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Preventing Maternal Deaths: A Critical Feminist Approach to Maternal Mortality in the United States

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PREVENTING MATERNAL DEATHS: A CRITICAL FEMINIST APPROACH TO MATERNAL MORTALITY IN THE UNITED STATES

ABSTRACT

With roughly 700 women dying each year as a result of pregnancy and/or delivery complications, the United States has the highest rate of maternal deaths in the developed world. As each year passes, the maternal death rate continues to increase, despite the fact that sixty percent of these deaths are preventable. Factors such as quality care, receiving accurate and timely medical diagnoses, and recognizing urgent maternal warning signs all contribute to the preventability of deaths and why women, particularly women of color, so often fall victim to this tragic phenomenon. As an effort to address maternal death in the United States, the Preventing Maternal Deaths Act ("PMDA"), a federal law designed to improve data reporting and investigation of maternal death within individual states, was enacted in 2018. The PMDA's goal is to support state maternal mortality review committees ("MMRCs") in their efforts to improve health care quality and health care outcomes for mothers. The PMDA, for five years, annually allocates twelve million dollars to interested states to either create new MMRCs or to support already existing MMRCs. Through a critical pragmatist feminist lens, this Article argues that the PMDA has a crippling reliance on arbitrary data collection and fails to require or enforce any solution that would be beneficial to women before, during, and after pregnancy. The PMDA simply funds the collection of data, and by failing to enforce systematic and institutional solutions, prevents women from getting the care and attention they truly need. As a result, the PMDA's effectiveness is disappointingly limited, despite its aim to provide a comprehensive approach to combating the issue of maternal death in the United States. Looking forward, this Article suggests that the PMDA be revised to reflect the women-centered and social action principles of pragmatist feminism.

I. INTRODUCTION

The year was 2015.[1] Amanda Rose Kotrba, a thirty-year-old mother from Florida, was pregnant with her second child.[2] As a woman whose first birthing experience, seven years prior, resulted in an emergency Cesarean section ("C-section") due to issues with her placenta—"the organ that supplies nutrients to the developing fetus"— Amanda was no stranger to the uncertainties of pregnancy and childbirth.[3] Quite frankly, it frightened her.[4] Yet, Amanda found herself pregnant once again, overcome by a fear she never quite got over.[5] Shortly before the end of her ninth month, Amanda began to frequently visit the doctor and emergency room due to irregular bleeding, back pain, and stomach pain.[6] Amanda became vocal about her concerns, constantly telling her mother and the medical staff about her pain and that she worried her placenta was failing again.[7] Despite her cries for help, the nurses and doctors consistently sent her home.[8] On January 24, 2016, Amanda underwent another emergency C-section.[9] Along with extreme bleeding, Amanda's placenta had become detached from the walls of her uterus, causing a placenta abruption.[10] On January 26, only thirty-six hours later, Amanda died.[11]

Amanda's story, and the stories of hundreds of thousands of women like her, shine a light on the unfortunate reality that is maternal mortality in the United States of America. With roughly 700 women dying each year as a result of pregnancy and/or delivery complications[12], the United States has the highest rate of maternal deaths in the developed world.[13]As each year passes, the maternal death rate steadily increases, despite the fact that sixty percent of these deaths are preventable.[14] Factors such as quality care, receiving accurate and timely

1. Nina Martin et al., *Lost Mothers,* PROPUBLICA (Oct. 4, 2017), https://www.propublica.org/article/lost-mothers-maternal-health-died-childbirth-pregnancy.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. Martin et al., *supra* note 1.

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. Martin et al., *supra* note 1.

12. *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/.

13. Martin et al., *supra* note 1.

14. KAISER FAM. FOUND., *supra* note 12; Stacey Millett, *Preventable Maternal Deaths Continue to Occur in the U.S.*, PEW, https://www.pewtrusts.org/en/research-and-analysis/articles/2020/01/06/preventable-maternal-deaths-continue-to-occur-in-the-us (last visited Mar. 1, 2022); Nina Martin & Renee Montagne, *The Last Person You'd Expect to Die in Childbirth*, PROPUBLICA

medical diagnoses, and recognizing urgent maternal warning signs all contribute to the preventability of deaths and why women, particularly women of color, so often fall victim to this tragic phenomenon.[15]

As an effort to address maternal death in the United States, the Preventing Maternal Deaths Act ("PMDA") was enacted in 2018.[16] The PMDA is a federal law designed to improve data reporting and investigation of maternal death within individual states.[17] The Act's goal is to support state maternal mortality review committees in their efforts to improve health care quality and health care outcomes for mothers.[18] Maternal mortality review committees ("MMRCs") are multidisciplinary collectives of experts tasked with reviewing and evaluating every maternal death in a jurisdiction with the goal of understanding and preventing similar deaths in the future.[19] The PMDA, for five years, annually allocates twelve million dollars to interested states to either create new MMRCs or to support already existing MMRCs.[20]

When examining laws such as the PMDA, it is important to position its functionality and impact in a larger legal and social context. Theories of critical feminism allow for this holistic, in-depth analysis. Critical feminist theory is rooted in the radical notion that women are people.[21] Though there are several critical feminist theories, they all focus on tackling the "woman question"—identifying and confronting the "omission of women and their needs from the analysis of any societal issue."[22] Critical pragmatist feminist theory, in

(July 28, 2017), https://www.propublica.org/article/die-in-childbirth-maternal-death-rate-health-care-system.

15. *Pregnancy-Related Deaths in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 16, 2022), https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html. *See also* Angie DeRosa et al., *The Meaning of a Noun*, CONTEMPORARY OB/GYN (Aug. 31, 2021), https://www.contemporaryobgyn.net/view/the-meaning-of-a-noun (noting that "pregnant person" is becoming a more commonly used phrase in the medical community, but for the purposes of efficiency the article will use "woman/women").

16. KAISER FAM. FOUND., *supra* note 12.

17. Preventing Maternal Deaths Act of 2018, Pub. L. No. 115–344 § 2(1), 132 Stat. 5047, 5047.

18. 42 U.S.C. § 247b-12(a)(1) (2018); *H.R. 1318 (115th): Preventing Maternal Deaths Act of 2018*, GOVTRACK, https://www.govtrack.us/congress/bills/115/hr1318/summary (last visited Mar. 10, 2022); Khouloude Abboud, *Why the United States Is Failing New Mothers and How it Can Counteract its Rapidly Climbing Maternal Mortality Rate*, 30 HEALTH MATRIX 407, 411 (2020).

19. Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1234 (2020); *Enhancing Reviews and Surveillance to Eliminate Maternal Mortality*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 29, 2022), https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html (last reviewed Sept. 19, 2022).

20. Bridges, *supra* note 19; Abboud, *supra* note 18, at 428.

21. Stephanie M. Wildman, *Critical Feminist Theory, in* ENCYCLOPEDIA OF LAW & SOCIETY: AMERICAN AND GLOBAL PERSPECTIVES 348, 348 (David S. Clark ed., 2007).

22. *Id.*

particular, hones in on the individual and collective experiences of women within systems of oppression.[23]

With this framework applied, the PMDA's actual effectiveness is disappointingly limited, despite its aim to provide a comprehensive approach to combating the issue of maternal death in the United States. Whilst scholars, maternal health activists, and politicians all agree that understanding the factors that contribute to maternal death is important,[24] the solution to maternal death—as exemplified by the PMDA—does not solely lie in obtaining an abundance of disconnected information. Through a critical pragmatist feminist lens, this Article argues that the PMDA has a crippling reliance on arbitrary data collection and fails to require or enforce any solution that would be beneficial to women before, during, and after pregnancy. The PMDA simply funds the collection of data, and by failing to enforce systematic and institutional solutions, prevents women from getting the care and attention they truly need.

This Article proceeds as follows. Part II will review the available data concerning maternal health and mortality in the United States. Part III will provide an extensive overview of the PMDA as a potential solution to solving the issue of maternal death followed by an overview of critical feminism as a legal theory. Framing the issue through a pragmatist feminist lens, Part IV will critique the PMDA by identifying its structural pitfalls and suggest that the act be revised to (1) require all state MMRCs to specifically focus on the data collection and analysis of individual experiences and existing structures that make it harder for women to have safe and healthy childbirth experiences; and (2) require all state MMRCs to develop and enforce a course of action that includes specific strategies that will equitably address the issues uncovered by their newly focused data collection and analysis.

II. FACTUAL BACKGROUND: MATERNAL MORTALITY IN THE UNITED STATES

As defined by the World Health Organization ("WHO"), maternal mortality is "the annual number of female deaths from any cause related to or aggravated by pregnancy or its management…during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy."[25] When discussing causes of maternal mortality and the ways in which laws such as the PMDA aim to address those causes, one must acknowledge the multitude of factors that contribute to maternal death. The

23. Judy Whipps & Danielle Lake, *Pragmatist Feminism*, *in* STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., 2020) https://plato.stanford.edu/entries/femapproach-pragmatism/.

24. Eugene Declercq and Laurie Zephyrin, *Maternal Mortality in the United States: A Primer*, THE COMMONWEALTH FUND 6 (Dec. 2020), https://www.commonwealthfund.org/sites/default/files/2020-12/Declercq_maternal_mortality_primer_db.pdf.

25. *Maternal Deaths*, WORLD HEALTH ORG., https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622 (last visited Mar. 2, 2022).

following section will explain in detail the causes and measurements of maternal death as well as the history of data collection on maternal mortality in the United States.

A. Causes of Maternal Mortality

As reported in a recent Centers for Disease Control and Prevention ("CDC") study, the majority of maternal deaths relate to the following cardiovascular conditions: heart muscle disease (11%), blood clots (9%), high blood pressure (8%), stroke (7%), infection (13%) severe postpartum bleeding (11%), and a "category combining other cardiac conditions (15%)"[26] Additionally, certain clinical causes of maternal death are determined based on the timing of the mother's death.[27] As described in The Commonwealth Fund's report on maternal mortality in the United States:

> During pregnancy, hemorrhage and cardiovascular conditions are the leading causes of death. At birth and shortly after, infection is the leading cause. In the postpartum period, often during the time when new parents are out of the hospital and beyond the traditional six- or eight-week post-pregnancy visit, cardiomyopathy (weakened heart muscle) and mental health conditions (including substance use and suicide) are identified as leading causes.[28]

Along with clinical factors, some scholars attribute social conditions such as lack of women's postpartum care and the government's "failure to oversee and regulate hospitals and healthcare providers" as causes of the United States' high maternal mortality ratio ("MMR").[29] Many maternal deaths, those caused by "infection, blood clots, and hemorrhage", typically occur during the postpartum period (after the mother has delivered her child).[30] With access to health care after the child is born, which would allow for mothers to receive continued care and treatment, these deaths are often avoidable.[31] That said, unfortunately "[m]ost health plans in the United States only cover a single visit to a health care provider around 6 weeks after birth unless the woman has a recognized complication."[32] As previously mentioned, scholars also attribute the lack of federal oversight and regulation of hospitals to maternal death, one stating that "many hospitals have not implemented measures that are known to identify pregnancy complications and prevent death and "'[t]he fragmented nature of

26. Declercq & Zephyrin, *supra* note 24, at 8.
27. *Id.* at 9.
28. *Id.*
29. Bridges, *supra* note 19, at 1246.
30. *Id.*
31. *Id.*
32. *Id.* (quoting Debra Bingham et al., *Maternal Mortality in the United States: A Human Rights Failure*, 83 CONTRACEPTION 189, 190 (2011)).

health care financing and delivery also leads to a fragmented and uncoordinated approach to oversight.'"[33]

B. Measuring Maternal Mortality

To truly understand maternal mortality in the United States, it is crucial to distinguish the three specific measurements of maternal death. These three measurements are pregnancy-associated mortality, pregnancy-related mortality, and MMR.[34] Pregnancy-associated mortality is defined as "death while pregnant or within one year of the end of the pregnancy, irrespective of cause."[35] This measurement is considered the starting point for most analyses of maternal death.[36] Pregnancy-related death is defined as "death during pregnancy or within one year of the end of pregnancy from: a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy."[37] This measurement, which is used by the CDC to specifically report U.S. trends, is usually reported as a "ratio per 100,000 live births."[38] Finally, MMR is defined as "death while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes".[39] In contrast to pregnancy-related mortality, MMR is a measurement used by the WHO to conduct international comparisons.[40] That said, MMR is also reported as a ratio of maternal deaths per 100,000 live births.[41] For the purposes of this analysis, MMR will be the primary measurement discussed.

C. History of Data Collection on Maternal Mortality in United States

Data collection on maternal mortality in the United States became a national priority in the early twentieth century.[42] Initially, participating states were involved in individual data collection.[43] However, in 1915, each participating state's data was synthesized into a comprehensive, national estimate.[44] In 1933, with all states participating in data collection, the national MMR was reported

33. Bridges, *supra* note 19, at 1246–47; AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 85 (2010).

34. Declercq & Zephyrin, *supra* note 24, at 2.

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*

39. Declercq & Zephyrin, *supra* note 24, at 3.

40. *Id.*

41. *Id.*; Abboud, *supra* note 18, at 412.

42. Declercq & Zephyrin, *supra* note 24, at 4.

43. *Id.*

44. *Id.*

as 619 deaths per 100,000 live births—a noticeably high ratio in comparison to MMRs of comparable countries.[45] That said, both in the United States and across the globe, the rate of maternal mortality was on a steady decrease during most of the twentieth century as women gained access to improved maternity resources.[46] In fact, the U.S. MMR had decreased to thirty-seven deaths per 100,000 live births by 1960.[47] Though one death is one too many, this decrease seemed promising. This trend continued throughout the 1980s and into the 1990s and eventually stabilized in the late 1990s as the MMR maintained about nine deaths per 100,000 live births.[48] Though the MMR began to rise again around 1997, it stabilized once more at fourteen deaths per 100,000 births in 2008.[49] As of 2018, the United States ranked last overall in maternal mortality among eleven industrialized nations with an estimated 17.4 deaths per 100,000 live births—"approximately 660 maternal deaths per year."[50] According to the CDC, the MMR significantly increased in 2019 at 20.1 deaths per 100,000 live births—approximately 754 deaths.[51] In 2020, the U.S. MMR hit 23.8 deaths per 100,000 live births and, when focusing on Black maternal mortality, the rate significantly increased to 55.3 deaths per 100,000 live births.[52]

Prior to the PMDA, there was very little legislation addressing maternal health and no effective way of systematically confronting and collecting data regarding maternal deaths in the United States.[53] Though data collection became a national priority in the early twentieth century, as mentioned above, the effectiveness and quality of said collection was questionable. That said, many scholars and academics alike have linked this history of poor-quality data

45. *Id.*

46. *Id.*

47. Declercq & Zephyrin, *supra* note 24, at 4.

48. *Id.*

49. *Id.*

50. *Id.* at 1; Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, THE COMMONWEALTH FUND (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries; Gianna Melillo, *US Ranks Worst in Maternal Care, Mortality Compared With 10 Other Developed Nations*, AJMC (Dec. 3, 2020), https://www.ajmc.com/view/us-ranks-worst-in-maternal-care-mortality-compared-with-10-other-developed-nations; Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2019*, NAT'L CTR. FOR HEALTH STAT. 1, 3 (Apr. 2021), https://www.cdc.gov/nchs/data/hestat/maternal-mortality-2021/E-Stat-Maternal-Mortality-Rates-H.pdf.

51. Hoyert, *supra* note 50.

52. Virginia Langmaid, *Study of Wealthy Nations Finds American Women Most Likely to Die of Preventable Causes, Pregnancy Complications,* CNN HEALTH (Apr. 5, 2022, 4:19 PM), https://www.cnn.com/2022/04/05/health/us-women-health-care/index.html.

53. *See* Katy Backes Kozhimannil et al., *Beyond the Preventing Maternal Deaths Act: Implementation and Further Policy Change*, HEALTH AFFS. (Feb. 4, 2019), https://www.healthaffairs.org/do/10.1377/forefront.20190130.914004/ (discussing how the PMDA sets up a federal infrastructure to assess maternal deaths where one did not previously exist).

regarding maternal deaths to the United States' constantly high MMR.[54] This argument stems from the belief that the two current national systems of data collection on maternal mortality—the National Center for Health Statistics ("NCHS") and the Pregnancy Mortality Surveillance System ("PMSS")—are inadequate.[55]

Both the NCHS and PMSS fall under the CDC umbrella, but have unique ways of assessing maternal mortality.[56] To begin, the NCHS-administered system "uses information found on death certificates to identify deaths from pregnancy-related causes that occur during a woman's pregnancy, during childbirth, or up to forty-two days postpartum."[57] The "pregnancy checkbox" often included on state death certificates indicates that the deceased woman was recently pregnant, which allows epidemiologists to identify pregnancy-related deaths.[58] PMSS, on the other hand, was created as a product of the Maternal Mortality Special Interest Group of the American College of Obstetricians and Gynecologists and a handful of individual state health departments.[59] PMSS is similar to NCHS's system in that it uses the "pregnancy checkbox" on death certificates to identify pregnancy-related deaths.[60] That said, PMSS is unique in that it additionally "identifies cases of maternal deaths through birth certificates or fetal death certificates that have been linked to a woman's death certificate . . . [and] considers a maternal death to be one that occurs up to a year postpartum."[61] In general, most experts have agreed that NCHS and PMSS are not structured or capable to produce effective data on maternal mortality.[62] This incapability is due to several factors. First, both the NCHS and PMSS rely on limited information provided on a death certificate to determine why a woman died.[63] These death certificates determine the reasons for a death through the International Classification of Diseases ("ICD") codes, which allows a medical professional to pinpoint what he or she believes is the cause of the death, but do not "communicate the interconnected stressors and system failures, often

54. Bridges, *supra* note 19, at 1287.

55. *Id.* at 1288; Ai-ris Collier & Rose L. Molina, Maternal Mortality in the United States: Updates on Trends, Causes, and Solutions 3 (July 23, 2020) (author manuscript available on PUBMED) (published in final edited form at 22 NEOREVIEWS e561 (2019)).

56. Bridges, *supra* note 19, at 1287–88; Collier & Molina, *supra* note 55.

57. Bridges, *supra* note 19, at 1288.

58. *Id.*; BUILDING U.S. CAPACITY TO REVIEW AND PREVENT MATERNAL DEATHS: REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES 12 (2018), https://reviewtoaction.org/sites/default/files/2021-03/Report%20from%20Nine%20MMRCs%20final_0.pdf.

59. Bridges, *supra* note 19, at 1288.

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.* at 1288–89.

community specific, that contributed to a particular maternal death."[64] Second, the incompleteness of data collected by the NCHS and PMSS only allow for the identification of disparities and trends; "they are incapable of answering the more difficult question of *why* women are dying and what could be done to prevent these deaths."[65] Third, the national aspect of NCHS and PMSS inevitably increases the chance of missing cases of pregnancy-related deaths and maternal mortality, as opposed to a more state driven, localized surveillance system.[66] This idea stems from the belief that local bodies are much more equipped to create a comprehensive analysis of maternal death than a national body.[67] These local bodies are state MMRCs and have been considered the "gold standard" for analyzing maternal deaths.[68]

III. LEGAL BACKGROUND: THE PREVENTING MATERNAL DEATHS ACT OF 2018 AND CRITICAL FEMINIST THEORY

Given the concerns outlined above, legislators and maternal health advocates were eager to find what they believed to be equitable and effective solutions to improve maternal mortality rates across the nation. For this Article's analysis to proceed, the legal foundation for both the PMDA and critical feminist theory must be laid. Not only will these synopses provide context for the discussion, they will also begin to highlight the ways that the PMDA is ineffective through the lens of critical feminism. That said, the following section will explain in detail the PMDA, followed by an overview of critical feminist theory and pragmatist feminism.

A. The Preventing Maternal Deaths Act of 2018

As a bipartisan federal response to the increasing maternal death rate and desire for more "accurate" data, the 115th Congress under former President Donald Trump passed the PMDA on December 21, 2018.[69] The PMDA was

64. Bridges, *supra* note 19, at 1289 (quoting YALE GLOBAL HEALTH JUSTICE P'SHIP, WHEN THE STATE FAILS: MATERNAL MORTALITY & RACIAL DISPARITY IN GEORGIA 56 (2018)). *See also* Collier & Molina, *supra* note 55 (discussing how issues such as ICD code accuracy and variation in states' implementation of the pregnancy checkbox present a challenge to measuring maternal mortality).

65. Bridges, *supra* note 19, at 1289.

66. *Id.*

67. *See id.* (suggesting that a national surveillance system—"as opposed to a state or local level surveillance system—increases the likelihood that [the system] will overlook some pregnancy-related deaths").

68. *Id.* at 1290.

69. KAISER FAM. FOUND., *supra* note 12; Bridges, *supra* note 19, at 1286; 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.

introduced on March 2, 2017,[70] and prior to its introduction, the issue of maternal mortality was often characterized as a "Democratic" cause, which ultimately stalled congressional action toward the issue.[71] However, given that the PMDA was party-neutral, the law was able to effectively bring both Democrats and Republicans to the table.[72]Additionally, with national media attention bringing the issue of maternal death to the forefront of societal conversation, the PMDA was able to gain support from both the public and legislators.[73] In fact, news stories such as USA Today's investigative series, "Deadly Deliveries," which reported on thousands of seemingly preventable maternal deaths, led mothers across the nation to contact their legislators and ask that they support the bill.[74] As awareness increased, the support for the PMDA and sense of urgency for Congress to take action increased.[75] After passing on a unanimous voice vote in the House of Representatives, Representative Jaime Herrera Beutler of Washington, a Republican and one of the bill's initial sponsors, stated that it was the "biggest step that Congress has ever taken to date to address maternal mortality."[76] Sentiments were similar among communities of maternal health advocates as they hailed the bill as "a critical first step" toward saving more mothers and reducing the country's mortality rate.[77]

The purpose of the PMDA is:

> [t]o establish or continue a Federal initiative to support State and tribal maternal mortality review committees, to improve data collection and reporting around maternal mortality, and to develop or support surveillance systems at the local, State, and national level to better understand the burden of maternal complications and mortality and to decrease the disparities among populations at risk of death and severe complications from pregnancy.[78]

Additionally, according to the Congressional Research Service, a nonpartisan division of the Library of Congress, the PMDA "amends the Public Health Service Act to reauthorize through FY2023 and revise certain … (CDC) programs" to achieve said purpose.[79] The PMDA, for five years, annually

70. GOVTRACK, *supra* note 18.

71. Bridges, *supra* note 19, at 1287.

72. *See id.* (discussing the PMDA's party-neutral status and how the bill was sponsored by Republican Rep. Jaime Herrera Beutler).

73. Laura Ungar, *'A Critical First Step': Maternal Death-Prevention Bill Passes the House*, COURIER J. (Dec. 12, 2018, 4:17 PM), https://www.courier-journal.com/story/news/2018/12/12/maternal-mortality-bill-passes-us-house/2281797002/.

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. 42 U.S.C. § 247b-12(a)(1) (2018); Abboud, *supra* note 18, at 428.

79. GOVTRACK, *supra* note 18.

allocates twelve million dollars to interested states to either create new MMRCs or to support already existing MMRCs.[80]

Around the time of the PMDA's passage, just thirty-six states had formed MMRCs, and due to a lack of funding, the majority of those MMRCs were not fully functional.[81] The PMDA requires that the MMRCs created and/or supported by the law's federal funding include "multidisciplinary and diverse membership that represents a variety of clinical specialties."[82] This can include, but is not limited to, "health officials, epidemiologists, statisticians, and other representatives from medical specialties that provide care to pregnant and postpartum women."[83] The main priority of a state MMRC created or supported by the PMDA is to collect and review data in order to investigate causes of maternal death in its state.[84] That said, the PMDA requires these MMRCs to: "(1) identify adverse outcomes that may cause pregnancy-related death; (2) identify trends, patterns, and disparities in adverse outcomes; and (3) develop recommendations based on the summaries and information collected."[85] In order to complete data collection, each participating state's MMRC will work in collaboration with the state's Vital Statistics Unit.[86] The Vital Statistics Unit in each individual state is tasked with

> (1) match[ing] each death record associated with a pregnancy-related death with either a live birth certificate or an infant death record for the purpose of identifying deaths of women that occurred during or within one year of pregnancy; (2) identify[ing] the underlying or contributing cause of each pregnancy-related death; (3) collect[ing] the necessary data from medical examiners and coroner reports; and (4) us[ing] other methods, such as random sampling of reported deaths, to identify maternal deaths.[87]

The thought process behind the PMDA is that with the information acquired from data collection, each MMRC can identify patterns and trends to create recommendations that have the potential to reduce maternal death.[88] That said, once the data is collected and reviewed, the PMDA requires each state MMRC to "provide the CDC with an annual report that includes: (1) the MMRC's data, findings, and recommendations for that fiscal year; and (2) information regarding whether or not the MMRC implemented any recommendations from

80. Bridges, *supra* note 19; Abboud, *supra* note 18, at 428.

81. Bridges, *supra* note 19, at 1292.

82. Preventing Maternal Deaths Act of 2018, Pub. L. No. 115–344 § 2(5), 132 Stat. 5047, 5048; Abboud, *supra* note 18, at 428.

83. Abboud, *supra* note 18, at 428.

84. *Id.* at 429.

85. *Id.*; Preventing Maternal Deaths Act of 2018 § 2(5), 132 Stat. at 5050.

86. Abboud, *supra* note 18, at 429.

87. *Id.*; Preventing Maternal Deaths Act of 2018 § 2(5), 132 Stat. at 5049.

88. Abboud, *supra* note 18, at 429.

the previous fiscal year."[89] Communication with and approval by the CDC is a requirement, but action taken to implement MMRC recommendations after the report is submitted is not.[90]

B. Critical Feminist Theory

Critical feminist theory is a term that embodies a plethora of nuanced theories and concepts.[91] At its core, feminist theory as a whole, and the variety of critical feminist theories, maintain several underlying principles.[92] As noted in the Encyclopedia of Law & Society: American and Global Perspectives, "all feminist theories make gender a central focus of inquiry, asking 'the woman question'…[which] identifies and challenges the omission of women and their needs from the analysis of any societal issue."[93] Additionally, "a key methodology to all forms of feminist theory is consciousness-raising, whereby women share their personal stories, weaving a pattern that illuminates a broader picture of societal treatment of women."[94] That said, critical feminist theories expand feminist critique from a variety of angles. These critical feminist theories include theories such as dominance theory, pragmatist feminism, and critical race feminism, just to name a few.[95]

Looking at the PMDA, a self-proclaimed women-centered law, through a pragmatist feminist lens allows for both a comprehensive and critical analysis. Pragmatist feminism emerged in the 1990's as an evolved approach to feminist philosophy.[96]This critical feminist theory "utilizes and integrates core concepts of pragmatism, including its emphasis on pluralism, lived experience and public philosophy, with feminist theory and practice with a focus on social change."[97] As described in the Stanford Encyclopedia of Philosophy, both early and contemporary pragmatists reject the idea of a universal truth discovered through logical analysis or revelation.[98] Instead, pragmatists value the knowledge gained through human experiences with an emphasis on "the social context of epistemological claims."[99] Additionally, pluralism is a key principal to pragmatists; the philosophy contributes to the belief that knowledge is shaped

89. *Id.*

90. *See id.* ("[C]ommunication with and approval by the CDC is required to ensure that the MMRCs are using best practices in order to collect, review, and analyze maternal death data.").

91. Wildman, *supra* note 21, at 348.

92. *Id.*

93. *Id.*

94. *Id.* at 348–49.

95. *Id.* at 349.

96. Whipps & Lake, *supra* note 23.

97. *Id.*; Wildman, *supra* note 21, at 349.

98. Whipps & Lake, *supra* note 23.

99. *Id.*

by a variety of viewpoints.[100] On the basis thereof, the individual and collective experiences of women are at the core of pragmatist feminist philosophy.[101] The interconnectedness of pragmatism and feminism "situates social and political issues in historical, geographic and relational contexts and particularly addresses systems of oppression that have marginalized the voices of women and people of color."[102] In her essay unpacking the complexities of feminism and pragmatism, Margaret Jane Radin states:

> Pragmatism and feminism largely share, I think, the commitment to finding knowledge in the particulars of experience. It is a commitment against abstract idealism, transcendence, foundationalism, and atemporal universality; and in favor of immanence, historicity, concreteness, situatedness, contextuality, embeddedness, narrativity of meaning. If feminists largely share the pragmatist commitment that truth is hammered out piecemeal in the crucible of life and our situatedness, they also share the pragmatist understanding that truth is provisional and ever-changing. Too, they also share the pragmatist commitment to concrete particulars. Since the details of our life are connected with what we know, those details matter. Thus, the pragmatist and the feminist both arrive at an embodied perspectivist view of knowledge.[103]

When applying the principles established by Radin and other feminist scholars, we must, before all else, place the truth of individual experience at the forefront of all analyses.

IV. ANALYSIS AND SOLUTION: REVISING THE PREVENTING MATERNAL DEATHS ACT

When applying the principles of pragmatist feminism, the PMDA is simply ineffective. Not only does the law minimize the individual experience in data collection, it makes solution-based action a choice. The following section will critique the PMDA in that it (1) does not have a clear focus regarding data collection, allowing for the omission of relevant factors and individual narratives that contribute to maternal mortality and (2) does not require any tangible action once the data is collected. Additionally, the section will suggest that the PMDA be revised to reflect the women-centered and social action principles of pragmatist feminism by (1) requiring all state MMRCs to specifically focus on the data collection and analysis of individual experience and existing structures that make it harder for women to have safe and healthy childbirth experiences and (2) requiring all state MMRCs to develop and enforce a course of action that

100. *Id.*

101. *Id.*

102. *Id.*

103. Margaret Jane Radin, *The Pragmatist and the Feminist*, 63 S. CAL. L. REV. 1699, 1707 (1990).

includes specific strategies that will equitably address the issues uncovered by their newly focused data collection and analysis.

A. Data, Data, and More Data

At its core, the PMDA aims to improve the overall quality of information available about maternal mortality.[104] However, there are strong arguments to suggest that the need for further data collection on maternal mortality is misdirected and unnecessary.[105] Granted, the United States, through the PMDA, has made it its mission to better understand the issue of maternal death and prevent it from happening.[106] Yet, the United States still remains as having one of the highest MMRs in the world.[107] So, what does this tell us? To start, it confirms that one of the most crucial pitfalls of the PMDA, and the sentiments that fueled its creation, is the data collection in and of itself. Consider the following questions through a pragmatist feminist lens: what role does the "data" being collected through the PMDA funding actually play in preventing the death of women during and after childbirth? Has said data led to any equitable change toward providing these women with the solutions they truly need? The answer, quite frankly, is debatable. However, it is particularly clear that the law fails to establish a comprehensive focus regarding what data is being collected, allowing for the omission of marginalized voices, relevant factors, and individual narratives that contribute to maternal mortality. For example, studies show that postpartum care—the care a woman receives after birth—is one of the most determining factors in whether or not she will survive.[108] Yet, individual state MMRCs have the autonomy to forgo this reality due to the selective nature of the PMDA's data collection requirements. An MMRC has the full autonomy to pick and choose which concern it finds the most concerning and focus on that. An MMRC *may* collect data on a woman's access to postpartum care—or any other factor for that matter—but is by no means required to. Pragmatist feminism requires that we "make communication possible where before there was silence"[109], and in the context of the PMDA and maternal deaths, requires that

104. Bridges, *supra* note 19, at 1287.

105. *See id.* at 1315 (noting that "there is an abundance of evidence demonstrating that the mere existence of a state MMRC that reviews every maternal death in a state is no guarantor of safe pregnancies and childbirths for women" and that "if there is a limited pot of money, and that money can either be spent gathering information about a problem or making concrete interventions that are known to be effective ways to address the problem, it is a fascinating political choice to pursue the former over the latter").

106. Preventing Maternal Deaths Act of 2018, Pub. L. No. 115–344, 132 Stat. 5047.

107. Declercq & Zephyrin, *supra* note 24, at 1.

108. Usha Ranji et al., *Expanding Postpartum Medicaid Coverage*, KAISER FAM. FOUND. (Mar. 9, 2021), https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/.

109. Radin, *supra* note 103, at 1708.

the PMDA place particular emphasis on understanding and addressing those collective and individual experiences of women, such as the struggle to maintain a healthy body and mind after childbirth, that are so often ignored.

Prior to the PMDA, state MMRCs had a great amount of variability in quality.[110] In fact, as reported by ProPublica, some MMRCs "'rely on volunteers to do their work….publish reports irregularly and, in some cases, do not address the issue of preventability at all.'"[111] Additionally, not all MMRCs reviewed every pregnancy-related death, they simply reviewed a select number of cases.[112] Thus, the PMDA aimed to repair those inconsistencies "by establishing guidelines for the work that these bodies perform."[113] However, these PMDA "guidelines" are still arbitrary in nature and reinforce variability in data. As previously mentioned, the PMDA simply requires MMRCs to: "(1) identify adverse outcomes that may cause pregnancy-related death and (2) identify trends, patterns, and disparities in adverse outcomes."[114]Nowhere in the act does it provide state MMRCs with specific focus areas known to contribute to maternal deaths or require states to pay particular attention to any subset of data.

So, this begs the question: if the PMDA's sole purpose is to collect data in order to " "prevent" maternal death, why is the data collection so arbitrary, non-conclusive, and ultimately ineffective to improving the pregnancy and child birthing experience for women? This ineffectiveness can be contributed to the false narrative of what data collection truly is. We as a society tend to think of data collection as retrieving all the possible information available. However, this emphasis on the *all* ultimately silences the individual experience. The vagueness in the PMDA language such as "trends, patterns, and adverse outcomes" allows for broad interpretation of what data should be collected, ultimately creating gaps in relevant and important narratives. Having such a broad, all-encompassing guideline for data collection removes the individual experience from the conversation, and thus prevents women from actually being heard—a key pillar of pragmatist feminist theory.

B. All Data, No Action

The PMDA requires each state MMRC to "provide the CDC with an annual report that includes: (1) the MMRC's data, findings, and recommendations for that fiscal year; and (2) information regarding whether or not the MMRC implemented any recommendations from the previous fiscal year."[115] Though

110. Bridges, *supra* note 19, at 1292.

111. *Id.* (quoting Martin, *supra* note 69, at 2).

112. Bridges, *supra* note 19, at 1292.

113. *Id.*

114. Abboud, *supra* note 18, at 429; Preventing Maternal Deaths Act of 2018 § 2(5), Pub. L. No. 115–344, 132 Stat. 5047, 5050.

115. Abboud, *supra* note 18, at 429.

MMRCs are required to report their findings, the law does not require any further action on behalf of the state or the MMRC. The PMDA's inability to enforce action exemplifies the romanticization of information and reinforces the notion that more data, regardless of strength, is the key to solving maternal mortality. This is obviously not the case.

If we as a nation are to believe that combating maternal mortality is a true concern of both the federal and state governments, it can be quite confusing to learn that, through the PMDA, change is optional. With that understanding, it is logical to conclude that the PMDA is disingenuous in its goal to "prevent" maternal death. "Prevent," as defined by the Merriam-Webster Dictionary, is "to keep from happening or existing."[116] How does one prevent without action? Pragmatist feminism is rooted in social change. When applying its principles here, pragmatist feminism requires that the PMDA make action a central focus. Data alone does not have the ability to keep maternal deaths from happening or existing—the action taken after information is learned, on the contrary, may.

C. Solution: Applying Pragmatist Feminism to the PMDA

If we apply pragmatist feminism to the PMDA, a re-focused goal is essential in making the law more effective. As explained above, pragmatist feminism centers women's experiences in its philosophy, while valuing social action.[117] The PMDA has the ability to do just that through one or both measures. First, the PMDA can be amended to apply the women-centered principles of pragmatist feminism by requiring all state MMRCs to specifically focus on the data collection and analysis of identified existing structures that make it harder for women to have safe and healthy childbirth experiences, placing the individual and collective narratives of women at the forefront of data collection and analysis. Second, the PMDA can be amended to require all state MMRCs to develop *and* enforce a course of action that includes specific strategies that will equitably address the issues uncovered by their newly focused data collection and analysis. This mandated action plan allows for women to actually receive the equitable change in the areas that impact them the most.

If amended in this way, the PMDA has the potential to be a tool that truly prevents maternal deaths, not just report on them. To achieve this goal, the PMDA must re-imagine what it means to "prevent." The PMDA, like other federal legislation, is stuck in a reactive system that waits for a crisis to occur before acting. This must change. The PMDA must become a proactive solution in the fight to improve maternal mortality, not just a system where mistakes, poor judgment, and missed opportunities are brought to the light. Instead of waiting for a woman to die to figure out why, MMRCs have the ability to take

116. *Prevent*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/prevent (last visited Jul. 3, 2022).

117. Whipps & Lake, *supra* note 23.

preventive action. For example, state MMRCs could use a portion of the PMDA funding to create spaces to speak with mothers about their pregnancies and the factors that contributed to their birthing experience, both negative and positive. The information learned from these conversations can be implemented into policy changes that provide women with supportive resources and our health systems with the tools necessary to care for and protect women before, during, and after childbirth. MMRCs have the ability to facilitate this change, and the PMDA must make that goal intentional.

V. CONCLUSION

When looking back at Amanda's death, the simple conclusion is that she died from a medical condition—a placenta abruption. The deeper—and much more necessary—realization would conclude that our health care systems and institutions failed her. When coming to terms with a reality so disheartening and concerning as maternal mortality in the United States, it is often easy to offer short term solutions for intricate, multifaceted problems. In other words, government officials and lawmakers tend to address the convenient, not the significant. The United States has a history of ignoring or trivializing the needs of women, crafting legislation and policies that directly impact women without women in mind. The PMDA is no different. Though the intent of the PMDA is noble, its effectiveness is clearly questionable. That said, with pragmatist feminist principles applied through more focused data collection and emphasis on action after data is collected, maternal mortality in the United States may see the equitable change it so desperately needs.

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