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More Money, More Problems: Why H.R. 1318 is an Insufficient Fix to Remedy the Maternal Mortality Crisis

More Money, More Problems: *Why H.R. 1318 is an Insufficient Fix to Remedy the Maternal Mortality Crisis.*

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Introduction

Maternal mortality is generally defined as a death that occurs due to childbirth or pregnancy complications within the first six weeks of a woman giving birth.[1] Some medical commentators expand the definition of maternal mortality by recognizing maternal mortality as any death related to postpartum or pregnancy complications within one year of birth.[2] In the early 1800s, maternal-related deaths occurred from, amongst other things, lack of standard processes, lack of adequate knowledge on treating pregnancy complications (like infections), and lack of suitable training in medical schools.[3] High maternal deaths persisted until 1933 when the White House called a conference that prompted the beginning of maternal mortality review committees at the state level.[4] These committees led medical advancements to

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1. Neel Shah, *A Soaring Maternal Mortality Rate: What does it mean for you?*, Harv. Med. Sch.: Harv. Health Blog (Oct. 16, 2018, 11:15 AM), https://www.health.harvard.edu/blog/a-soaring-maternal-mortality-rate-what-does-it-mean-for-you-2018101614914.

2. *See* Katy B. Kozhimannil, et. al., *Beyond the Preventing Maternal Deaths Act: Implementation and Further Policy Change*, Health Aff.: Health Aff. Blog (Feb. 4, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190130.914004/full/.

3. Lienna Feleke-Eshete, *The Crisis Facing American Women: Policy Solutions to Address Maternal Mortality in the United States*, Johns hopkins sheridan libraries (May 2019), https://jscholarship.library.jhu.edu/handle/1774.2/61783.

4. *See id.*

emerge, causing a decrease in maternal deaths consistently from 1948 through 1982. During these years the maternal death rate became stagnant and low.[5]

Between 1990 and 2013 maternal mortality has nearly doubled in the United States as opposed to other countries.[6] Per every 100,000 live births, there are 26.4 deaths in the United States.[7] In fact, the United States has the highest rate of maternal mortality in the industrialized world.[8]

Unfortunately, maternal mortality did not become a political issue until public figures, like Beyoncé and Serena Williams,[9] began speaking out about near-death experiences while giving birth. For example, T.V. phenomenon Judge Glenda Hatchett's daughter-in-law, Kira Johnson, died due to pregnancy-related complications in 2016.[10] Stories like Beyoncé's, Serena Williams, and Kira Johnson caused a public outcry. Consequently, two years after Kira Johnson's death and a year after Serena William's near-death experience, Congress passed H.R. 1318, The Preventing Maternal Deaths Act ("H.R. 1318").[11] Congress's intent in passing H.R. 1318 was to address the increase in maternal-related deaths by providing funding for state research.[12] However, H.R. 1318 is insufficient as it provides no actual remedy for aggrieved families nor does it provide plaintiffs with standing to sue in the event a state fails to follow the protocols set place in the Act.

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5. *Id.*

6. Kozhimannil, et al., *supra* note 2. (discussing that in other countries, maternal mortality remains low or has declined).

7. GBD 2015 Maternal Mortality Collaborators, *Global, Regional, and National levels of Maternal Mortality, 1990-2015: A Systematic Analysis for the Global Burden of Disease Study 2015*, 388 THE LANCET 1775, 1784-93 (Oct.8, 2016), https://www.thelancet.com/action/showPdf?pii=S0140-6736%2816%2931470-2. (Relating to 9.2 deaths in the United Kingdom, 9 deaths in Portugal and Germany, 7.8 deaths in France, 7.3 deaths in Canada, 6.7 deaths in the Netherlands, 5.6 deaths in Spain, 5.5 deaths in Australia, 4.7 deaths in Ireland, 4.4 deaths in Sweden, 4.2 deaths in Italy and Denmark, and 3.8 deaths per 100,000 in Finland).

8. Katherine Ellison & Nina Martin, *Nearly Dying in Childbirth: Why Preventable Complications Are Growing in U.S.*, NPR (Dec. 22, 2017, 12:17 PM), https://www.npr.org/2017/12/22/572298802/nearly-dying-in-childbirth-why-preventable-complications-are-growing-in-u-s.

9. Allyson Chiu, *Beyoncé, Serena Williams Open Up About Potentially Fatal Childbirths: A Problem Especially For Black Mothers*, WASHINGTON POST (Aug. 7, 2018, 7:22AM), https://www.washingtonpost.com/news/morning-mix/wp/2018/08/07/beyonce-serena-williams-open-up-about-potentially-fatal-childbirths-a-problem-especially-for-black-mothers/.

10. Sheila M. Poole, *TV Judge Glenda Hatchett and Son Fight for Lives of New Mothers*, ATLANTA J. CONST. (Mar. 9, 2018), https://www.ajc.com/marketing/judge-glenda-hatchett-and-son-raise-awareness-maternal-deaths/Z5Jg8DcqSz4NQLMKpP6PML/

11. Preventing Maternal Deaths Act, H.R. 1318, 115th Cong. (2018) (enacted).

12. *Id.*

This note will be divided into four sections. Section I will highlight a common case of maternal mortality: the Kira Johnson story. Section II will explain in detail H.R. 1318 and examine state requirements under the Act. Section III will address the shortcomings of H.R. 1318, including why H.R. 1318 is insufficient in remedying maternal mortality. Last, section IV recommends how Congress should amend H.R. 1318, including providing a civil remedy for victims of maternal mortality.

I. CASE STUDY: THE KIRA JOHNSON STORY.

Young, healthy, successful, multi-lingual, a businesswoman, a wife, and a mother: this was Kira Johnson.[13] April 12, 2016, was supposed to be a joyous day for Kira Johnson and her family.[14] Charles Johnson, Kira's husband, was elated about the birth of their second baby boy and stated, "My family is complete. . .Kira and I had always wanted two boys."[15] Kira and Charles chose Cedars Sinai Medical Center which was, at the time, ranked the eighth best hospital in the country by U.S. News and World Report.[16] Kira and Charles arrived at Cedars Sinai at 2:00 PM for Kira's scheduled cesarean section surgery, (commonly known as a "C-section") and ten hours later Charles was told that Kira died.[17]

The events leading up to Kira's death are outlined in the Complaint filed by Charles Johnson against Cedars Sinai Medical Center and the doctors, Arjang Naim M.D., Benham Kashanchi M.D., and others, that were attending to Kira on April 12th.[18] The birthing events occurred as follows: at 2:00 PM, Kira was taken to the operative suite; at 2:15 PM, a foley catheter was inserted; at 2:31 PM, delivery began; and at 2:33 PM, Kira and Charles' baby boy, Langston, was

13. *See* Tahra Johnson, *Maternity Care in Crisis*, NCLS 16, 17 (2019), https://www.ncsl.org/Portals/1/Documents/magazine/articles/2019/Maternal_Jan2019.pdf; *See also* Elizabeth Chuck, *An amazing First Step: Advocates hail Congress's Maternal Mortality Prevention Bill*, NBC NEWS (Dec. 19, 2018, 5:38 AM), https://www.nbcnews.com/news/us-news/amazing-first-step-advocates-hail-congress-s-maternal-mortality-prevention-n948951.

14. Erica Y. King, *Widowed Father Works With Congresswoman on Legislation to Prevent Maternal Deaths*, ABC NEWS (Jan. 6, 2019, 2:26 PM), https://abcnews.go.com/Health/widowed-father-works-congresswoman-legislation-prevent-maternal-deaths/story?id=59846228.

15. *Id.*

16. *Id.*

17. *Id.*

18. Complaint for Damages at 1, Johnson v. Cedars-Sinai Medical Center, (No. BC655107), 2017 WL 1157300 (Cal. Super. Ct. 2017).

born.[19] Most people are eager to expand their families and the idea of entering but never leaving the hospital is unlikely to cross their minds, especially as patients of a renowned hospital. Charles Johnson, definitely did not anticipate the events to follow because Kira had an uneventful and healthy pregnancy.[20] Unfortunately, at 4:45 PM, Kira's fundus had risen from +2 to +4 CMS above the umbilicus,[21] this condition is often associated with the failure of the uterus to contract after delivery and can lead to postpartum hemorrhaging.[22] Postpartum hemorrhaging ("PPH") is generally defined as a blood loss of 500 ml or more within twenty-four hours after birth.[23]

At 5:00 PM, blood was first recognized in Kira's foley catheter; by 5:24 PM, Kira's catheter was draining bright red blood and a nurse was notified.[24] Dr. Naim was informed of Kira's repeated blood loss and fundus levels, and at 5:30 PM, Kira's catheter was replaced; at 5:38 PM, Kira's catheter was again filled with blood.[25] At this time, Kira was given a bedside ultrasound which showed a 6 CM fluid collection of blood in her bladder, thus, causing a hematoma[26] concern.[27] Dr. Naim was, once again, informed of Kira's condition.[28] Kira was given pain medication and at 6:12 PM, labs were ordered. The results of the labs showed Kira's white blood count, red blood count, hemoglobin, and hematocrit were all abnormal.[29] At 6:44 PM, another attending physician-Dr. Stuart Martin M.D.- performed a "stat" CT of Kira's abdomen and pelvis, as well as a CT urogram.[30] Kira's medical records stated that the reason for the abdomen and CT urogram was for a "surgical emergency," the records also indicated that Kira suffered from intrac-

19. *Id.* at 3

20. *See* Chuck *supra* note 13, at 4 n.13.

21. Complaint for Damages, *supra* note 18, at 3 n.1 ("The fundus is the upper rounded extremity of the uterus above the openings of the uterine tubes.").

22. *See Id.*,, at 3.

23. *WHO Recommendations on Prevention and Treatment of Postpartum Hemorrhage and the WOMAN Trial*, WORLD HEALTH ORG. (June 15, 2017), https://www.who.int/reproductivehealth/topics/maternal_perinatal/pph-woman-trial/en/.

24. Complaint for Damages, *supra* note 18, at 3.

25. *Id.* at 3–4:.

26. *Id.* at 4 n.2 ("A hematoma is a mass or abnormal collection of clotted blood within the tissues.").

27. *Id.*, at 4 n.18, at 4.

28. *Id.* at 4.

29. *Id.* at 4 (Complaint stated that Kira's lab results were: White Blood Count 19.1 when the normal range is 4-11; Red Blood Count 3.01 when normal range is 3.6-5.11; Hemoglobin 9.2 when the normal range is 12-16; and Hematocrit 27% when the normal range is 36-47%).

30. Complaint for Damages, *supra*, note 18, at 5.

table abdominal pain and showed frank blood in her catheter.[31] Kira's bleeding persisted and Dr. Naim was, once again, made aware of Kira's condition.[32]

At 8:00 PM, Kira was examined by *another* doctor, Dr. Churchill, and he was informed that Kira had produced blood but little to no urine, despite being given fluids consistently; he did nothing.[33] During this time, Kira's medical records indicated that her heart rate was tachycardic, which means she had a resting heart rate of at least 100 beats per minute.[34] At 8:47 PM, according to Kira's medical records, Dr. Naim, finally examined Kira with full knowledge of the status of her condition.[35] At 10:44 PM, the CT scans that had been ordered "stat" four hours earlier still had not been completed.[36] In fact, Kira's medical records indicate that the CT scans never were performed.[37] Ten minutes later Kira's nurse notified Dr. Churchill and another doctor that Kira's blood pressure was in the 70's/50's. At this time, Kira's blood pressure cuffs were changed, but her blood pressure remained low (82/53).[38] At 11:25 PM, Dr. Naim was notified of a concern that Kira had active internal bleeding.

At 11:42PM, Dr. Churchill and Dr. Sharma were informed by Kira that she felt "groggy."[39] Dr. Naim was notified, again, and took no immediate action; instead he decided to "continue expectant management at this time," (i.e., essentially "business as usual").[40] Consequently, a massive transfusion protocol was initiated on Kira; a massive transfusion protocol means packed red blood cells, platelets, and plasma given in large quantities to support circulation and coagulation during massive hemorrhage.[41] Finally, at 12:30 AM, on April 13, 2016, Kira was taken to surgery where doctors found three liters of blood in her abdomen.[42] At 2:22 AM, Kira was pronounced dead.[43]

31. *Id.* at 5.
32. *Id.* at 4.
33. *Id.* at 6.
34. *Id.*
35. *Id.* According to the complaint, Dr. Naim knew that Kira's levels were abnormal, knew that Kira's heart rate was consistent with tachycardia, and knew that Kira had a possible hematoma (large blood clot).
36. Complaint for Damages, *supra* note 18, at 7 1
37. *Id.* at 7.
38. *Id. at 7:4.*
39. *Id.*
40. *Id.*
41. *Id.*
42. Complaint for Damages, *supra* note 18, at 8.
43. *Id.*

Kira's autopsy stated that her cause of death was due to hemorrhagic shock from acute hemoperitoneum post-cesarean section.[44]

As previously mentioned, Charles Johnson sued Cedars Sinai Medical Center on behalf of Kira on the ground of negligence.[45] The Complaint, filed in the Superior Court of California, listed two causes of action: wrongful death and negligent infliction of emotional distress.[46] Kira Johnson's story caused a public outcry.[47] Luckily for Charles Johnson, he had the assistance of his mother (Judge Glenda Hatchett) on how to remedy the loss of his wife by utilizing the courts to get the justice he and his family deserved.

At common law, medical malpractice occurs when a doctor fails to exercise the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances.[48] In Kira's case, Dr. Naim, Dr. Churchill, and the others attending to Kira failed to exercise the requisite standard of care by allowing Kira to bleed for hours with full knowledge of her abnormal blood levels. But for Kira's doctors' failure to perform necessary CT scans, Kira would still be alive today-as would many other women who die from pregnancy-related complications at the hands of physicians. Some attorneys posit that medical malpractice caps are connected to maternal mortality because many states have placed caps on the amount survivors can recover after losing a loved one to medical negligence.[49] Eight out of the nine states with the highest maternal mortality rates-including the District of Columbia-also have a cap on damages available to recover from medical malpractice.[50]

Moreover, Kira Johnson's story began with hope but turned into heartache. However, thanks to our justice system, Kira's family not only received the compensatory justice they deserved, but Kira's story also served as a catalyst of what is happening to many women today at

44. *Id.*

45. Natalie Stone, *TV Judge Glenda Hatchett's Son Suing Hospital Over Alleged Wrongful Death of His Wife Who Died Hours After Giving Birth*, PEOPLE (May 13, 2017, 12:21 AM), https://people.com/tv/glenda-hatchett-son-suing-hospital-wife-death-after-birthing-baby/.

46. *See* Complaint for Damages, *supra* note 18, at 1.

47. While conducting research in furtherance of this note, a "Google" search proved that Kira Johnson's story was heard and written about on multiple public forums including in front of Congress and prominent websites such as ABC News, National Geographic, Atlanta Journal Constitution, NBC News, Daily Mail, YouTube, Now This, and more.

48. *Medical Malpractice*, BLACK'S LAW DICTIONARY (5th Pocket ed. 2016).

49. The Carlson Law Firm, *Do Medical Malpractice Caps Influence Maternal Mortality?*, CARLSON ATTORNEYS (Aug. 24, 2018), https://www.carlsonattorneys.com/news-and-update/maternal-mortality.

50. *Id.*

the hands of negligent physicians. Unfortunately, many women do not have the resources or the opportunity that Kira's husband, Charles, had to fight for Kira. Likewise, there is no criminal law requiring doctors to admit to mistakes made in childbirth that led to death or serious injury.[51] In 2018, Congress passed bipartisan bill H.R. 1318, *The Preventing Maternal Deaths Act* as a response to stories such as Kira's.

II. H.R. 1318, THE PREVENTING MATERNAL DEATHS ACT, EXPLAINED.

On December 21, 2018, Congress passed the *Preventing Maternal Deaths Act of 2018*, which amends the Public Health Service Act (42 U.S.C. 247b-12).[52]

> The purpose of the act is:
> [T]o support states in their work to save and sustain the health of mothers during pregnancy, childbirth, and in the postpartum period, to eliminate disparities in maternal health outcomes for pregnancy-related and pregnancy-associated deaths, to identify solutions to improve health care quality and health outcomes for mothers, and for other purposes.[53]

Essentially, the Act helps states improve how they track and investigate deaths related to pregnancy and birth.[54] Congress also passed H.R. 315 (Improving Access to Maternity Care Act) and S. 3029 (PREEMIE Reauthorization Act of 2018),[55] both of which address maternal and infant health and mortality.[56] Furthermore, section 1 of The Preventing Maternal Deaths Act, simply lists the revised name; section 2, lists the amended section of the Public Health Service Act, which essentially makes up the majority of the "new and improved" Preventing Maternal Deaths Act and also outlines the requirements for each state to create Maternal Mortality Review Committees ("MMRCs") beginning at section (d).[57]

51. *Id.*

52. Preventing Maternal Deaths Act, H.R. 1318, 115th Cong. (2018) (enacted).

53. *Id.*

54. Nina Martin, *"Landmark" Maternal Health Legislation Clears Major Hurdle*, PROPUBLICA (Dec. 12, 2018, 12:56 PM), https://www.propublica.org/article/landmark-maternal-health-legislation-clears-major-hurdle.

55. Although mentioned, these acts will not be the focus of this note. This note's goal is to address the Preventing Maternal Deaths Act only.

56. Amy Chen, et al., *2017-2018 Federal Legislative Proposals Relating to Maternal and Infant Health and Mortality*, HEALTH L. (Jan. 3, 2019), https://healthlaw.org/resource/2017-2018-federal-legislative-proposals-relating-to-maternal-and-infant-health-and-mortality/.

57. Preventing Maternal Deaths Act, H.R. 1318, 115th Cong. (2018) (enacted).

Section (d) of H.R. 1318, titled Maternal Mortality Review Committees ("MMRCs"), states that in order for a state to participate in the program there must be:

> (a) "multidisciplinary and diverse membership that represents a variety of clinical specialties. . .and individuals or organizations that. . .represent the populations in the area covered by such committee that are most affected by [maternal mortality]", and (b) "demonstrate to the Center for Disease Control ("CDC") that such [MMRCs] have methods and processes for data collection. . .that are reliable best practices."[58]

Furthermore, section (d)(2) provides the process for confidential reporting by the States, while section (d)(3) provides the process for data collection and review.[59] Section (d)(4) requires that MMRCs keep all information obtained confidential, except as provided in section (d)(5), which allows for reports to be sent to the CDC.[60] Section (d)(6) allows states to partner together to gather research, while section (d)(7) lists the mechanisms Indian tribes should follow.[61] Lastly, section (d)(8) places a responsibility on the secretary to make the research, found under section (d)(5), available consistent with federal and state privacy laws.[62]

Overall, the H.R. 1318 can be summarized as: an Act that provides states, and federally recognized Indian tribes and organizations, with funding to: (1) track maternal mortality, (2) create maternal mortality review committees, (3) provide local departments of health with funding to establish education programs for providers related to quality maternal care, (4) disseminate a uniform reporting form, and (5) allow public disclosure in state reports.[63]

III. Why H.R. 1318 is An Insufficient Fix to the Maternal Mortality Crisis.

As mentioned above, H.R. 1318 provides federal funding for states to create maternal mortality review committees ("MMRCs").[64] Although H.R. 1318 provides funding, it is an insufficient approach to remedy the maternal mortality crisis in the United States because it: (a) does not mandate state/tribal participation in the program; (b) ig-

58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.*
62. *Id.*
63. Chen et al., *supra* note 56.
64. *See id.*

nores the fact that there is already ample research surrounding maternal mortality; and (c) does not provide aggrieved families with an actual remedy, since the sole purpose of the Act takes place once someone has already died. This means that not until the harm has occurred-a woman dying due to pregnancy-related complications-does the Act become meaningful. Frankly put, H.R. 1318 allows the federal government to throw money at an open wound when the government should use its plenary power to remedy the wound before the injury occurs.

Additionally, H.R. 1318 overlooks one of the most disturbing aspects of maternal mortality, the fact that maternal mortality disproportionately impacts communities and people of color.[65] African American mothers are three to four times more likely to die from child-birth-related complications.[66] In addition, African American infants are twice as likely to die from child-birth-related complications.[67] Yet when senators, such as Corey Booker[68] and Kamala Harris (amongst others),[69] introduced bills that were aimed toward the obvious racial issues in maternal health their bills were denied.[70]

Additionally, H.R. 1318 does not mandate state participation in the federally funded program through maternal MMRCs. MMRCs, are formed at the state level to provide a more detailed investigation of pregnancy-associated and pregnancy-related deaths, than what is reported on death certificates.[71] Although MMRCs can be helpful in after-the-fact reporting, the language of H.R. 1318 makes state and tribal participation, in the federal program, a mere option; leaving the states or tribes to decide if they want to opt-in or not. Maternal mortality is a human rights issue that must be addressed and remedied; state

65. Amy Roeder, *America is Failing Its Black Mothers*, HARV. PUB. HEALTH, Winter 2019, https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/.

66. *Id.*

67. *Achievements in Public Health, 1900-1999: Healthier Mothers and Babies*, CDC.GOV, Oct. 1, 1999, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4838a2.htm.

68. Sen. Cory Booker A. [D-NJ] introduced the MOMMIES Act, S. 3494, 115th Cong. (2018). (unenacted), which established a series of programs and requirements under Medicaid and Children's Health Insurance Program (CHIP) relating to maternal health. The Act would further support African American women and children because of its focus on expanding Medicaid and Medicare programs.

69. Sen. Kamala Harris D. [D-CA], amongst other senators, introduced Maternal CARE Act, S. 3363, 115th Cong. (2018) (unenacted), which provided funding for evidence-based quality improvements that tackled racial disparities in health care. The Act also directed the National Academy of Medicine to incorporate implicit bias training into physician education.

70. Chen et al., *supra* note 56.

71. Daniel Young, *Maternal Mortality Review Committees*, NETWORK PUB. HEALTH L. 1, 2 (2018), https://www.networkforphl.org/_asset/bytdhv/MMRC-Issue-Brief-PFDEL_DY.pdf.

participation should be mandatory. Since participating in MMRCs is optional, this means that if states opt-out, then the women in that state (and their families) remain at risk for being impacted by maternal mortality. This reality, that states reserve the right to make maternal mortality a priority or not, makes H.R. 1318 problematic for women and families.

Also, H.R. 1318 willfully ignores the fact that ample research already exists that explain why women are dying due to pregnancy and birth-related complications.[72] MMRCs have been in place, at some level, since 1933 as a result of the report issued by the White House Conference on Child Health Protection.[73] This report demonstrated the correlation between poor aseptic practice, overuse of operative deliveries, and high maternal mortality rates.[74] Some commentators and politicians claim that H.R. 1318 is a "landmark" bill.[75] Although laudable, H.R. 1318 is no different than the efforts put forth in 1933, and even then, maternal mortality remained a threat to women and families through the twenty-first century.

72. *See generally* Nina Martin & Renee Montagne, *U.S. Has the Worst Rate of Maternal Deaths in the Developed World*, NPR.ORG (May 12, 2017, 10:28 AM), https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world; Suzanne Delbanco et al., *The Rising U.S. Maternal Mortality Rate Demands Actions from Employers*, HARV. BUS. REV. (June 28, 2019), https://hbr.org/2019/06/the-rising-u-s-maternal-mortality-rate-demands-action-from-employers; Ziba Taghizadeh et al., *Claims about Medical Malpractices Resulting in Maternal and Perinatal Mortality Referred to Iranian Legal Medicine Organization During 2011-2012*, NCBI.GOV (July 22, 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5590359/; Alison Young et al., *Hospitals Blame Moms When Childbirth Goes Wrong. Secret Data Suggests It's Not That Simple*, USA TODAY (Nov. 13, 2019, 10:34 AM), https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2019/03/07/maternal-death-rates-secret-hospital-safety-records-child birth-deaths/2953224002/; John Kelly et al., *The Secret Number Maternity Hospitals Don't Want You to Know, and Why We're Revealing It*, USA TODAY (June 28, 2019, 11:43 AM), https://www.usatoday.com/story/news/investigations/deadly-deliveries/2019/03/07/child birth-complication-rates-secret-heres-why-were-revealing-them/2927105002/; Emily K. Kaplan, *Reducing Maternal Mortality*, N.Y. TIMES (Mar. 5, 2019), https://www.nytimes.com/2019/03/05/well/family/reducing-maternal-mortality.html; Tara Haelle, *Why Your Hospital's C-Section Rate Can Be Hard to Find*, CONSUMER REPORTS (May 16, 2017), https://www.consumerreports.org/c-section/why-your-hospitals-c-section-rate-can-be-hard-to-find/; Sally C. Curtin M.A. et al., *Maternal Morbidity for Vaginal and Cesarean Deliveries, According to Previous Cesarean History: New Data From the Birth Certificate, 2013*, 64 NAT. VITAL STATISTICS REP. 1 (2015). (The aforementioned sources are just a few that were read while compiling research for this note, however, there is much more available should one take time to look).

73. Feleke-Eshete, *supra* note 3, at 8.

74. *Id.*

75. Martin, *supra* note 54 (quoting Rep. Jaime Herrera Beutler [R-Wash.] . . . "We're going to investigate every single [death] because these moms are worth it [.]").

Moreover, H.R. 1318 does not provide aggrieved families with an adequate or actual remedy, since the sole purpose of the Act takes place once someone has already died. Mothers deserve actual protection provided by the federal government, not after-the-fact research. Women who die in child-birth require the justice that Kira Johnson's family received: (1) nation-wide notice of a negligent doctor; (2) an adequate investigation as to how the tragedy occurred; and most importantly (3) compensation for the tragedy caused by negligent physicians. Kira Johnson's story is tragic; but her family received adequate media coverage and were compensated accordingly.

H.R. 1318 needs a remedy just as other federal statutes have, preferably a civil remedy except in the case of gross or wanton conduct.[76] Laws that provide consequences for volitional acts or omissions serve as deterrent effects for future social harms.[77] Adding a remedy to H.R. 1318 would essentially create a medical malpractice component for physicians who act negligently. When the medical malpractice liability system is working properly, court verdicts and previously awarded settlements would both compensate injured patients and deter future harmful medical events.[78] However, the justice system's ability to deter depends on consistent court rulings.[79] When a federal or state statute is in place, courts have guidance on how to decide particular issues impacting an insular group of people. Some commentators argue that adding a remedy to H.R. 1318 will have adverse effects on the health care industry as it could deter hospitals from reporting errors and state that it "punishes" all medical providers by placing them under scrutiny.[80]

Studies support the argument that remedies, such as compensation vis a vi medical malpractice, play a vital role in patient safety.[81] Additionally, it was found that malpractice litigation, helped hospitals understand their weaknesses and led to improvements with care which

76. *See* Civil Rights Act of 1964 § 7, 42 U.S.C. § 2000e et seq (1964) (which grants the federal government the power to, "enforce the provisions of the [statute] through appropriate remedies, including reinstatement or hiring of employees with or without back pay, as will effectuate the policies of this section, and shall issue such rules, regulations, orders and instructions as it deems necessary and appropriate to carry out its responsibilities under this section.").

77. *See generally* Swapna Majumdar, *Lawsuits Used to Shrink India's Maternal Deaths*, WE NEWS (Sept. 24, 2009), https://womensenews.org/2009/09/lawsuits-used-shrink-indias-maternal-deaths/.

78. *See* Carlson Law Firm, *supra* note 49.

79. *Id.*

80. *Id.*

81. Joanna C. Schwartz, Note, *A Dose of Reality for Medical Malpractice Reform*, 88 N.Y.U. L. REV. 1224, 1228 (2013).

results in improved patient safety.[82] Furthermore, lawsuits provide useful information for medical malpractice insurance providers.[83] In turn, insurance providers will deny coverage to a high-risk or consistently negligent doctor, which can cut that doctor off from hospital affiliations, clinics, and in some states force them to close their practice.[84] However, when laws shield doctors from medical malpractice liability, it practically eliminates insurance company's oversight and reduces incentives for carriers and physicians to keep track of and reduce risks.[85] Adding a remedy for victims of maternal mortality, under H.R. 1318, would provide families with the justice they deserve and also hold negligent physicians and hospitals liable.

CONCLUSION

Maternal mortality is a human rights issue because it affects all women, men, and children despite social, political, or racial background.[86] When Congress passed H.R. 1318, it did so with the full intention of helping states figure out the "why" behind the substantial increase of fatality numbers.[87] Unfortunately, as ample research shows; the "why" is quite clear. Hospitals and physicians act negligently by failing to provide mothers the requisite standard of care in pregnancy or child-birth occurrences. Ultimately leading to preventable deaths and injuries. The Centers for Disease and Control Prevention ("CDC") posits that more than sixty percent of pregnancy-related complications are preventable.[88] Furthermore, ProPublica and NPR teamed up to conduct research regarding maternal mortality for six months and found the following:

> (a) more American women are dying of pregnancy-related complications than any other developed country and only in the U.S. has the rate of women who die been rising;

82. *Id.* at 1267.

83. *See* The Carlson Law Firm, *supra* note 49.

84. *Id.*

85. *Id.*

86. Many political commentators, such as the commentators mentioned throughout this paper, have applauded H.R. 1318 for its unique bipartisan nature.

87. *See generally, Bipartisan Bill to Prevent Maternal Deaths Passes U.S. House*, (Dec. 11, 2018), https://degette.house.gov/media-center/press-releases/bipartisan-bill-to-prevent-maternal-deaths-passes-us-house#:~:text=H.R.,to%20prevent%20future%20mothers' %20deaths.

88. Emily Pollack, *CDC: 3 in 5 Pregnancy-related Deaths Among US Women Could be Prevented*, NATION'S HEALTH.ORG (Aug. 2019), https://www.thenationshealth.org/content/49/6/5.2#:~:text=of%20the%20approximately%20700%20women,Morbidity%20and%20Mortality%20Weekly%20Report.

> (b) there's a hodgepodge of hospital protocols for dealing with potentially fatal complications, allowing for treatable complications to become lethal;
>
> (c) hospitals—including those with intensive care units for newborns—can be woefully unprepared for a maternal emergency;
>
> (d) federal and state funding show only six percent of block grants for "maternal and child health" actually go to the health of mothers; and
>
> (e) in the U.S, some doctors entering the growing specialty of maternal-fetal medicine were able to complete that training without ever spending time in a labor-delivery unit.[89]

Allocating more money to further research, when under-utilized research already exists and is readily available, does not seem to make logical sense as it provides an opportunity for states to continue to ignore the information that is already there. Additionally, many physicians exhibit racist and sexist mannerisms that are likely linked to implicit biases.[90] As one columnist put it, "We find the responses the hospitals have are full of these dog whistles and tones that are anti-black and anti-woman. . .[t]his statement is a perfect example of how black women feel entering this hospital: You're poor, you're uneducated, you're fat."[91]

Congress should revisit and amend H.R. 1318 and mandate state participation in the MMRCs instead of making MMRCs optional. Additionally, it is imperative that H.R. 1318 live up to its name, *Preventing Maternal Deaths*, by including a remedy for aggrieved families of deceased women and families. Providing a remedy allows H.R. 1318 to live up to its name because a remedy allows for a lawsuit; a lawsuit serves as an effective deterrent effect for future medical negligence concerning maternal mortality.

"Giving birth should be your greatest achievement, not your greatest fear."[92]

—Jane Weideman

89. Renee Montagne, *U.S. Has the Worst Rate of Maternal Deaths in the Developed World*, NPR.ORG (May 12, 2017, 10:28 AM), https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world.

90. Alison Young et al., *Hospitals Blame Moms When Childbirth Goes Wrong: Secret Data Suggests It's Not That Simple*, USA TODAY (Nov. 13, 2019, 10:34 AM), https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2019/03/07/maternal-death-rates-secret-hospital-safety-records-childbirth-deaths/2953224002/.

91. *Id.*

92. Jane Weideman, QUOTERY, https://www.quotery.com/quotes/giving-birth-greatest-achievement-not (last visited March 18, 2022).

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