

DISSENTING STATEMENT AND REBUTTAL OF COMMISSIONER GAIL L. HERIOT

This report of the U.S. Commission on Civil Rights—entitled “Racial Disparities in Maternal Health”—deals with an important topic: Too many mothers, especially African American and American Indian/Alaska Native mothers, are needlessly dying.

Alas, like many of our Commission reports, this one is a disappointment. We’re unlikely to save lives if we don’t make a greater effort to sort out fact from fiction. I don’t see nearly enough of that effort in this report.

I will discuss in this Statement a few of what I believe are the report’s more significant problems.¹¹⁰⁶ But perhaps the most serious is its repeated allegation—usually in the form of unexamined quotes from supposed experts—that “racism” is what’s causing racial disparities in maternal mortality. This allegation (which lately I have also been seeing on publicly funded posters and billboards here in San Diego) will not help us reduce maternal deaths. Instead, it will encourage racial minority mothers to view medical professionals as hostile or even malicious. That is much more likely to make things worse than better.

A. IT IS UNLIKELY THAT AMERICAN WOMEN ARE DYING IN CHILDBIRTH TODAY AT RATES 50% HIGHER THAN THEY DID A GENERATION AGO.

¹¹⁰⁶ In this Statement, for the sake of accuracy, I use the same terminology used by the underlying study to which I am referring at the time. For example, some studies say, “non-Hispanic black,” some say, “non-Hispanic African American,” some say, “African American,” etc. I do not use the novel descriptor “Latinx,” although this report frequently does so even when citing to underlying studies that use the term “Hispanic.” *See, e.g.*, Rep. at 37, n. 234 (asserting that “Black and Latinx individuals report higher levels of stress than White respondents,” whereas the underlying study refers only to “Black and U.S.-born Hispanic individuals”). I note that Hispanic respondents consistently prefer the terms “Hispanic” or “Latino” over “Latinx.” *No Preferred Racial Term Among Most Black, Hispanic Adults*, GALLUP (Aug. 4, 2021), <https://news.gallup.com/poll/353000/no-preferred-racial-term-among-black-hispanic-adults.aspx> (showing only 5% of Hispanic respondents prefer the term “Latinx”).

I do not deal with severe maternal morbidity in this Statement and concentrate instead on maternal mortality. The reason for that is that, if one’s goal is to determine whether rates of morbidity are increasing or decreasing, the statistics on morbidity discussed in the report are hopelessly flawed. It is extremely difficult for physicians to agree on what should count as severe maternal morbidity. As time goes on, what gets viewed as “severe” naturally changes. The CDC has chosen to get at the issue indirectly by assuming all cases in which the mother receives a transfusion are cases of “severe maternal morbidity.” But that’s counting the treatment, not the condition. Rather than showing that severe morbidity is getting worse and worse, these statistics may simply mean that treatment is getting better and better as doctors increasingly use transfusions just to be on the safe side.

I sympathize with the CDC’s difficulty and realize that for certain purposes counting the number of transfusions numbers can be useful. Keeping track of “severe treatments” can help hospitals that are seeking to go over each such case in detail to ensure that no error has occurred. But they aren’t much good for agencies like the Commission that are engaged in making broad policy recommendations.

The report quotes—with seeming approval—Dr. Neel Shah who stated that a woman today is “50 [percent] more likely to die in childbirth than her own mother was.”¹¹⁰⁷ Rep. at xii. The report echoes that claim in its own voice when it states that “overall maternal mortality rates in the United States have worsened during the past 30 years.” Rep. at 29.¹¹⁰⁸

¹¹⁰⁷ To support this assertion, the report cites an advocacy organization, Global Citizen, which in turn cites the Associated Press, which in turn quotes Dr. Neel Shah, co-founder of another advocacy organization. Rep. at xii (citing Jackie Marchildon, *Racial Bias in Health Care Is Killing Mothers Around the World*, GLOBAL CITIZEN (May 10, 2019), <https://www.globalcitizen.org/en/content/racial-inequalities-maternal-mortality-rates/> (citing Ashley Welch, *More Than Half of Pregnancy-Related Deaths Are Preventable*, Associated Press (May 7, 2019), <https://www.cbsnews.com/news/more-than-half-of-pregnancy-related-deaths-are-preventable-cdc-says/> (quoting Dr. Neel Shah))). Primary sources are much to be preferred, especially when making a claim as surprising as this one. Surprising claims have an unsurprising tendency to be untrue.

In his proposed findings for the Commission, Commissioner Adegbile asked the full Commission to adopt Shah’s figures as one of its “Findings.” His proposal was voted upon at our public business meeting and did not pass. Transcript of U.S. Commission on Civil Rights Telephonic Business Meeting at 68 (July 23, 2021).

Additionally, Commissioner Adegbile asked the Commission to adopt other dubious “Findings.” For example, one proposed finding stated, “In one sample, Black infants were over 3.5 times more likely than white infants to die in their first year of life.” That Finding cited to page 154 of the report, which says, “In Raleigh-Durham, a city [sic: Raleigh and Durham are two cities, one mainly in Wake County and the other wholly within Durham County] known internationally for exceptional medical care and resources . . . Black infants are 3.5x more likely to die than white babies in their first year of life.” The footnote cites to “Triangle Black Maternal Wellness Collaborative, Public Comment.” That comment states, “In Durham in 2018, only 60% of Black pregnant people received prenatal care in their first trimester and Black infants are 3.5X more likely than White infants to die in their first year of life.” No citation is provided for this assertion. The Commission should not be assuming the accuracy of a public comment that does not provide a citation. The 2018 infant mortality statistics for North Carolina recorded 23 total infant deaths in Durham County in 2018; 3 were non-Hispanic white and 10 were non-Hispanic African American. *2018 North Carolina Infant Mortality Report*, N.C. ST. CTR. FOR HEALTH STAT. (Sept. 26, 2019), <https://schs.dph.ncdhhs.gov/data/vital/ims/2018/2018rpt.html>.

Perhaps this is what the Triangle Black Maternal Wellness Collaborative meant. But this is much too small a sample size to tell us about Durham County in general, much less to suggest that Durham County’s experience might reflect national or even state trends.

For those trends, the following would be more accurate and telling: In North Carolina in 2018, there were 300 non-Hispanic white infant deaths (or 4.7 per 1,000 live births) and 363 non-Hispanic African American infant deaths (or 12.5 per 1,000 live births). *Id.* Thus, one could say that non-Hispanic African American infants were about 2.7 times more likely than non-Hispanic white infants to die in North Carolina in 2018. Nationwide infant mortality rates in 2018 were 4.63 per 1,000 live births for non-Hispanic white infants and 10.75 per 1,000 live births for non-Hispanic black infants. Danielle M. Ely & Anne K. Driscoll, *Infant Mortality in the United States, 2018: Data From the Period Linked Birth/Infant Death File*, 69 NAT’L VITAL STAT. REP. 1, 4, (July 16, 2020). Thus, one could say that non-Hispanic black infants were about 2.3 times more likely than non-Hispanic white infants to die across the country in 2018.

¹¹⁰⁸ Similarly, it states: “The pregnancy-related mortality ratio (reported from PMSS data) in 1987 was 7.2 pregnancy-related deaths per 100,000 live births as compared to 17.3 deaths per 100,000 live births in 2017. As previously mentioned, National Center for Health Statistics data differs slightly, showing that the maternal mortality rate in 1987 was 6.6 deaths per 100,000 live births as compared to 17.4 in 2018, showing a higher estimated increase of 163 percent. Both data sets show a high increase in maternal mortality.” Literally, the foregoing statements may well be true in the sense that these are indeed the reported numbers. But they omit to state that the reason for the increase is much more the difference in how statistics are kept than in the actual numbers of maternal deaths.

If the rate of maternal mortality were indeed up 50%, that would be alarming. But this is unlikely. All or nearly all of this alleged increase appears to be an artifact of changes in how the United States keeps track of maternal mortality.¹¹⁰⁹

Here's the story as I understand it: In 2003, a pregnancy question was added to the revision of the U.S. Standard Certificate of Death.¹¹¹⁰ This question includes a series of checkboxes designed to elicit whether the decedent was pregnant at the time of her death or whether she had been pregnant in the last year.¹¹¹¹

These checkboxes were added for a reason: Researchers feared that pregnancy-related deaths were being under-reported and hoped the checkboxes would improve the likelihood that a pregnancy-related death would be reported as such.¹¹¹²

The checkboxes made it more likely that a physician preparing a death certificate would inquire into the decedent's pregnancy status. If it turned out she was or had recently been pregnant, the physician could be more attentive to the possibility that pregnancy increased the likelihood of the

¹¹⁰⁹ See *Detailed Evaluation of Changes in Data Collection Methods*, NAT'L CTR. FOR HEALTH STAT. (Nov. 21, 2019), <https://www.cdc.gov/nchs/maternal-mortality/evaluation.htm>.

¹¹¹⁰ See *U.S. Standard Certificate of Death*, <https://www.cdc.gov/nchs/data/dvs/death11-03final-acc.pdf>.

¹¹¹¹ Two alternative time frames are given for recent pregnancies—those within 42 days and those that occurred between 43 days and one year before the death.

¹¹¹² Researchers may well have been right that pregnancy-related deaths were being under-reported. But that issue is a complicated one. What should count as a pregnancy-related death? That depends in part on why one wants to know the number of pregnancy-related deaths that have occurred. If the only point of keeping data on pregnancy-related deaths is to make international comparisons, then what's important is that each country define pregnancy-related death in the same way so that apples are being compared to apples. But rarely will that be the whole point. Further methodological issues have to be resolved before the count can begin: Pregnancy may be a "contributing factor" to a particular death in the sense that it increased the likelihood that the death would occur without it necessarily being so that without the pregnancy the death would not have occurred. For example, suppose being more than eight months into a pregnancy increases the chance that a woman of childbearing age will die of a heart attack by 30%. But if ten women who are more than eight months pregnant all die of a heart attack, that does not mean all ten would have survived if they had not been pregnant. And it may be impossible to tell which ones would have survived and which ones would have died even if they had not been pregnant.

Physicians tend to collect data on death in the hope that they can learn from that data and reduce deaths in the future. Physicians therefore are interested in cases in which, for example, hypertension increases by 20% the likelihood of a death in a general scenario, even if they can't tell whether the death would have occurred anyway in a particular case. Lawyers and judges, on the other hand, are often in the business of assigning legal liability and hence tend to be concerned with whether pregnancy is more likely than not a "but for" cause of the death. If the death probably would have occurred anyway, lawyers and judges would ordinarily prefer not to classify it as a "pregnancy-related death."

Causation has been a slippery concept since the days of Aristotle. See ARISTOTLE, *THE METAPHYSICS* (John H. McMahon, trans., 1991); see also Bertrand Russell, *On the Notion of Cause*, in 6 *THE COLLECTED PAPERS OF BERTRAND RUSSELL: LOGICAL AND PHILOSOPHICAL PAPERS 1909–1913* (J. Slater, ed., 1992).

For a discussion of the checkboxes, see Lauren M. Rossen et al., *The Impact of the Pregnancy Checkbox and Misclassification on Maternal Mortality Trends in the United States, 1999–2017*, 3 NAT'L CTR. FOR HEALTH STAT. VITAL HEALTH STAT. 1 (2020).

death. Such cases could, for example, be referred to medical professionals with expertise in making a judgment about pregnancy relatedness.

The federal government, however, does not directly control the form of death certificates. Individual states do. Not all states were quick to adopt the checkbox recommendation (and some had made efforts even before 2003 to improve the likelihood that a pregnancy-related death would be reported as such). As each state eventually fell into line, the reported rate of maternal mortality ticked up in that state—not because more pregnancy-related deaths were occurring, but rather because more deaths were being classified as pregnancy-related. This is exactly what those who recommended the checkboxes had hoped for. We shouldn't be surprised that what they intended is what actually happened.

The National Center for Health Statistics recognizes this: “Estimated trends suggest that the observed increases in [maternal mortality rates] from 1999 through 2017 reported in the literature were largely due to the staggered implementation of the checkbox. Potential misclassification of pregnancy status using the pregnancy checkbox likely also contributed, which disproportionately inflated [maternal mortality rates] among women aged 40 and over.”¹¹¹³

Collecting accurate statistics about complex medical issues is a lot harder than one might imagine. Unfortunately, changes (including improvements) in the methods for collecting and analyzing data can end up making comparisons between the pre- and post-change time periods unreliable.¹¹¹⁴ The so-called increase in maternal mortality rates appears to be largely, if not totally, an instance of exactly that.¹¹¹⁵

¹¹¹³ *Id.* at 1 (“Accounting for the checkbox, predicted [maternal mortality rates] did not change significantly from 1999 through 2017, although trends varied by subgroup (age, race and Hispanic origin, cause of death).”). See also Daniel B. Nelson et al., *Population-Level Factors Associated with Maternal Mortality in the United States, 1997–2012*, 18 BMC PUBLIC HEALTH 1007 (2018).

¹¹¹⁴ The horrifying death rates for COVID-19 that were being reported out of Italy, Spain, and a number of other countries early in the pandemic are a good example of this. Those rates decreased dramatically as the pandemic wore on. At first blush, one may want to attribute the decrease to dramatically improved methods of treatment. But that would be a mistake; the death rates are not actually comparable. Most of the difference probably came from a dramatic rise in the number of COVID-19 tests available for use. Early in the pandemic, there was a shortage of such tests. Consequently, only those with serious symptoms were being tested. Many milder COVID-19 cases were not being caught. As tests became plentiful, COVID-19 cases with mild symptoms or no symptoms at all were being identified. In computing the death rates, these cases were being added to the denominator. That made the death rate appear to be dramatically declining when in fact it was probably a case of better identifying the many COVID-19 cases that were *not* resulting in death. See Jon Hamilton, *Antibody Tests Point To Lower Death Rate For The Coronavirus Than First Thought*, NPR (May 28, 2020), <https://www.npr.org/sections/health-shots/2020/05/28/863944333/antibody-tests-point-to-lower-death-rate-for-the-coronavirus-than-first-thought>; see also David Baud et al., *Real Estimates of Mortality Following COVID-19 Infection*, 20 LANCET INFECTIOUS DISEASES 773 (2020) (“Notably, the full denominator remains unknown because asymptomatic cases or patients with very mild symptoms might not be tested and will not be identified. Such cases therefore cannot be included in the estimation of actual mortality rates, since actual estimates pertain to clinically apparent COVID-19 cases.”). For the same reason, international comparisons must be taken with a grain of salt. Mexico, for example, is still reporting

Interestingly, at other points in the report, it asserts (somewhat inconsistently) that pregnancy-related deaths have *not decreased* over the last few decades.¹¹¹⁶ This is a more modest assertion. From the medical literature I have been able to look at, it may well be true (or at least closer to true than anyone would like).

Even this assertion, however, must be viewed cautiously. What, for example, is a pregnancy-related death? Is it necessary that the death would not have occurred without the pregnancy? That's a very high standard, especially if the proof of that connection must be drawn by clear and convincing evidence. At the other extreme, is it sufficient that pregnancy increased the likelihood that the death would occur? That's a very low standard, especially if the pregnancy need only

a death rate that is similar to those reported by Italy and Spain early in the pandemic. But Mexico continues to have a shortage of COVID-19 tests. These tests are likely going to those experiencing serious symptoms, who are also those most likely to die. The real COVID-19 death rate in Mexico is likely lower than what is being reported. See *RCP Corona Virus Tracker: Coronavirus (COVID-19) Global Deaths*, REALCLEARPOLITICS, <https://www.realclearpolitics.com/coronavirus/> (last visited Aug. 13, 2021).

¹¹¹⁵ The report also states that maternal mortality rates are higher in the United States than they are in many other developed nations. The question one must always ask is whether data collection and analysis in those other countries are similar or different to what is done here. Efforts are almost certainly being made to ensure that they are, but efforts do not always produce results.

One reason for pessimism on this front is that within this country it is doubtful that the even states employ uniform methods for collection and analysis. According to one report, reported maternal death rates have increased dramatically between 1997 and 2012 in Georgia, but not at all in Alabama. Indiana's rates have shot up; North Carolina's have barely changed. Daniel B. Nelson et al., *Population-Level Factors Associated with Maternal Mortality in the United States, 1997–2012*, 18 BMC PUBLIC HEALTH 1007 (2018). Such changes seem implausible to me.

It is worth noting that the United States also tends to lag behind many other developed nations in infant mortality. Yet a closer look suggests that this is largely the result of the different ways that countries keep statistics on the issue:

It has been widely reported that the United States has a relatively high infant mortality rate compared with other developed countries: More than 23,000 American infants died in 2014, or about 6 for every 1,000 live births, putting us on par with countries like Serbia and Malaysia. Most other developed countries -- as geographically diverse as Japan, Finland, Australia and Israel -- have lower rates, closer to 2 or 3 deaths out of every 1,000. However, carefully parsing out the data shows that the story is more complicated than those simple statistics.

The first nuance is one of definition. Infant mortality is defined as the death of babies under the age of one year, but some of the differences between countries can be explained by a difference in how we count. Is a baby born weighing less than a pound and after only 21 weeks' gestation actually "born?" In some countries, the answer is no, and those births would be counted as stillbirths. In the United States, on the other hand, despite these premature babies' relatively low odds of survival, they would be considered born -- thus counting toward the country's infant mortality rates.

These premature births are the biggest factor in explaining the United States' high infant mortality rate.

Tex. A&M Univ., *Why American Infant Mortality Rates Are So High* (Oct. 13, 2016), <https://www.sciencedaily.com/releases/2016/10/161013103132.htm>.

¹¹¹⁶ I found it surprising that the report would make both assertions—that pregnancy-related maternal deaths have gotten much worse and that they have not gotten better—without clarifying the situation more. Perhaps the report was drafted by more than one hand.

slightly increase the likelihood of death given the rest of the decedent's medical profile. Whatever standards apply, the odds that they will be evenhandedly implemented over long decades are not very great, particularly given that deaths that occur as much as one year after the birth may still be counted as pregnancy related. The tendency is going to be to inflate the numbers over time.

Of course, to fully appreciate where we are, it is worth knowing that the reduction in maternal mortality over the past century has been astonishing. According to the CDC, “[a]t the beginning of the 20th century, for every 1000 births, six to nine women in the United States died of pregnancy-related complications.” By 1997, that rate “declined almost 99% to less than 0.1 reported death per 1000 live births.”¹¹¹⁷

Just in case your eyes got tired and you didn't quite read that last sentence, let me restate it: *Maternal death declined almost 99% over the course of the 20th century.* That's not just improvement. It's a medical triumph.

But when strides are that impressive, they may be difficult to sustain over time. Major breakthroughs were important to achieving that result—like the discovery of penicillin by Scottish scientist Alexander Fleming, the synthesis of the labor-inducing hormone oxytocin by American biochemist Vincent du Vigneaud, and the discovery of a drug—methyldopa—that manages hypertension for pregnant women, among others, by researchers at American pharmaceutical corporation Merck & Co.¹¹¹⁸ Discoveries like those don't happen every day.¹¹¹⁹

Nonetheless, it is fair to ask: Why haven't maternal mortality rates gone down in more recent years? Why have they stalled (assuming the data are correct that they have stalled)? Most Americans have been lucky enough to live through an era of fairly sustained improvement in many aspects of their lives. Why not here?

A significant part of the answer might be that in recent decades more Americans have become obese,¹¹²⁰ and more obesity means more hypertension and more diabetes, both of which lead to higher maternal mortality rates.¹¹²¹ Another part of the answer might be that a higher percentage of births are to women over 40,¹¹²² and maternal mortality rates for women over 40 have always

¹¹¹⁷ Nat'l Ctr. for Chronic Disease Prevention and Health Promotion, *Achievements in Public Health, 1900–1999: Healthier Mothers and Babies*, 48 MORBIDITY AND MORTALITY WKLY. REP. 843, 849, (Oct. 1, 1999).

¹¹¹⁸ WALTER SNEADER, *DRUG DISCOVERY: A HISTORY* 168, 219, 290 (2005).

¹¹¹⁹ Smaller improvements—the kind that are made through better nutrition, better maternal education, or better professional education—matter too. Unlike the major breakthroughs, these often proceed one mother, one nurse midwife or one obstetrician at a time.

¹¹²⁰ Cheryl D. Fryar et al., Nat'l Ctr. for Health Stat., *Prevalence of Overweight, Obesity, and Severe Obesity Among Adults Aged 20 and Over: United States, 1960–1962 Through 2015–2016*, 3 (Sept. 2018).

¹¹²¹ Wilbert S. Aronow, *Association of Obesity with Hypertension*, 5 *ANNALS OF TRANSLATIONAL MED.* 350 (2017).

¹¹²² T. J. Mathews & Brady E. Hamilton, *Mean Age of Mothers is on the Rise: United States, 2000–2014*, 232 NAT'L CTR. FOR HEALTH STAT. DATA BRIEF 1 (Jan. 2016).

been much higher than those for younger mothers. I will comment more on causes in a later section of this Statement.

For now, allow me to put the problem in perspective. The number of pregnancy-related maternal deaths per year now is approximately 700. That's 700 too many—especially given that the CDC estimates that 60% of these deaths are in one way or another “preventable.” We can and must do better. But it's also true that according to the CDC in 2019 there were 47,511 deaths by “intentional self-harm” in the United States.¹¹²³ Additionally, 39,107 individuals died from motor vehicle accidents, 19,141 died from homicide, 11,252 died from malnutrition, 3,692 died from accidental drowning and submersion, and 2,692 died from accidental exposure to smoke, fire, and flames.¹¹²⁴ All of these areas—very much including pregnancy-related deaths—need improvement.¹¹²⁵ The question is how to go about getting that improvement.

B. WHILE IT IS TRUE THAT AFRICAN AMERICAN AND AMERICAN INDIAN/ALASKA NATIVE MOTHERS HAVE HIGHER PREGNANCY-RELATED MORTALITY RATES THAN WHITE MOTHERS, IT IS **NOT TRUE** THAT ALL CATEGORIES OF MINORITY MOTHERS HAVE HIGHER MORTALITY RATES THAN WHITE MOTHERS. THE RATES FOR HISPANIC AND LIKELY FOR ASIAN MOTHERS ARE ACTUALLY **LOWER**. THIS DETRACTS SOMEWHAT FROM THE NOTION THAT HAS BECOME POPULAR IN RECENT YEARS—THAT RACIAL DISPARITIES IN MATERNAL MORTALITY ARE LARGELY DUE TO RACISM.

¹¹²³ *Underlying Cause of Death 1999–2019*, <https://wonder.cdc.gov/ucd-icd10.html>.

¹¹²⁴ *Id.*

Racial disparities can be found for these modes of death too, but the disparities often cut in quite different directions. For example, for suicides, the highest rates for per 100,000 (age-adjusted) were for non-Hispanic American Indian or Alaska Native at 11.0 (Female) and 33.8 (Male). Notably, the next highest group was non-Hispanic white at 7.9 (Female) and 28.2 (Male). Suicide rates for non-Hispanic blacks (2.8 Female/11.4 Male), Hispanics (2.6 Female/11.2 Male) and non-Hispanic Asian or Pacific Islanders (3.9 Female/ 9.9 Male) are much lower. Sally C. Curtin & Holly Hedegaard, *Suicide Rates for Females and Males by Race and Ethnicity: United States, 1999 and 2017*, NAT'L CTR. FOR HEALTH STAT. 1, 3–4 (June 2019).

This holds true for women of prime childbearing years in particular. For example, for women ages 25-44, the suicide rates for non-Hispanic American Indian or Alaska Natives and for non-Hispanic whites were 20.7 and 10.4 respectively. By contrast, the rates for non-Hispanic blacks, non-Hispanic Asian or Pacific Islanders and Hispanics were 4.3, 4.2 and 3.5.

For automobile accident deaths, American Indians or Alaska Natives are represented at more than twice the overall rate per 100,000 in population. The fatality rate for non-Hispanic whites, on the other hand, exceed those for both non-Hispanic African Americans and Hispanics, but only by a small amount. The rate for Asians is less a third that of the other groups. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., *TRAFFIC SAFETY FACTS: 2006 DATA, RACE AND ETHNICITY 2* (2009).

Among homicide victims, black Americans are vastly over-represented relative to their numbers in the population with ~53.7% of the total. *Number of Murder Victims in the United States in 2019, by Race/Ethnicity and Gender*, (Feb. 2, 2021), <https://www.statista.com/statistics/251877/murder-victims-in-the-us-by-race-ethnicity-and-gender/>.

¹¹²⁵ Curtin & Hedegaard, *supra* note 1124, at 3.

One of the underlying themes of the report is that racism accounts for the differing maternal mortality rates in the United States. For example, the report quotes with seeming approval the written testimony of Joia Crear-Perry, the founder of the National Birth Equity Collaborative. Dr. Crear-Perry, a physician whose own medical career has not been without considerable controversy,¹¹²⁶ stated: ““We know the root causes of poor maternal health—racism and gender oppression inside of healthcare systems and every other facet of society.”” Rep. at xii.¹¹²⁷ In her oral testimony, she also stated, ““Not valuing the lives of Black and indigenous people is driving the maternal health crisis in the United States.””¹¹²⁸ Similarly, the report quotes the written testimony of Jonathan Webb, CEO of the Association of Maternal & Child Health Programs: ““[F]or decades, we have looked at race as a factor in determining or predicting potential health outcomes. More recently, research demonstrates that racism and not race is the actual risk factor.”” Rep. at 29.¹¹²⁹

If so, one might expect racism to take its toll on all minority races, not just African Americans and American Indian/Alaska Natives. But the facts are otherwise. The pregnancy-related

¹¹²⁶ According to the opinion of the Louisiana State Board of Medical Examiners, Dr. Crear-Perry’s medical license was initially suspended in 2008 after her hospital privileges were suspended by Baptist Memorial Medical Center [now called Ochsner Baptist Medical Center]. Based on her representation that she would take remedial training, she was permitted to treat the privileges suspension by Baptist Memorial as a leave of absence. Rather than undergo that training, she sought and obtained hospital privileges at East Jefferson General Hospital without informing that hospital that her privileges at Baptist Memorial had been suspended. This was, of course, against East Jefferson’s rules, so she was suspended there too. Her initial license suspension was stayed on several conditions, including the following: (1) that she refrain from practicing obstetrics until such time as she completes an additional year of residency in that specialty as approved by the board; (2) that a board-approved physician supervise and monitor her practice; and (3) that she get a comprehensive medical and mental health examination. The board found that she had failed to comply with any of those conditions. Her license was thus fully suspended in 2009. In re Joia Crear-Perry, M.D., Certificate No. 023616, Opinion and Ruling, Louisiana State Board of Medical Examiners, No. 09-A-017 (Dec. 14, 2009). See also Martha Carr, *Mitch Landrieu’s Acting Health Director Joia Crear-Perry Steps Down Amid Controversy Over Suspended Medical License*, NOLA.COM (May 8, 2010), https://www.nola.com/news/politics/article_0e8ad81a-c6f7-543d-9853-fc526d91a44c.html; *New Orleans’ Acting Health Director Faces Medical Malpractice Suits*, *Station Reports*, NOLA.COM (May 7, 2010), https://www.nola.com/news/politics/article_eb389fbf-7d6c-51e4-9870-f0a2fcf48a3a.html.

In 2014, her license was reinstated. The reinstatement order recited that she had told the board that she had “no intention of engaging in the practice of medicine in a clinical or institutional setting but instead wish[ed] to pursue a career in health care administration.” In re Joia Crear-Perry, M.D., Certificate No. 023616, Order for Reinstatement of Unrestricted License, Louisiana State Board of Medical Examiners, No. 09-A-017 (Aug. 11, 2014).

The experience of having one’s medical license suspended is likely to have influenced Crear-Perry’s attitude toward the healthcare system generally and needs to be considered in evaluating her accusations.

¹¹²⁷ Citing Joia Adele Crear-Perry, M.D., F.A.C.O.G., Founder and President, National Birth Equity Collaborative, Written Statement for the Maternal Health Briefing Before the U.S. Commission on Civil Rights, November 13, 2020 at 1.

¹¹²⁸ USCCR, *Racial Disparities in Maternal Health*, YouTube (Nov. 13, 2020), <https://www.youtube.com/watch?v=FUnERDDFDTM> (beginning at 1:24:45).

¹¹²⁹ Citing Jonathan Webb, Chief Executive Officer, Association of Maternal & Child Health Programs, Written Statement for the Racial Disparities in Maternal Health Briefing before the U.S. Comm’n on Civil Rights, Nov. 13, 2020, at 2.

mortality rates for Hispanic and very likely for Asian American mothers are *lower* than the rates for whites.¹¹³⁰

The CDC report cited by the Commission clearly shows that from 2007 to 2016, the pregnancy-related mortality rate for Hispanic mothers was 11.5 per 100,000 live births while the rate for non-Hispanic white mothers was 12.7. Put differently, Hispanic mothers were 10% less likely than non-Hispanic white mothers to suffer such a death (per 100,000 births).¹¹³¹

The Asian American rate is more difficult to come by. That's because the CDC report combines Asians with Pacific Islanders. But, it is usually helpful to disaggregate Asians and Pacific Islanders where possible, because the numbers are often quite different—sometimes strikingly different.¹¹³² Combining them can obscure more than it illuminates.¹¹³³

In this case, it is likely that disaggregation would show that the rate for Asian mothers is somewhat lower than the rate for white and Hispanic mothers, while the rate for Pacific Islanders is much higher. Such is the evidence from Hawaii, where the numbers of Asian and the number of Pacific Islanders (including Native Hawaiians) is the largest in the nation in terms of a percentage of the population. According to an article entitled *Our Mothers Are Dying: The Current State of Maternal Mortality in Hawai'i and the United States*, Pacific Islanders were 44% of maternal deaths while only 22% of the population. Asians were 32% of maternal deaths while 37% of the population.¹¹³⁴

Another way that one can get at the differences between Asian maternal mortality and Pacific Islander maternal mortality is to look at the differences in the rates of characteristics that are associated with maternal mortality. A study on pre-pregnancy obesity with subgroups

¹¹³⁰ Commissioner Kirsanow, in his Statement, contends that the Report deliberately obscures the lower Hispanic rate specifically “[b]ecause the Commission is committed to the narrative that the comparatively poor maternal outcomes of black women are due to ‘systemic racism.’” I touch on the counterproductive narrative of “systemic racism” in Section D below.

¹¹³¹ This does not appear to be simply a result of the average age of Hispanic mothers; maternal mortality rates for Hispanics tend to be lower than white rates even within particular age ranges (e.g. 20-24 and above 40 years of age). See Emily E. Petersen, et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, 68 MORBIDITY AND MORTALITY WKLY. REP 762, 763. (Sept. 6, 2019).

¹¹³² See, e.g., Andrew E. Williams, et al., *Work, Weight, and Wellness: the 3W Program: A Worksite Obesity Prevention and Intervention Trial*, 15 OBESITY 16S, (Sept. 6, 2007), (showing that Pacific Islanders have the highest rates of obesity (46%) and shortest life expectancy (68 years) of any U.S. race/ethnic group and that the body mass index (BMI, kg/m²) of Pacific Islanders and Filipinos is greater than that of Whites, while BMI of other Asians is lower than that of Whites).

¹¹³³ See Janice Hata & Adam Burke, *A Systematic Review of Racial and Ethnic Disparities in Maternal Health Outcomes among Asians/Pacific Islanders*, 3 ASIAN/PACIFIC ISLAND NURSING J. 139 (2019) (noting that “[s]tudies that disaggregate APIs are limited” and “highlighting the need to understand the unique differences in maternal health and obstetric outcomes”).

¹¹³⁴ Melanie Maykin & Stacy Pai-Jong Tsai, *Our Mothers Are Dying: The Current State of Maternal Mortality in Hawai'i and the United States*, 79 HAWAII J. HEALTH & SOC. WELFARE 302 (2020). The authors state that these figures above are “stratified by a single-race identifier.”

disaggregated shows 22.3% of non-Hispanic whites; 32.4% of Hawaiians; 60.23% of Samoans; 2.58% of Chinese; 4.25% of Japanese; 3.26% of Vietnamese; 18.98% of Cubans; 27.95% of Mexicans; and 19.92% of Central/South Americans with pre-pregnancy obesity.¹¹³⁵

Yet another way to get at the issue is to look at *infant* mortality, which tends to track maternal mortality rates reasonably well (though not perfectly). Here the CDC disaggregates. It reports that the Asian infant mortality rate per 1,000 live births is 3.6, which is somewhat better than the non-Hispanic white rate of 4.6. The Native Hawaiian or Other Pacific Islander rate, on the other hand, is much higher at 9.4, which places it in between the American Indian/Alaska Native rate of 8.2 and the non-Hispanic black rate of 10.8.¹¹³⁶

The report appears at certain points to be deliberately obscuring these facts. Rather than make it clear that the pregnancy-related mortality rate for Hispanic mothers is lower than that for white mothers, the report focuses only on the notion that it is higher “in some geographic areas.” Rep. at x. But this is always the case. If one carves up the territory carefully enough, one can always find a place where the disparities are reversed. In general, for example, African Americans and women earn less than whites and men. But on the street where Oprah Winfrey lives, that may well not be true.¹¹³⁷

For Asians the report states: “Pregnancy-related mortality is also slightly elevated for Asian women (a 1.1 disparity ratio) Rep. at x. This is simply error. The source it cites is for “Asian/Pacific Islander,” not Asian Americans alone. Given how little the two populations have in common for so many measures of medical well-being, that is a serious error.¹¹³⁸

What does all this tell us? For one thing it tends to discredit the hypothesis that racism is the root of the disparity issue. Anyone familiar with American history, especially that of the American West, knows that discrimination against Hispanics and Asians was a serious problem and it has not altogether disappeared. Yet the rate of pregnancy-related mortality for Hispanics and likely for Asians is lower, not higher, than that for whites. Something more is going on here.

C. THE PROXIMATE CAUSES OF RACIAL DISPARITIES IN PREGNANCY-RELATED MORTALITY ARE DIVERSE AND COMPLICATED.

If not racism, then what? Why are mortality rates so high for African American, American Indian/Alaska Native and almost certainly Pacific Islander mothers? I doubt anyone can explain

¹¹³⁵ Gopal K. Singh & Jessica N. DiBari, *Marked Disparities in Pre-Pregnancy Obesity and Overweight Prevalence among US Women by Race/Ethnicity, Nativity/Immigrant Status, and Sociodemographic Characteristics, 2012–2014*, J. OF OBESITY (2019).

¹¹³⁶ Ely & Driscoll, *supra* note 1107, at 4.

¹¹³⁷ The only example the report gives—New York City—is for “maternal morbidity,” not maternal mortality. Rep. at 26.

¹¹³⁸ See Petersen et al., *supra* note 1131, at 763.

that fully. Nevertheless, there are a number of things that are clear, some of which may be intuitive and others which may not be. Here are just a few:

- (1) TWINS: Women who are bearing twins, triplets or more are more likely to suffer complications or death than women bearing a single child at a time. One multi-country study found the maternal mortality rate for twin birth was almost four times that for single births.¹¹³⁹ Comparing the birthrates tabulated in the study shows that, for reasons I can't explain, non-Hispanic black mothers have a 22.5% higher twin birth rate than non-Hispanic white mothers.¹¹⁴⁰ The non-Hispanic black birth rate for triplets or higher was 10.5% higher than the non-Hispanic white rate.¹¹⁴¹ On the other hand, the twin birth rate for Hispanic mothers was 26.34% lower than the rate for non-Hispanic white mothers, and the rate for triplets or more was 31.6% lower.¹¹⁴²

These data are consistent over the years and are in line with what I believe to be the maternal mortality rates by race and ethnicity for the four largest racial/ethnic groups in the country. It is worth pointing out that, given the lower Hispanic rate, the differing rates are unlikely to be caused by lower socio-economic status, the availability of insurance, or racism.

- (2) HYPERTENSION: Hypertension is a huge risk factor for pregnancy-related mortality. Complications from hypertension for the mother can include preeclampsia, eclampsia, and stroke; for the infant: preterm delivery and low birth weight.¹¹⁴³ I was not able to find statistics specific to pregnancy on this issue. I did find, however, that for women generally, rates of hypertension were as follows: non-Hispanic black (41.5%), non-Hispanic white (26.5%), Hispanic (26.2%), and non-Hispanic Asian (23.5%). These numbers may well overstate the rate of hypertension among women of childbearing age. But I have no evidence to suggest the racial disparities would be less striking.¹¹⁴⁴

Note again that these figures are in line with maternal mortality rates by race and ethnicity with African Americans faring the worst, followed by whites, then by Hispanics, and finally by Asian Americans (assuming my belief that disaggregating Asians Americans from Pacific Islanders would put them in a somewhat better position than Hispanics is correct).

¹¹³⁹ See Danielly S. Santana et al., *Twin Pregnancy and Severe Maternal Outcomes: The World Health Organization Multicountry Survey on Maternal and Newborn Health*, 127 *OBSTETRICS & GYNECOLOGY* 631, 637 (2016).

¹¹⁴⁰ See Joyce A. Martin et al., *Births: Final Data for 2019*, NAT'L VITAL STAT. REP., Mar. 23, 2021, at 47 (tabulating twin and triplet and higher-order multiple births in the United States from 2010 to 2019 by race and Hispanic origin of mother).

¹¹⁴¹ See *id.*

¹¹⁴² See *id.*

¹¹⁴³ See *High Blood Pressure During Pregnancy*, CDC (May 6, 2021), <https://www.cdc.gov/bloodpressure/pregnancy.htm>.

¹¹⁴⁴ Sung Sug (Sarah) Yoon et al., *Hypertension Prevalence and Control Among Adults: United States, 2011–2014*, NAT'L CTR. FOR HEALTH STAT. DATA BRIEF, NOV. 2015, at 2–3.

Some have argued that African American hypertension rates are high because African Americans must put up with racism and racist micro-aggressions. But for a variety of reasons this seems unlikely to be the explanation for differences in rates. To begin with, hypertension (chronic high blood pressure) is not usually associated with anxiety. Anxiety causes temporary spikes in blood pressure, not hypertension.¹¹⁴⁵ Moreover, the racial group most likely to be diagnosed with anxiety disorders appears to be whites, not African Americans.¹¹⁴⁶ Similarly, it appears to be Hispanics, not African Americans who are most likely to be depressed.¹¹⁴⁷ That makes it unlikely that racism is the explanation for African Americans being the outlier in hypertension rates.

It is also worth pointing out that suicide rates tend to detract from the argument that African Americans' hypertension rates are a reflection of uniquely difficult lives due to racism. Here we have reasonably reliable comparisons: Suicide rates are much higher for non-Hispanic whites (7.9 female / 28.2 male) than for non-Hispanic blacks (2.8 female / 11.4 male).¹¹⁴⁸ Non-Hispanic Asian or Pacific Islander females commit suicide at a higher rate (3.9) than their non-Hispanic black counterparts, while non-Hispanic Asian or Pacific Islander males commit suicide at a lower rate (9.9).¹¹⁴⁹ Hispanic rates of suicide (2.6 female / 11.2 male) are slightly lower than non-Hispanic black rates for both sexes.¹¹⁵⁰

Note that suicide due to post-partum depression is not considered a pregnancy-related death under current recordkeeping practices and that, if it were considered, it would probably help shrink the black-white racial disparities we see today. Rep. at 6.

- (3) DIABETES: Women with diabetes prior to their pregnancy are more likely to suffer complications or death than other women.¹¹⁵¹ According to National Vital Statistics Reports, non-Hispanic black mothers were 62.5% more likely to have been diagnosed pre-pregnancy with diabetes than non-Hispanic white mothers.¹¹⁵² American Indian or Alaska Native mothers were 212.5% more likely to have been so diagnosed. The figures

¹¹⁴⁵ See Sheldon G. Sheps, *Anxiety: A Cause of High Blood Pressure?*, MAYO CLINIC, <https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/anxiety/faq-20058549> (“Anxiety doesn't cause long-term high blood pressure (hypertension). But episodes of anxiety can cause dramatic, temporary spikes in your blood pressure.”).

¹¹⁴⁶ See Anu Asnaani et al., *A Cross-Ethnic Comparison of Lifetime Prevalence Rates of Anxiety Disorders*, 198 J. NERVOUS & MENTAL DISEASE 551 (2010).

¹¹⁴⁷ See Dorothy D. Dunlop et al., *Racial/Ethnic Differences in Rates of Depression Among Preretirement Adults*, 93 AM. J. PUB. HEALTH 1945 (2003).

¹¹⁴⁸ Curtin & Hedegaard, *supra* note 1124, at 3–4.

¹¹⁴⁹ *Id.*

¹¹⁵⁰ *Id.*

¹¹⁵¹ See *Diabetes and Pregnancy*, CDC (July 14, 2020), <https://www.cdc.gov/pregnancy/diabetes.html>.

¹¹⁵² Joyce A. Martin et al., *Births: Final Data for 2019*, NAT'L VITAL STAT. REP., Mar. 23, 2021, at 31.

for Native Hawaiian or Other Pacific Islander, Hispanic and Asian mothers were 125%, 37.5%, and 25% higher respectively.¹¹⁵³

These numbers, too, are in line with maternal mortality rates with the exception of the rate for whites, who fare better on diabetes relative to Asians and Hispanics than they did on hypertension.¹¹⁵⁴

- (4) OBESITY: Body weight is a risk factor that is related to diabetes and hypertension, but may also be independent of those factors. According to the National Vital Statistics Reports, 75.0% of Native Hawaiian or Other Pacific Islander mothers, 68.4% of American Indian or Alaska Native mothers, and 65.9% of non-Hispanic black mothers were obese or overweight (defined as a BMI of 25.0 or over). The corresponding figures for Hispanic, non-Hispanic white, and non-Hispanic Asian mothers were 63.2%, 52.2%, and 33.9% respectively.¹¹⁵⁵

Note that these numbers are in line with the maternal mortality rates by race I have discussed so far with the exception of the rate for Hispanics, who were more likely to be “obese or overweight” than whites, but less likely to experience a pregnancy-related death.

Hardly anyone is foolish enough to call someone with a BMI of 25 “obese.” I therefore wondered what the figures would look like if they were focused on what is much more likely to be called obesity (defined as a BMI of 30 or greater) or extreme obesity (defined as a BMI of 40 or greater). Would they be even more in line with the racial disparities in maternal mortality or would they be less in line?

I was not able to find mother-specific figures for obesity or extreme obesity (keeping the above definitions in mind). But I did find that 40.4% of American women are either obese or extremely obese, while 9.9% are extremely obese.¹¹⁵⁶ The racial disparities

¹¹⁵³ *Id.*

¹¹⁵⁴ The report refers repeatedly to the fact that the maternal mortality rate is high even for college-educated African American mothers. *E.g.*, Rep. at 23. To some, this is thought to be evidence for the notion that racism must be to blame. A more likely explanation is that some adverse medical conditions are higher among African Americans than among other Americans even after level of education is accounted for, possibly for genetic or other reasons not understood at this time. Diabetes is an example; it is usually less common the higher one goes on the educational ladder. The one exception I have found is for African Americans. According to one study, the incidence of diabetes among African Americans with a bachelor’s degree or higher was 6.3, which was higher than the rate for African Americans with some college but no bachelor’s degree (5.9). It is also higher than the incidence of diabetes in Non-Hispanic whites with only a high school diploma (6.0), some college but no bachelor’s degree (4.3), or a bachelor’s degree or higher (3.2) and for Hispanics with only a high school diploma (5.6), some college but no bachelor’s degree (4.5), or a bachelor’s degree or higher (3.5). Luisa N. Borrell et al., *Education and Diabetes in a Racially & Ethnically Diverse Population*, 96 AM. J. PUBLIC HEALTH 1637 (2006) (“Educational attainment was inversely associated with diabetes prevalence among Whites, Hispanics, and women but not among Blacks.”).

¹¹⁵⁵ *Id.*

¹¹⁵⁶ See *Overweight & Obesity Statistics*, NAT’L Inst. OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES, <https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity> (last updated Aug. 2017).

were also mostly consistent with the racial disparities in maternal mortality: For example, African American adults are 33% more likely to be obese than Non-Hispanic whites and 63% more likely to suffer from extreme obesity.¹¹⁵⁷ At the other extreme, non-Hispanic Asians are only about a third as likely as non-Hispanic whites to suffer from obesity and extreme obesity was too rare to be accurately measured in the study.¹¹⁵⁸ But here's the interesting part: Hispanic adults are 17% *more* likely than non-Hispanic white adults to be obese, but they are 6.6% *less* likely to suffer from extreme obesity.¹¹⁵⁹ For extreme obesity, therefore, the racial disparities are precisely in line with those of maternal mortality I have discussed with African Americans faring worst, then whites, then Hispanics and finally Asian Americans. While these statistics are hardly the last word on this topic, they are interesting.¹¹⁶⁰

What does all this tell us? How can it help us reduce maternal mortality? As a lawyer rather than a medical professional, I am not in the best position to make concrete recommendations. The same is true of our Commission staff. Yet concrete recommendations are what's needed—most likely focused on factors like hypertension, diabetes, and obesity—not vague resolutions to spend more money or to do more research. Hospitals could paper the walls with government reports that generally recommend more research and spending. Reports like that are not much help in solving the problem.

One of the disappointing aspects of the report is its lack of curiosity about what the CDC meant when it estimated that 60% of pregnancy-related deaths are “preventable.”¹¹⁶¹ Rep. at xiii. Preventable how? And by whom? Should pregnant women be encouraged to purchase home

¹¹⁵⁷ *Id.*

¹¹⁵⁸ *See id.*

¹¹⁵⁹ *See id.*

¹¹⁶⁰ A study dealing only with California yielded only slightly different results. It showed 14.9% of white California women delivering in 2007 were obese (BMI 30-40); 22% of black California women; and 20.3% of Hispanic California women. *See* Jonathan M. Snowden et al., *The Impact of Maternal Obesity and Race/Ethnicity on Perinatal Outcomes: Independent and Joint Effects*, 24 *OBSIDITY* (SILVER SPRING) 1590 (2016). On the other hand, 2.6% of white California women delivering in 2007 were a BMI of above 40; 5.7% of black California women; and 2.8% of Hispanic California women. *Id.* Obesity in Asian California women was comparatively negligible. *See id.* In both cases, the Hispanic rate of obesity (BMI 30-40) was well above the white rate, but the Hispanic rate of extreme obesity (BMI above 40) was very close to the white rate. *Id.*

¹¹⁶¹ When the CDC says a death was preventable, it does not mean that medical professionals are responsible. For example, the CDC calls smoking the number 1 cause of preventable death. *See The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General*, U.S. DEP'T OF HEALTH & HUMAN SERV. (2014) (“Most smokers visiting health care settings are now routinely asked and advised about tobacco use. On the other hand, cigarette smoking remains the chief preventable killer in America, with more than 40 million Americans caught in a web of tobacco dependence.”). That's not something a doctor or nurse can do for a patient. They can recommend, cajole, and even prescribe ways to make quitting easier, but in the end, it's up to the individual patient to quit.

blood pressure monitors and report their readings each day to their doctors?¹¹⁶² Should doctors be more aggressive in prescribing anti-hypertensive drugs? Should they counsel extremely obese women to lose weight before they get pregnant? Should they counsel ultrahigh-risk women not to have children?

D. IT IS COUNTERPRODUCTIVE TO DIVERT ATTENTION AWAY FROM THE FACTORS THAT LEAD TO MATERNAL MORTALITY WITH VAGUE CLAIMS OF RACISM. WE SHOULD NOT BE TRYING TO CAUSE AFRICAN AMERICAN AND OTHER MINORITY MOTHERS TO VIEW THE MEDICAL PROFESSION WITH UNWARRANTED SUSPICION.

It is fashionable these days to attribute nearly everything to racism. Much—from Italian fashion to Trader Joe’s¹¹⁶³—has been alleged to be racist.

¹¹⁶² Blood pressure monitors are available on Amazon for less than \$20. Should doctors provide them at no additional charge?

¹¹⁶³ In recent years, charges of racism have been leveled at the filibuster in the U.S. Senate, the Texas Rangers, weight loss, the “yoga-industrial-complex,” Italian fashion, veganism, Dungeons & Dragons, the celebration of American tomboys, the National Park System, the interchangeability of yams and sweet potatoes, Jane Austen, women, the films “Alien” and “Predator,” robots, the air we breathe, Wolfgang Mozart, several Dr. Seuss books, fried chicken, Western Philosophy, and Trader Joe’s. See Mike Allen, AXIOS: AXIOS AM (Mar. 18, 2021), <https://www.axios.com/newsletters/axios-am-c514b18c-70bf-4fa3-8f67-6553d4757246.html> (“Sen. Elizabeth Warren told Alayna Treene the Senate’s legislative filibuster, which requires 60 votes for most legislation, wasn’t a creation of the founding fathers . . . ‘The filibuster has deep roots in racism, and it should not be permitted to serve that function, or to create or to create a veto for the minority. In a democracy, it’s majority rules.’”); Karen Attiah, *The Texas Rangers’ Team Name Must Go*, WASH. POST (July 13, 2020, 12:06 PM), <https://www.washingtonpost.com/opinions/2020/07/13/texas-rangers-team-name-must-go/>; Lindo Bacon & Sabrina Strings, *The Racist Roots of Fighting Obesity*, SCI. AM. (July 2020), <https://www.scientificamerican.com/article/the-racist-roots-of-fighting-obesity2/>; Susanna Barataki, *How to Decolonize Your Yoga Practice*, DECOLONIZING YOGA (Feb. 7, 2015), <https://decolonizingyoga.com/decolonize-yoga-practice>; Soffia Bettiza, *Is Italian fashion racist?*, BBC NEWS (Sept. 8, 2020), <https://www.bbc.com/news/av/world-europe-54061928>; Alexis de Coning, *Why So Many White Supremacists Are into Veganism*, VICE (Oct. 23, 2017), <https://www.vice.com/en/article/evb4zw/why-so-many-white-supremacists-are-into-veganism>; Cecilia D’Anastasio, *D&D Must Grapple With the Racism in Fantasy*, WIRED (Jan. 24, 2021, 7:00 AM), <https://www.wired.com/story/dandd-must-grapple-with-the-racism-in-fantasy/>; Lisa Selin Davis, *The Racist History of Celebrating the American Tomboy*, LIT. HUB (Aug. 11, 2020), <https://lithub.com/the-racist-history-of-celebrating-the-american-tomboy/>; Devin Dwyer & Stephanie Ebbs, *America’s national parks face existential crisis over race*, ABC NEWS (July 1, 2020), <https://abcnews.go.com/Politics/americas-national-parks-face-existential-crisis-race/story?id=71528972>; Margaret Eby, *The Difference Between Yams and Sweet Potatoes Is Structural Racism*, FOOD & WINE, <https://www.foodandwine.com/vegetables/the-difference-between-yams-and-sweet-potatoes-is-structural-racism> (last updated Feb. 6, 2020); Jenny Gross, *A Jane Austen Museum Wants to Discuss Slavery. Will Her Fans Listen?*, N.Y. TIMES (Apr. 27, 2021), <https://www.nytimes.com/2021/04/27/world/europe/jane-austen-slavery-museum.html>; Jenn M. Jackson, *Women Have Always Been a Part of White Supremacy*, TEEN VOGUE (July 1, 2020), <https://www.teenvogue.com/story/women-white-supremacy-history-america/>; Tamari Kitossa, *How Hollywood’s ‘Alien’ and ‘Predator’ Movies Reinforce Anti-Black Racism*, CONVERSATION (Aug. 16, 2020, 8:12 AM), <https://theconversation.com/how-hollywoods-alien-and-predator-movies-reinforce-anti-black-racism-127088>; Harmon Leon, *Why Are So Many Robots White? Study Shows There’s a Racial Bias*, OBSERVER (Aug. 9, 2019), <https://observer.com/2019/08/robot-racial-bias-study/>; Julia Lurie, *This is How Racist Your Air Is*, MOTHER JONES (Apr. 28, 2014), <https://www.motherjones.com/environment/2014/04/air-pollution-racial-disparities/>; Jack Malvern, *Why Mozart is a Singular ‘Symbol of the White Patriarchy’*, THE TIMES (Oct. 28, 2020), <https://www.thetimes.co.uk/article/why-mozart-is-symbol-of-the-white-patriarchy-580vpw173>; Mark Pratt, *6 Dr.*

The report is replete with such allegations.¹¹⁶⁴ Most, if not all, are in the form of quotes from individuals who purport to be experts on the topic. In addition to the quotes from Dr. Joia Crear-Perry and Jonathan Webb cited above, there are many others in the report alleging racism: Ndidi Amutah-Onukagha, Assistant Dean for Diversity, Equity & Inclusion and Associate Professor of Public Health and Community Medicine at Tufts Medical School is quoted about how “racism is embedded in the healthcare system.” Rep. at 29. Congresswoman Ayanna Pressley is quoted expressing similar sentiments: “[T]he fact that my grandmother died in childbirth in the 1950s and Black women are four times more likely to still die really is just, you know, condemnation and confirmation of the embedded biases and systemic racism throughout our healthcare system.” Rep. at 64. Dr. Taraneh Shirazian is quoted noting that “[s]ystemic racism is one of the challenges affecting Black women and maternal mortality in New York State.” Rep. at 60. Even during the Commission’s public business meeting one commissioner attributed racial disparities to “structural racism in our healthcare system” and stated that “black women are treated differently in the maternity ward than others in terms of being listened to, and recognized as custodians of their own care, and advocates of their own care.”¹¹⁶⁵

The following quote from an article by Deirdre Cooper Owens and Sharla M. Fett particularly caught my eye, since it attempts to focus attention away from factors that directly increase the likelihood of maternal death:

It seems that, rather than addressing systemic racism in obstetrics and gynecology, medical practitioners have instead to some extent emphasized all the ways Black women allegedly make themselves prone to being ill during their pregnancies. Black pregnant women and non-gender binary folks are told their fatness, advanced age, dietary choice,

Seuss Books Won't Be Published for Racist Images, A.P. (Mar. 2, 2021), <https://apnews.com/article/dr-seuss-books-racist-images-d8ed18335c03319d72f443594c174513>; Melissa Thompson, *I've always loved fried chicken. But the racism surrounding it shamed me*, GUARDIAN (Oct. 13, 2020), <https://www.theguardian.com/food/2020/oct/13/ive-always-loved-fried-chicken-but-the-racism-surrounding-it-shamed-me>; Bryan W. Van Norden, *Western Philosophy is Racist*, AEON (Oct. 31, 2017) <https://aeon.co/essays/why-the-western-philosophical-canon-is-xenophobic-and-racist>; Jenny G. Zhang, *Trader Joe's to Remove Product Names Like Trader José and Trader Ming's Following Accusations of Racism*, EATER (Jul. 21, 2020, 11:33 AM), <https://www.eater.com/2020/7/21/21332645/trader-joes-changes-racist-product-names-branding-online-petition>.

¹¹⁶⁴ One of the most puzzling suggestions of racism in the report is Dr. Crear-Perry’s remark that “black and brown bodies” are at a disadvantage because they are more likely to be treated at a teaching hospital. She objects that we are taking the patients that “actually need the most” and “sending them to places where there is training,” and she mentioned Grady Memorial Hospital in Atlanta as an example. Rep. at 50. All my life I’ve been told that teaching hospitals—hospitals that are associated with a medical school—tend to be the best hospitals. (And indeed my family actively tried to get my father transferred to a teaching hospital when he was gravely ill.) A 2002 study reviewed the empirical literature comparing teaching hospitals to ordinary hospitals. The strong weight of the evidence was that teaching hospitals—particularly major teaching hospitals like Grady—are at least as good as ordinary hospitals and frequently better on most measures of quality. Of course, nearly everyone understands that teaching hospitals excel at rare and cutting edge medical treatments and research. It was useful to know that they also frequently excel at routine treatments as well. John Z. Ayanian & Joel S. Weissman, *Teaching Hospitals and Quality of Care: A Review of the Literature*, 80 MILBANK Q. 569 (2002).

¹¹⁶⁵ Transcript, *supra* note 1107, at 24 (quoting Commissioner Yaki).

and lack of prenatal care have increased their chances of dying during childbirth. Yet, whereas Black pregnant people and mothers are made into culprits and the initiators of their deaths, doctors, nurses and the hospitals they run are not looked at as critically as they should be.¹¹⁶⁶

Rep. at 61. If the goal is to reduce deaths, it is not clear that focusing attention away from the factors Owens and Fett identify is a good idea.¹¹⁶⁷ I have similar concerns over Congresswoman Ayanna Pressley’s recommendation in her testimony before the Commission. Rep. at 125. She stated there that Congress should declare racism a “public health crisis” and create a national center for anti-racism within the CDC.¹¹⁶⁸ This approach, too, seems ill-suited to saving lives. It works well, however, if the goal is to attract the applause of Americans for whom ideology has become more important than saving lives.

Unfortunately, this report is not the only place one finds vague allegations of “racism” cited as the cause for racial disparities in maternal death. Here in San Diego County, where I reside, billboards and posters have been popping up with photographs of African American mothers with the following message:

Our black mothers are 3x more likely to die during pregnancy because of racial bias.

¹¹⁶⁶ Deirdre Cooper Owens & Sharla M. Fett, *Black Maternal and Infant Health: Historical Legacies of Slavery*, 109 AM. J. PUB. HEALTH 1342 (2019).

A similar sentiment is taken from a written statement submitted to the Commission by Nicolle L. Gonzales, Medical Director & Founder of the Changing Woman Initiative:

Not only do Native American women experience disproportionately higher maternal mortality rates than [sic] white or Hispanic women, they are portrayed in the data like it is there [sic] fault for not accessing prenatal care in the first trimester, or that they have higher rates of obesity and diabetes—when needed services, education, access to clean water, healthy foods, and adequately funded services are lacking, across the nations.

Rep. at 1. Jonathan Webb appears to agree. He is quoted in the report this way:

If we are looking to really advance racial equity, we need to shift our conversation from eliminating racial and ethnic disparities in maternal and infant health specifically—which continues a focus and blame on people—to eliminating the systemic, structural, and institutional inequities that produce the racial disparities. We also need to acknowledge that these systems, structures, and institutions were not created to produce equitable outcomes for Black, Indigenous, Latinx, Pacific Islanders, and other People of Color. They are products of systems created over time that create an advantaged group and a disadvantaged group, in part because communities of color have not had a seat at the table in the creation of these systems.

Rep. at 54.

¹¹⁶⁷ With obesity, hypertension and diabetes, it isn’t a matter of being made into “culprits.” Some bodies have all the luck and can keep off weight and avoid hypertension and diabetes seemingly without effort. Most of us are not so lucky. We all have to play the cards we’re dealt. One role physicians, nurses and other health professionals have traditionally played is to advise their patients on how to best play those cards. They shouldn’t be discouraged from fulfilling that role.

¹¹⁶⁸ Since giving her testimony, she has sponsored such a bill. Anti-Racism in Public Health Act of 2021, H.R. 666, 117th Cong. (2021) (establishing “within the [CDC] a National Center on Antiracism and Health and a law enforcement violence prevention program. . . . [which] must declare racism a public health crisis, collect and analyze data, and administer research and grant programs to address racism and its impact on health and well-being.”).

Others contain similar messages: “Our black infants are 3x more likely to die **because of racial bias**,” “Our babies are 60% more likely to be premature **due to discrimination**,” and “**Racism hurts your baby** long before they are born.”

The boldface type is in the original; I have not added it.

These posters and billboards are part of a campaign—titled Black Legacy Now—funded by the County of San Diego.¹¹⁶⁹ They were rolled out with great fanfare this past January.

What is the point of the accusations of racism, racial bias, and discrimination? I find it hard to imagine why someone would make such claims if he or she is motivated by a desire to reduce maternal and infant deaths among African Americans. If anything these messages will make things worse. They will tend to frighten African American (and possibly other minority) mothers into being unduly suspicious of medical care providers. That’s not a step in the right direction.¹¹⁷⁰

It is well established that African American mothers are less likely than other mothers to see a doctor early in their pregnancies. As far as I know, no one has studied exactly why. But this lack of early medical attention probably accounts for some portion of the high rate of maternal mortality among that group.¹¹⁷¹ Suggesting to these mothers that the medical profession is racist is unlikely to make them seek that help more readily. More likely it will do the opposite.

The problem is not just with pregnancy-related medical attention. African Americans are also less likely to seek to be vaccinated against COVID-19 than other Americans.¹¹⁷² As of May, CDC data showed that only 22% of blacks had received a shot. On the other hand, by then, 45% of American Indians, 41% of Asians, 33% of whites, and 29% of Hispanics had received at least one shot.¹¹⁷³ This is not because African Americans are less likely to be insured or to have the financial resources to pay for the shots. The shots are free. Part of the reason is almost certainly a lack of trust in the medical establishment.

¹¹⁶⁹ See generally *The Issue*, BLACK Legacy NOW, <https://blacklegacynow.com/> (last visited Aug. 13, 2021).

¹¹⁷⁰ In his Statement, Commissioner Gilchrist writes, “Now do I believe health care providers are intentionally trying to kill women and singling out Black women in particular? Absolutely not!” I fear, however, that this report does not make that sentiment clear and will continue to contribute to the fear campaign.

¹¹⁷¹ The difference does not appear to be simply a result of fewer resources to devote to medical care (though that may be a factor). Planned pregnancies are more likely to result in prompt medical attention than unplanned pregnancies. In 2011, the rate of unplanned pregnancies among non-Hispanic blacks was 79 per 1,000 women ages 15–44. Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374 *NEW ENG. J. OF MED.* 843 (2016). For non-Hispanic whites, the rate was less than half that—33 per 1,000. *Id.*

¹¹⁷² See Amelia M. Jamison et al., “You Don’t Trust a Government Vaccine”: Narratives of Institutional Trust and Influenza Vaccination among African American and White Adults, 221 *SOC. SCI. & MED.* 87 (2019).

¹¹⁷³ Hannah Recht et al., *Stark Racial Disparities Persist in Vaccinations, State-Level CDC Data Shows*, WEBMD (May 20, 2021), <https://www.webmd.com/vaccines/covid-19-vaccine/news/20210520/racial-disparities-persist-in-vaccinations-cdc-data-shows>.

This lack of trust in the medical profession in general is likely hurting African Americans in other ways too. In one study of privately insured patients, African Americans (and other minorities too) failed to follow through with instructions to take medicine more often than whites did.¹¹⁷⁴ In that study, African Americans were 38.9% more likely to fail to take a prescribed anti-hypertensive as directed.¹¹⁷⁵ Similarly, they were 32.5% more likely to fail to take an oral anti-diabetic as directed.¹¹⁷⁶ The reason for this unlikely to be lack of financial resources, since all the patients in the study were privately insured. Instead, lack of trust in a doctor's recommendation may be playing a significant role. Hypertension and diabetes are unseen killers. It's easy for a patient who distrusts the doctor's advice to decide treatment is unnecessary or undesirable. That kind of distrust can be deadly.

At press conference launching The Black Legacy Now project held on January 29, 2021, one woman working on the project spoke as follows: "When I was pregnant it was complicated finding care. I especially wanted a black OB/GYN to deliver my baby. And [it's] very hard to find one in San Diego. I finally found care with a team of midwives and doulas."¹¹⁷⁷

Everyone should be able to agree that delays in seeking medical attention in the early stages of pregnancy are undesirable. But when the delay is motivated by the patient's desire to find a doctor who is of a particular race, it is also ill-advised.¹¹⁷⁸ San Diego County is only about 5% African American, which is less than half the proportion of the country as a whole. It is thus not a surprise that there are not a lot of black OB/GYNs here. Like the rest of the country, we have a shortage of OB/GYNs generally.¹¹⁷⁹ Why tell African American mothers things that may cause them to want to limit themselves to OB/GYNs of their own race? Why make finding an OB/GYN that much more difficult?

¹¹⁷⁴ See Zhiwen Xie et al., *Racial and Ethnic Disparities in Medication Adherence Among Privately Insured Patients in the United States*, 14 PLOS ONE (2019) (numbers derived from Table 2, which give adherence rates rather than non-adherence rates).

¹¹⁷⁵ *Id.*

¹¹⁷⁶ *Id.*

¹¹⁷⁷ Countysandiego, *Black Legacy Now Campaign Launches In San Diego County*, YOUTUBE (Jan. 29, 2021), <https://www.youtube.com/watch?v=OzZq2NXMrLY>.

¹¹⁷⁸ It is worth noting, however, that, nationwide, African Americans are only slightly under-represented among OB/GYNs relative to their numbers in the population at large. They are 11.1% of OB/GYNs, while 13.4% of the population at large. William F. Rayburn et al., *Racial and Ethnic Differences Between Obstetrician-Gynecologists and Other Adult Medical Specialists*, 127 OBSTETRICS & GYNECOLOGY 148 (2016). Compared to the other specialties studied in that article (family medicine, general internal medicine, emergency medicine, and general surgery), obstetrics & gynecology had more African Americans.

¹¹⁷⁹ The American Colleges of Obstetricians and Gynecologists predicted in 2017 this would result in 8,000 fewer practitioners than needed by 2020. I have seen no data suggesting that this prediction was not fulfilled. See DOXIMITY, 2019 OB-GYN WORKFORCE STUDY 3 (Sept. 2019).