁵ Holland, *supra* note 104.

¹¹⁶ *Id.*

¹¹⁷ *Id.*

Because the techniques developed by doctors like Sims were important to the development of gynecological medicine, the horrific nature in which they were developed is still often overlooked.¹¹⁸ To this day, Sims is celebrated as the “father of modern gynecology.”¹¹⁹ Medical textbooks and journals have been slow to mention any controversy over Sims’ legacy, with one study finding that they continued to celebrate his achievements without much criticism.¹²⁰ For example, the speculum, which Sims designed and is used to, is still commonly referred to as the “Sims speculum.”¹²¹ The stereotype perpetuated by Sims that Black pregnant people do not experience pain in childbirth has a clear link to modern physicians not taking Black pain seriously in the context of reproductive healthcare, ultimately contributing to the disparity in maternal deaths between Black and white pregnant people.

C. Stereotypes of Black Fertility

The racist myths perpetuated about the physical limitations of Black people have their origins in creating justifications for slavery, but they had a much further reach. Throughout American history, prejudices have been created and perpetuated about Black women to ensure their classification as sub-human and to justify the abuse of the Black body, often in the form of stereotypes about Black fertility.¹²² Three main stereotypes fall into this category: the Jezebel, the Welfare Queen, and the Angry Black Woman.

Named after the biblical wife of King Ahab, the character of Jezebel was a common depiction of enslaved Black women.¹²³ The Jezebel is a “purely lascivious creature” who was “governed by her erotic desires” and whose “sexual prowess led men to wanton passion.”¹²⁴ Generally created as a direct contrast to the pure, true white woman, the Jezebel character defined Black women not only as sexually promiscuous, but bad mothers.¹²⁵ The promiscuous Jezebel was used to show that Black people “procreate with abandon” and are innately and biologically predisposed to hyperfertility.¹²⁶ As recently

¹¹⁸ Sarah Zhang, *The Surgeon Who Experimented on Slaves*, THE ATLANTIC (Apr. 18, 2018), <https://www.theatlantic.com/health/archive/2018/04/j-marion-sims/558248/>.

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ See, e.g., Charlotte Bendon & Natalia Price, *Expert Review: Sims Speculum Examination*, 11 J. CLINICAL EXAMINATION 57 (2011) (stating that examination using the Sims speculum is an “important skill for medical students and doctors”).

¹²² Wynn, *supra* note 69 at 97.

¹²³ DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 10 (Vintage Books, 2d ed. 2017).

¹²⁴ *Id.*

¹²⁵ *Id.* at 11.

¹²⁶ *Id.* at 12.

as the 1990s, J. Philippe Rushton, a psychology professor at the University of Western Ontario, took inspiration from the stereotype, hypothesizing that Black women ovulate more frequently and develop sexually more quickly than white women.¹²⁷

Closely related to the hypersexual and overly procreative Jezebel is the character of the Welfare Queen, the “lazy mother on public assistance who deliberately breeds children at the expense of taxpayers to fatten her monthly check.”¹²⁸ The Welfare Queen perpetuates the idea that not only are Black women irresponsible with their own procreation, but that they manipulate the government and the taxpayer into giving them money to support their alleged deception.¹²⁹ The stereotype also represents a slight departure from the idea that Black people are merely incapable of making decisions for themselves, but that they deserve to be punished for the poor decisions they will inevitably make.¹³⁰

The third and more modern stereotype of Black women which contributes to negative prejudices about Black fertility is the Angry Black Woman (“ABW”), also known as the Sapphire.¹³¹ The ABW is sassy, rude, loud, overbearing, and bitter.¹³² This caricature of Black women has been made popular in television and movies in particular, commonly depicted with her hand on her hip, nagging and yelling at anyone who caused her problems.¹³³ Commonly known examples include Madea from Tyler Perry’s series of movies, Mammy in *Gone with the Wind*, and Harriette from *Family Matters*.¹³⁴ The ABW stereotype has resulted in the misconception that Black women who speak up for themselves are angry and vengeful.¹³⁵ In the context of healthcare, the Angry Black Woman stereotype potentially leads medical professionals to assume that any complaints coming from a Black pregnant person during pregnancy care are just the complaints of a rude ABW.¹³⁶ On the other hand, but potentially just as detrimental, it is highly likely that the Angry Black Woman character has led to a chilling effect in which Black

¹²⁷ *Id.*

¹²⁸ *Id.* at 17.

¹²⁹ *Id.*

¹³⁰ *Id.* at 18.

¹³¹ Wynn, *supra* note 69 at 98.

¹³² *The Sapphire Caricature*, FERRIS STATE UNIV. (last visited Dec. 28, 2020), <https://www.ferris.edu/HTMLS/news/jimcrow/antiblack/sapphire.htm>.

¹³³ Wynn, *supra* note 69 at 98.

¹³⁴ Brittney Cooper, *Black Women Are Not ‘Sassy’ — We’re Angry*, TIME (Mar. 15, 2018), <https://time.com/5191637/sassy-black-woman-stereotype/>.

¹³⁵ *Id.*

¹³⁶ *Id.* at 99.

pregnant people are less likely to speak their minds to medical professionals in order to avoid coming off as an ABW.¹³⁷

These stereotypes perpetuate the myth that Black women are irresponsible with their own reproductive health and cannot make decisions that benefit themselves or their children.¹³⁸ As Dorothy Roberts wrote, “American culture reveres no Black Madonna. It upholds no popular image of a Black mother tenderly nurturing her child.”¹³⁹ All of this results in the conscious or unconscious bias that Black people are not trustworthy with their own reproductive health and cannot manage it on their own ; that they do not experience pain as intensely as white pregnant people ; and consequently that they simply do not require the same level of pre and postnatal healthcare, ultimately contributing to the crisis of maternal deaths among Black pregnant people.¹⁴⁰

III. WHAT CAN BE DONE?

Because the maternal health crisis in the United States is a national one, federal legislation will be instrumental in addressing the issue and beginning to find a remedy. In 2018, President Donald Trump signed into legislation the Preventing Maternal Deaths Act, which provides funding for states to determine why maternal death rates in the United States are so high.¹⁴¹ The Act sets up federal funding to establish and support existing maternal mortality review committees (“MMRCs”) at the state level.¹⁴² Present in forty-eight states, the District of Columbia, New York City, Philadelphia, and Puerto Rico, MMRCs conduct reviews of individual pregnancy-related deaths, develop data, and provide recommendations aimed at preventing future pregnancy-related deaths.¹⁴³

The Preventing Maternal Deaths Act, however, is merely a step in the right direction for maternal health legislation rather than a complete solution. The Act does not require states to determine whether flawed medical care played any role in a given pregnancy-related death.¹⁴⁴ Many states’ MMRC reports focus on the mother’s lifestyle and choices, such as obesity, smoking, failure

¹³⁷ *Id.*

¹³⁸ *Id.* at 14.

¹³⁹ *Id.* at 15.

¹⁴⁰ William J. Hall, et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH e60, e61 (2015).

¹⁴¹ Wynn, *supra* note 69 at 86.

¹⁴² Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, § 2, 132 Stat. 5047.

¹⁴³ *Maternal Mortality Review Committees*, GUTTMACHER INST. (Dec. 1, 2020), <https://www.guttmacher.org/state-policy/explore/maternal-mortality-review-committees#>.

¹⁴⁴ Alison Young, *Mothers Are Dying. Will This Bill Help?*, U.S.A. TODAY (Dec. 19, 2018), <https://www.usatoday.com/story/news/investigations/deadly-deliveries/2018/12/19/maternal-mortality-rate-bill-targets-chidbirth-deaths/2339750002/>.

to seek prenatal care, and failure to wear a seatbelt, rather than the quality of pregnancy-related healthcare.¹⁴⁵ This is a serious flaw in the Act because approximately 60% of pregnancy-related deaths are preventable with proper medical intervention, so data regarding medical practices which lead to deaths is critical to understanding the totality of the crisis.¹⁴⁶ Further, the legislation fails to address or remedy the lack of standardized maternal mortality data collection among the United States.¹⁴⁷ States' MMRCs vary in their data collection methods.¹⁴⁸ Some states only mandate the collection of data and internal review without seeking any follow-up action via system-level changes, resulting in unstandardized and largely unhelpful data.¹⁴⁹ Black pregnant lives cannot be protected without reliable knowledge of maternal mortality data.

A. Legislation as a Tool

Because of its failure to acknowledge the necessity of examining medical care practices in determining the cause of maternal deaths, the Preventing Maternal Deaths Act should only be considered as a starting point for federal legislation aimed at addressing the United States' shameful maternal mortality rate. More policy work needs to be done. One of the most significant difficulties in addressing maternal mortality rates and the disproportionate rates among Black women in the United States is a lack of consistent data from state to state.¹⁵⁰ Federal legislation has a unique power to be able to find solutions to fix the problem of Black pregnant people dying at a higher rate than their white counterparts by standardizing care standards for state governments.¹⁵¹ In the last two Congressional terms, two key pieces of legislation introduced in the United States Congress directly address maternal mortality.¹⁵²

The Mothers and Offspring Mortality and Morbidity Act ("MOMMA's Act") has the express goal of improving "[f]ederal efforts with respect to the prevention of maternal mortality" and supports the standardization of data collection regarding maternal deaths. It also calls on the Centers for Disease Control ("CDC") to publish best practices for investigations like those

¹⁴⁵ *Id.*

¹⁴⁶ Beutler, *supra* note 2.

¹⁴⁷ Wynn, *supra* note 69 at 104.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*; Katy Backes Kozhimannil, et al., *Beyond The Preventing Maternal Deaths Act: Implementation And Further Policy Change*, HEALTH AFFAIRS (Feb. 4, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190130.914004/full/>.

¹⁵⁰ Kozhimannil, *supra* note 149.

¹⁵¹ *Id.*

¹⁵² *Id.*

performed by MMRCs.¹⁵³ Notably, the bill also calls for instituting implicit bias training for healthcare professionals and extending Medicaid postpartum coverage.¹⁵⁴

Similar to the MOMMA's Act, the goal of the Modernizing Obstetric Medicine Standards Act ("MOMS Act") is to "help prevent women from suffering from medical complications or dying before, during, and after childbirth."¹⁵⁵ The MOMS Act also calls on the CDC to publish best practices for MMRC investigations and provides funding for states and hospitals to implement best-practice standards.¹⁵⁶ It specifically allocates funding for low-income, at-risk, and rural populations.¹⁵⁷

The passage of these bills, and the future introduction of maternal health legislation, would provide a framework for the necessary standardization of maternal health standards and would consequently lead to an improvement in the maternal mortality rate of the United States.¹⁵⁸

B. Medicaid Reform

Although the federal legislature is an effective means of passing legislation that would improve maternal mortality rates and address the disparities between Black and white pregnant people, state governments are also in a position to highly influence and improve maternal health outcomes via Medicaid expansion.¹⁵⁹ As many as thirteen percent of all maternal deaths occur within six weeks of giving birth, ensuring that all pregnant people have sufficient medical insurance following childbirth is critical to lowering the maternal mortality rate in the United States.¹⁶⁰ Medicaid currently pays for approximately half of all births in the United States and the federal government

¹⁵³ H.R. 1897, 116th Cong. (2019). *See also id.*

¹⁵⁴ *Analysis of Federal Bills to Strengthen Maternal Health Care*, KAISER FAM. FOUND. (Dec. 21, 2020), <https://www.kff.org/womens-health-policy/fact-sheet/analysis-of-federal-bills-to-strengthen-maternal-health-care/>.

¹⁵⁵ Press Release, Kirsten Gillibrand, With Maternal Mortality Rates On The Rise In The United States, Gillibrand Announces New Legislation To Help Reduce Maternal Deaths, Help Hospitals Implement Best Practices To Prevent Women From Dying Before, During And After Childbirth (Aug. 28, 2018), <https://www.gillibrand.senate.gov/news/press/release/with-maternal-mortality-rates-on-the-rise-in-the-united-states-gillibrand-announces-new-legislation-to-help-reduce-maternal-deaths-help-hospitals-implement-best-practices-to-prevent-women-from-dying-before-during-and-after-childbirth>.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ Press Release, Congresswoman Robin Kelly, Rep. Kelly Re-Introduces MOMMA's Act to Address Maternal Health Crisis (May 20, 2021), <https://robinkelly.house.gov/media-center/press-releases/rep-kelly-re-introduces-momma-s-act-to-address-maternal-health-crisis>.

¹⁵⁹ Wynn, *supra* note 69 at 105.

¹⁶⁰ Julia Belluz & Nina Martin, *We're investigating how insurance gaps endanger mothers. This is why*, VOX (Apr. 25, 2019), <https://www.vox.com/2019/4/25/18514145/maternal-mortality-rates-medi-caid-insurance>.

requires states to offer Medicaid to low-income women during pregnancy.¹⁶¹ However, individuals who obtain Medicaid insurance are only guaranteed sixty days of extended coverage after giving birth.¹⁶² Because the percentage of uninsured non-elderly Black people in states without expanded Medicaid coverage is double that of people in states that have expanded their Medicaid program to include more postpartum insurance coverage, it is not a coincidence that Medicaid is another aspect of the American healthcare system that disproportionately disadvantages Black pregnant people.¹⁶³

Because Medicaid expansion and other such policy changes are state-level legislative actions, state governments should begin to bolster Medicaid protections for pregnant people who use Medicaid to pay for their pregnancy healthcare.¹⁶⁴ A recent study conducted by Georgetown University found that states that have expanded Medicare coverage have better maternal health outcomes, including increased access to preventive care, fewer adverse health outcomes before, during and after pregnancies, and lower maternal mortality rates.¹⁶⁵ The study also found that, unsurprisingly, Black pregnant people were disproportionately affected in states that have not expanded Medicaid coverage.¹⁶⁶ Currently, eleven states, primarily in the South, have not expanded Medicaid coverage to support pregnant people after giving birth.¹⁶⁷ Unsurprisingly, they rank among the lowest in the country in terms of Black women's health insurance coverage.¹⁶⁸ If these states were to expand Medicaid, approximately six in ten uninsured Black adults would be eligible.¹⁶⁹

If the remaining state governments who have not expanded their Medicaid coverage fail to do so, proposed federal legislation may make it mandatory.¹⁷⁰ The Maximizing Outcomes for Moms through Medicaid Improvement and Enhancement of Services Act ("MOMMIES Act"), would directly address

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ Young, *supra* note 144. See also Jennifer Tolbert, et al., *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Nov. 6, 2020), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population>.

¹⁶⁴ Young, *supra* note 144.

¹⁶⁵ Adam Searing & Donna C. Ross, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies*, GEO. UNIV. HEALTH POL'Y INST. 1 (May 2019).

¹⁶⁶ *Id.* at 6.

¹⁶⁷ Usha Ranji, et al., *Expanding Postpartum Medicaid Coverage*, KAISER FAM. FOUND. (Dec. 21, 2020), <https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage>.

¹⁶⁸ Black Mamas Matter Alliance and Center for Reproductive Rights, *Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care* 24 (2016), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

low health insurance rates and how they affect Black pregnant people.¹⁷¹ By amending the Social Security Act, the MOMMIES Act would extend postpartum Medicaid coverage to a full year after birth and ensure that all pregnant and postpartum individuals have full Medicaid coverage instead of coverage limited to pregnancy-related healthcare services.¹⁷²

C. Implicit Bias Training

The complexity of the maternal mortality crisis in the United States and the extent to which people of color are disproportionately affected by the nation's failure to protect its pregnant people demands that there not be one single solution. The aforementioned pieces of legislation are critical in establishing a foundation upon which to improve maternal health outcomes in the United States at the federal and state levels, but they are by no means a complete or holistic solution. One frequently recommended step that can be taken to reduce maternal mortality rates is the implementation of implicit bias training for medical professionals at all levels.¹⁷³ Implicit bias refers to "prejudicial attitudes towards and stereotypical beliefs about a particular social group or members therein."¹⁷⁴ Most individuals have unconscious prejudices towards other groups which affect their social interactions with individuals of those groups.¹⁷⁵ Implicit bias training can help medical students and professionals confront their own biases and learn how to counteract them when they interfere with how they deliver healthcare services.

Biases are particularly harmful in the medical profession as they can literally kill patients.¹⁷⁶ Many laypeople and medical professionals alike still hold the belief that there are biological, scientific differences between races and that, consequently, different races experience pain differently, echoing the racist pseudoscience furthered by doctors such as J. Marion Sims.¹⁷⁷ A 2016 study of 222 white medical students and residents found that approximately half of those surveyed believed at least one falsity about physical or biological differences between white and Black pain and health, such as the myth that Black peoples' nerve endings are less sensitive than white peoples'.¹⁷⁸

¹⁷¹ Press Release, Sen. Cory Booker, Ahead of Mother's Day, Booker, Pressley, Colleagues Introduce Bill to Improve Maternal Health Outcomes (May 8, 2019), <https://www.booker.senate.gov/news/press/ahead-of-mother-and-rsquo-day-booker-pressley-colleagues-introduce-bill-to-improve-maternal-health-outcomes>.

¹⁷² *Id.*

¹⁷³ Kozhimannil, *supra* note 149.

¹⁷⁴ Nao Hagiwara, et al., *A Call For Grounding Implicit Bias Training in Clinical and Translational Frameworks*, 395 THE LANCET 1457, 1458 (2020).

¹⁷⁵ *Id.*

¹⁷⁶ *Id.* at 1457–58.

¹⁷⁷ Hoffman, *supra* note 90 at 4296.

¹⁷⁸ Villarosa, *supra* note 79.

The students and residents were also asked to evaluate how much pain Black and white individuals experienced in different hypothetical situations.¹⁷⁹ One-third concluded that Black people experienced less pain, resulting in the providers being less likely to recommend an appropriate course of treatment.¹⁸⁰

Research has shown that teaching explicit strategies for individuals to implement in their daily lives is more effective in actually reducing and confronting bias rather than abstract education.¹⁸¹ Implicit bias training has become far more common in recent years, but medical institutions have only slowly begun utilizing this type of education.¹⁸² Healthcare facilities and medical schools should take the approach of teaching students and professionals concrete, specific strategies to help mitigate the negative effects of prejudice. For example, the Mayo medical schools in Arizona and Minnesota have required that their first-year medical students read implicit bias materials and take a bias test at the beginning of the school year.¹⁸³ Further, the medical director of the Office of Diversity and Inclusion at the Mayo Clinic has begun an institution-wide push for implicit bias training and resources, implementing tools such as checklists so that providers do not skip an aspect of treatment.¹⁸⁴ Reinforcing the power of the Mayo Clinic's decision to implement implicit bias training, a program that educated college students about five evidence-based strategies for combating prejudice (stereotype replacement, counter-stereotypical imaging, individuating, perspective taking, and contact) was shown to have resulted in lower implicit bias within eight weeks after the training.¹⁸⁵

Additionally, federal legislation has been proposed that would help medical schools implement implicit bias training. In 2019, the Maternal Care Access and Reducing Emergencies ("CARE") Act was introduced to the Senate, which would implement and fund implicit bias training for medical professionals.¹⁸⁶ The Act, supported by organizations like the American College of Obstetricians and Gynecologists and the Planned Parenthood Federation of

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ Hagiwara, *supra* note 174 at 1459.

¹⁸² *Id.* at 1457–59.

¹⁸³ Elizabeth Chuck, *How Training Doctors in Implicit Bias Could Save the Lives of Black Mothers*, NBC NEWS (May 11, 2018), <https://www.nbcnews.com/news/us-news/how-training-doctors-implicit-bias-could-save-lives-black-mothers-n873036>.

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

¹⁸⁶ Patreice A. Massey, *Sen. Kamala Harris Reintroduces Legislation Addressing Black Maternal Mortality Crisis*, NEW PITTSBURGH COURIER (June 5, 2019), <https://newpittsburgh-courier.com/2019/06/05/sen-kamala-harris-reintroduces-legislation-addressing-black-maternal-mortality-crisis/>.

America, would fund a program to address racial bias in maternal healthcare, allocate funds to identify “high-risk pregnancies,” and help medical schools implement training to recognize biases as part of clinical skills testing.¹⁸⁷ Although medical schools and facilities will need to implement bias training on an individual basis, federal funding would allow such institutions to do so without concern for cost. Instituting requirements for medical students and professionals to confront their biases is likely to result in better overall health outcomes for Black pregnant people. Requiring implicit bias training has the potential to improve rates of medical mistreatment of Black pregnant people during their maternal healthcare, ultimately resulting in fewer preventable deaths.

CONCLUSION

Maternal mortality deserves to be viewed as a public health crisis in the United States. As a result of long-standing, deeply entrenched racial stereotypes about Black people generally, Black women and pregnant individuals of other gender identities are disproportionately more likely to experience death or serious complications due to not being taken seriously about their experiences during pregnancy or childbirth than white pregnant people, regardless of socioeconomic status or level of education. Public awareness of why Black pregnant people are dying of entirely preventable causes is the first step. The responsibility to increase that awareness lies with lawmakers and medical professionals alike.

After a centuries-long effort to subjugate Black people, particularly Black women and those of other gender identities who can become pregnant, it should not come as a surprise that they die at disproportionately high rates of largely preventable pregnancy complications. However, little has actually been done to support the Black community in this regard and to ameliorate the causes of the Black maternal mortality crisis. Because the factors leading to the modern crisis, such as stereotypes of Black pain and the historical dehumanization of Black women for medical experimentation, are so vast and complex, it is easier to ignore the problem than it is to fix it. Therefore, an intersectional, conscientious, and holistic approach is necessary to save Black lives.

Legislation is one important tool to be utilized in the fight to improve health outcomes for America’s Black pregnant people. Bills both at the federal and state level should be written and passed to implement protections for pregnant people, such as standardized data collection and Medicaid reform. Legislation should also specifically acknowledge the history of racism

¹⁸⁷ *Id.*

embedded within the medical profession by introducing measures such as funding for implicit bias training among medical students and professionals.

However, legislation is not the only method by which maternal mortality should be addressed. Public health officials, educators, doctors, and medical students need to be a part of the solution. Black activists must be centered in the fight to protect Black lives, as they are the most familiar with the effects of racism on reproductive and maternal health. Organizations such as Black Mamas Matter are doing incredible work to make the American people, and medical professionals in particular, aware of how a history of racism has affected how Black pain is viewed and how that history has caused countless preventable deaths.