LEGAL BARRIERS TO MATERNAL HEALTHCARE EQUITY

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Abstract: In examining contemporary maternal healthcare inequity in clinical care delivery, we must study the critical role played by the legal institutions in creating and perpetuating this problem. Comprehensive systems within the United States require legal advocacy and judicial enforcement to take shape and maintain their structural integrity. Healthcare in this country is no different. Legal institutions helped form and further, both intentionally and inadvertently, the racial disparities that we currently battle. Legal history plays an integral role in understanding why racial disparities in maternal mortality persist. One way for legal professionals to contribute to the ongoing efforts to achieve maternal healthcare equity is to coordinate our efforts with clinical approaches and resources to create a cohesive legal and healthcare delivery model.

Keywords: Health Law; Healthcare Law; Maternal Health Equity; Health Equity; Healthcare Equity

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INTRODUCTION

Black women in this country are three to four times more likely to die during pregnancy and within the first-year post-partum than both Latine and non-Latine[1] White women.[2] States like Mississippi[3] or counties such as Harris County, Texas[4] have more bleak outcomes than the national median. In examining our nation's healthcare history, we have uncovered an undeniable truth: medical treatment and outcomes are heavily dependent on race.[5] Academic review on the role of clinical care delivery must likewise include the critical role played by the law in perpetuating maternal healthcare inequity. Contemporary discourse has often been critical of the current American healthcare system without historical contextualization, history plays an integral role in understanding why racial disparities in maternal mortality persist. Neutralizing the criteria for comparison to determine whether the root cause is socioeconomic and not on the basis of race has yielded a definitive determination. Even wealth is not an equalizer for outcomes because Black women are at a higher risk of mortality even with when controlling for economic circumstances.[6]

In January 2018, the analyses and criticisms of healthcare inequity boldly leapt into mainstream public discourse via an unlikely medium and with an unexpected messenger. Vogue Magazine interviewed internationally revered tennis player, Serena Williams, following the birth of her first child.[7] Following the interview, news outlets began to cover the topic of modern race-based healthcare disparities in maternal outcomes during pregnancy and the post-partum period *en masse*.[8] Serena Williams detailed her experience following her delivery via cesarean section and difficulty with breathing after undergoing the operation. At the time of her delivery, she was one of

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[1] This paper uses the word "Latine" to collectively encompass Latina, Latino, and non-binary Latinx people.

[2] Tara O'Neill Hayes & Carley McNeil, *Maternal Mortality in the United States*, September 9, 2019. (Americanactionforum.org).

[3] Emily Wagster Pettus, *Maternal mortality rate is much higher for Black women than white women in Mississippi, study says*, AP, December 7, 2023, https://apnews.com/article/mississippi-maternal-mortality-health-department-296067d522b89951280be2cd6f05c180 (last visited June 6, 2024).

[4] Monique Welch, *Harris County has had the highest Black maternal death rates in the U.S. for years. Here's why.*, Houston Landing: Diverse Communities, April 17, 2024, https://houstonlanding.org/harris-county-has-had-the-highest-black-maternal-death-rates-in-the-u-s-for-years-heres-why/ (last visited on June 6, 2024).

[5] Nikole Hannah-Jones, A New Origin Story: The 1619 Project, pp 318 – 322 (First Edition 2021).

[6] Claire Cain Miller, et. al., Childbirth Is Deadlier for Black Families Even When They're Rich Expansive Study Finds, February 12, 2023 (https://www.nytimes.com/interactive/2023/02/12/upshot/child-maternal-mortality-rich-poor.html) (last visited February 27, 2024).

[7] Rob Haskell, *Serena Williams on Motherhood, Marriage, and Making Her Comeback*, Vogue Magazine, January 10, 2018, https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018 (last visited February 27, 2024).

[8] Serena Williams, *Serena Williams: What my live-threatening experience taught me about giving birth,* CNN, https://www.cnn.com/2018/02/20/opinions/protect-mother-pregnancy-williams-opinion/index.html (last visited January 23, 2024); *See* Maya Salam, *For Serena Williams, Childbirth Was a Harrowing Ordeal. She's Not Alone.*, The New York Times, January 11, 2018, https://www.nytimes.com/2018/01/11/sports/tennis/serena-williams-baby-vogue.html; *See also* Alex Porteé, *Serena Williams on her near-death experience after giving birth: 'No one was really* listening', Today; Women's Health, https://www.today.com/health/womens-health/serena-williamss-essay-black-pregnancy-rcna23328 (last visited January 23, 2024).

the most-recognizable women in the world with wealth, power, and access[9] to healthcare facilities and providers who can utilize advancements unimaginable to the general public.[10] Williams's socioeconomic status and resources did not automatically translate to an immediate and full evaluation of her concerns about a pulmonary embolism,[11] even though she has a history of blood clots.[12] Her own insistence that she receive a particular test called a computed tomography (commonly known as a CT scan) and diagnostic processes probably prevented a negative health outcome, or potentially saved her life.[13] Pre-existing conditions, in this instance a history of blood clots, is the leading cause of maternal mortality in the United States.[14]

As a healthcare attorney in Ohio, it is simultaneously encouraging and dispiriting to review and analyze the Centers for Disease Control's (CDC) data in juxtaposition to A Report on Pregnancy-Associated Deaths in Ohio 2008-2016, a synopsis of data and statistics published by The Ohio Department of Health.[15] The aforementioned report on Ohio's inequitable outcomes gathered more comprehensive data than is ordinarily available with national sources. This report allows healthcare attorneys in the state to provide well-informed and supported client advice than some of the less specific information otherwise available. The CDC's Pregnancy Mortality Surveillance System is based only on vital statistics (e.g., birth certificate, death certificate, etc.) data submitted to the CDC by states.[16] The Ohio Pregnancy-Associated Morality Review Committee instead utilizes more sources of information to obtain more detailed and comprehensive data on maternal mortality in a process dubbed "the gold standard" by the committee in their review of maternal deaths.[17] This precision in data acquisition and analysis shows that the increase over the last decade in the more

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[9] Ashley L. Parker, *Cultural Responsiveness in Assisted Reproductive Technology: Chapter 9 Racial Disparities in Adverse Pregnancy Outcomes*, 141 (Danielle A. Kaplan, ed., 2024).

[10] Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, Vol. 95 New York University Law Review No. 5 1229, at 1232 (November 2020).

[11] Fiona Miller and Pringl Miller, MD, *Transgenerational Trauma and Trust Restoration*, Vol. 23 AMA Journal of Ethics No. 6, 480 (June 2021).

[12] Serena Williams had been hospitalized in 2011 due to a pulmonary embolism, which is most-commonly caused by a blood clot making its way into the lungs. Foundation to Advance Vascular Cures, *Serena Williams and her Experience with Pulmonary Embolisms*, January 13, 2018, https://www.vascularcures.org/news/pad-online-facebook-community-r9lp9-6jaw8-w6bln#:~:text=Serena%20Williams%20was%20previously%20hospitalized,the%20doctors%20when%20it%20reoccurred. (last visited February 28, 2024).

[13] Haskell, *supra* Note 7.

[14] University of Michigan, Increasing rates of chronic conditions putting more moms, babies at risk, Medical Xpress, November 7, 2017, https://medicalxpress.com/news/2017-11-chronic-conditions-moms-babies.html (last visited February 27, 2024).

[15] A Report on Pregnancy-Associated Deaths in Ohio 2008-2016, The Ohio Department of Health (2019), available electronically at https://odh.ohio.gov/wps/wcm/connect/gov/f5f620c6-d444-4873-bbc8-bbc76bba1a71/A_Report_on_Pregnancy-Associated_Deaths_in_Ohio_2008-2016+website+version.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-f5f620c6-d444-4873-bbc8-bbc76bba1a71-nvUTYCq.

[16] Centers for Disease Control and Prevention, Pregnancy Mortality Surveillance System, May 15, 2024, https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance/index.html last accessed August 18, 2024.

[17] A Report on Pregnancy-Associated Deaths in Ohio 2008-2016, The Ohio Department of Health (2019), available electronically at https://odh.ohio.gov/wps/wcm/connect/gov/f5f620c6-d444-4873-bbc8-bbc76bba1a71/A_Report_on_Pregnancy-Associated_Deaths_in_Ohio_2008-2016+website+version.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-f5f620c6-d444-4873-bbc8-bbc76bba1a71-nvUTYCq.

broadly defined terms "pregnancy-associated death"[18] and "pregnancy-related death"[19] makes the revelation more sobering that in Ohio, Black women were more than 2.5 times as likely to die than White women.[20] It is with this lens and experience that I have observed the mainstream attention-shift to maternal and fetal health outcomes on the national stage.

On January 20, 2025, within the first days of the second Trump administration, an Executive Order titled Regulatory Freeze Pending Review was issued. Per this action, federal departments and agencies, such as the CDC, are unable to propose or implement new rules that were not already published in the Federal Register prior to noon on January 20, 2025, unless the proposed/new rule undergoes a process of review and approval by a person politically appointed or designated by this current administration.[21] It is unclear whether states like Ohio will continue to collect and distribute such comprehensive data for public review and use. Other states, such as Texas, have already faced public scrutiny[22] for its most recent Maternal Mortality and Morbidity Review Committee report[23] which omits data for maternal mortality following the Supreme Court *Dobbs v. Jackson Women's Health Organization*[24] decision which overturned *Roe v. Wade*.[25] Investigative claims suggest that the restrictive abortion ban in Texas[26] following the *Dobbs*[27] decision has resulted in additional fatal outcomes[28] and omitting this type of data from information from 2022 and 2023 will prevent this information from facing scrutiny or granting public access. As long-standing tools used by health law researchers are impacted by political shifts, it is imperative to accurately reflect historical practices and document the lessons learned to guide legal approaches of the future.

Many legal scholars have written about the ongoing battle for healthcare equity

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[18] "Pregnancy-associated death. The death of a woman while pregnant or anytime within one year of pregnancy regardless of cause." *Id*.

[19] "Pregnancy-related death. The death of a woman while pregnant or within one year of the end of the pregnancy, regardless of duration and site of pregnancy, from any cause related to or aggravated by her pregnancy or its management (e.g., from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by physiologic effects of pregnancy)." *Id* at 10.

[20] *Id* at 14.

[21] Executive Order, *Regulatory Freeze Pending Review* (January 20, 2025), available electronically at https://www.whitehouse.gov/presidential-actions/2025/01/regulatory-freeze-pending-review/ (last visited January 24, 2025).

[22] Elaine Mallon, *Texas Committee Won't Examine Maternal Deaths in First Years After Abortion Ban*, Washington Examiner (Nov. 27, 2024), available electronically at Texas health committee won't review maternal deaths in 2022, 2023 - Washington Examiner (last visited January 24, 2025).

[23] Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2024: As Required by Texas Health and Safety Code, Section 34.015, Texas Health and Human Services (September 1, 2024), available electronically at https://www.dshs.texas.gov/sites/default/files/legislative/2024-Reports/MMMRC-DSHS-Joint-Biennial-Report-2024.pdf (last visited January 24, 2025).

[24] 597 U.S. 215 (2022).

[25] 310 U.S. 113 (1973).

[26] Texas Health & Safety Code § 170A.002.

[27] Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022).

[28] Erika Edwards, Zinhle Essamuah and Jason Kane, *A dramatic rise in pregnant women dying in Texas after abortion ban*, NBC News (September 20, 2024) available electronically at https://www.nbcnews.com/health/womens-health/texas-abortion-ban-deaths-pregnant-women-sb8-analysis-rcna171631 (last visited January 24, 2025).

in America,[29] and maternal healthcare inequity follows a similar trajectory.[30] We have come to acknowledge and accept historical and contemporary[31] systemic inequity in healthcare access and outcomes in the United States. Current obstetrical guidelines[32] have recommended the implementation of comprehensive programs to standardize care, while Federal initiatives via executive actions[33] and passed legislation,[34] regulation of insurance coverage requirements,[35] and proposed legislation[36] attempt to reduce maternal inequity.

Americans spend nearly double the annual amount on healthcare expenses as the average per person expenditure than the median for other high-income developed countries.[37] In spite of, or perhaps in part due to, spending more per person on healthcare; the United States of America has become infamous for its maternal morbidity and mortality rates when compared to other nations with approximately 80% of pregnancy-related deaths determined as preventable.[38] Under the bright glare of international scrutiny of these statistics, the maternal mortality rate in the United States

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[29] The role of implicit bias in structural disparities in healthcare has been researched extensively by scholars such as Dayna Bowen Matthew, Dean of George Washington University Law School in books and articles cited throughout this publication. Dayna Bown Matthew, *Toward a Structural Theory of Implicit Racial and Ethnic Bias in Health Care*, Vol. 25 Health Matrix 61 (2015).

[30] United States Department of Health and Human Services, *Healthy Women, healthy Pregnancies, Healthy Futures: Summary of the U.S. Department of Health and Human Services' Action Plan to Improve Maternal Health in America*, December 2020 available electronically at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//197501/hhs-maternal-health-action-plan-summary.pdf (last accessed September 16, 2024).

[31] Laura Specker Sullivan, *Trust, Risk, and Race in American Medicine*, Vol. 50 Hastings Center Report Issue 1, 18 (February 18, 2020).

[32] The 2022 American College of Obstetrics and Gynecologists, *Severe Hypertension in Pregnancy Safety Bundle (2022)*, Alliance for Innovation on Maternal Health (2022).

[33] Joseph Biden-Kamala Harris, President and Vice President of the United States, July 10, 2024, Statements and Releases from the White House Briefing Room, *The White House Blueprint for Addressing the Maternal health Crisis: Two Years of Progress*, https://www.whitehouse.gov/briefing-room/statements-releases/2024/07/10/the-white-house-blueprint-for-addressing-the-maternal-health-crisis-two-years-of-progress/ (last visited September 16, 2024).

[34] Preventing Maternal Deaths Acts of 2018, Pub. L. No. 115-344, 132 Stat. 5047 (2018).

[35] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).

[36] Black Maternal Health Momnibus Act, S. 1606 (2023); Black Maternal Health Momnibus Act, H.R. 3305 (2023).

[37] Emma Wager, Matthew McGough, Shameek Rakshit, Krutika Amin, and Cynthia Cox, *How does health spending in the U.S. compare to other countries?*, Peterson-KFF Health System Tracker, https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ (last visited June 6, 2024).

[38] Susanna L. Trost, Jennifer L. Beauregard, Ashley N. Smoots, Jean Y. Ko, Sarah C. Haight, Tiffany A. Moore Simas, Nancy Byatt, Sabrina A. Madni, and David Goodman, *Preventing Pregnancy-Related Mental Health Deaths: Insights from 14 US Maternal Mortality Review Committees, 2008-17*, 1551 Health Affairs Volume 40, Number 10 (October 2021).

is increasing.[39] In 2021,[40] Black non-Latine[41] people who gave birth[42] were 2.6 times more likely to die after delivery than their White counterparts.[43] In 2021, approximately 30% of material deaths were Black patients as recorded by the CDC with a significant percentage of these deaths occurring in the post-partum period.[44]

The existence of race-based healthcare disparities is not a new challenge, the American healthcare system was created and continually developed with the expectation of disparate care and outcomes which embedded racial bias within our healthcare delivery.[45] Consequently, past initiatives that singularly targeted a metric or subset of the population have been inadequate to eradicate the disparities.[46] "Recent efforts to identify root causes of maternal health inequity have highlighted how a focus on individuals and their experienced risk factors–clinical, behavioral, and even social determinants–reflect actions of the individual rather than the historical, systemic, structural, and political forces that created them."[47] Legal scholars have painstakingly documented the lingering inequity despite attempted remedial measures.[48] Systemic inequity remains because the healthcare, legal, and societal changes are too siloed to combat such a foundational and pervasive problem.

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[39] O'Neille Hayes, *supra* Note 2.

[40] There is a lag in data availability for maternal health outcomes, years are noted to provide context with the understanding that intervening years between their availability and this publication may vary.

[41] Other categories of non-Black patients also have heightened maternal mortality rates in comparison to their White counterparts, each marginalized group necessitates their own in-depth analysis rather than grouping them in this paper when I have not dedicated an adequate amount of time and research to their unique societal position. More information can be located on these statistics, as published by the United States Centers for Disease Control. Donna L. Hoyert, *Maternal mortality rates in the United States*, 2021. NCHS Health E-Stats. 2023 https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm (last visited June 6, 2024).

[42] Availability of statistics and further discussion may be limited to cis-gender categories as gathered and/or reported. This paper does not purport or assume that gender-diverse individuals or minors do not give birth, but due to the limitation of data the word "woman" may be used even if the imprecise data collection includes other groups.

[43] O'Neille Hayes, *supra* Note 2.

[44] Our current national tracking systems are limited to the time when the person is pregnant and within forty-two (42) days following the termination of the pregnancy which has been designated as a maternal death by the World Health Organization. As a result, this time period is used by the CDC in the publication of its statistics. While utilized as an international standard, the origins for that timeline is historically due to religious and cultural practices rather than medical reasons. Late maternal death is an expansion that encompasses the twelve (12) months following the pregnancy termination. *See.* World Health Organization's World Health Assembly, International Statistical Classification of Diseases, Tenth Revision (WHO WHA ICD-10). (https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf) (https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/j.1471-0528.2003.03007.x Maternal mortality: only 42 days?) (WHO ICD- Tenth Revision).

[45] Stephen C. Kenny, "A Dictate of Both Interest and Mercy"? Slave Hospitals in the Antebellum South, 65 Journal of the History of Medicine and Allied Sciences, 1 (January 1, 2010).

[46] The prohibition of race-based (among other forms) discrimination for entities that received federal funding pursuant to Title VI of the Civil Rights Act of 1964, did not resolve enduring problems to obtain healthcare equity. Sara Rosenbaum & Sara Schmucker, *Civil Rights and the Courts in Shaping Health Equity; Viewing Health Equity through a Legal Lens: Title VI of the 1964 Civil Rights Act*, 771 Journal of Health Politics, Policy and Law, Vol. 42, No. 5, October 2017.

[47] Joia Crear-Perry, MD, et al., *Social and Structural Determinants of Health Inequities in Maternal Health*, Vol. 30 Journal of Women's Health No. 2, 230 at 231 (2021).

[48] *See* Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care*, pp 9 – 31 (2015).

Comprehensive systems within the United States require legal advocacy and judicial enforcement to take shape and maintain their structural integrity. Healthcare in this country is no different. Legal institutions helped form and further, both intentionally and inadvertently, the racial disparities that are currently enmeshed.[49] Practitioners, legal academics, legislators with law education and backgrounds, and the judicial system have an obligation to work purposefully and systematically to undo the damage done by the legal profession that aided in the entrenchment of inequity in American healthcare. Such approaches require historical context with multi-faceted solutions.[50] The previous health law approach of evaluating the actions of healthcare practitioners at arm's length based on slotting the role of health law into existing clinical framework[51] is justifiably falling away to a more influential role which incorporates social justice and equitable outcomes in the field of health law.[52] One way to target and dismantle existing inequity, is to develop a comprehensive understanding of the historical practices used to build and sustain delivery of women's healthcare in this country.[53] With a historically-informed knowledge base, legal institutions should advocate for and provide legal solutions to advance maternal equity with a pathway to properly address these embedded disadvantages. To design and maintain the field of healthcare law, we must propose innovations detached from the tether to pervasive inequity to work toward a comprehensive reconfiguration of healthcare delivery.

There exists a commonality between the geographically diverse patient populations of the average pregnant Black American[54] woman, an internationally awarded tennis star, Black pregnant women in Mississippi, Ohio, and Harris County, Texas. The connecting thread is the shared history of racist discrimination which spans the country and is woven into the fabric of American healthcare. This is not a quilt of unrelated events leading to the same outcome, there is a single cord that creates the knit of congruity for all these patients. There is significant contemporary legal research with in-depth analyses on social, economic, and environmental factors that impact the health

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[49] Erin C. Fuse Brown, J.D., M.P.H & Aaron S. Kesselheim, M.D., J.D., M.P.H., The History of Health Law in the United States, Vol. 387 The New England Journal of Medicine No. 4 289 (July 28, 2022).

[50] Contextual understanding matters: "You think you just fell out of a coconut tree? You exist in the context of all in which you live and what came before you." Kamala Harris, Vice President of the United States, May 10, 2023, Remarks at the Swearing-In Ceremony of Commissioners for the White House Initiative on Advancing Educational Equity, Excellence, and Economic Opportunity for Hispanics, https://www.whitehouse.gov/briefing-room/speeches-remarks/2023/05/10/remarks-by-vice-president-harris-at-swearing-in-ceremony-of-commissioners-for-the-white-house-initiative-on-advancing-educational-equity-excellence-and-economic-opportunity-for-hispanics/ (last visited June 6, 2024).

[51] Mark A. Hall, *The History and Future of health Care Law: An Essentialist View*, 41 Wake Forest L. Rev 347 (2006).

[52] Lois Shepherd, *Assuming Responsibility*, 41 Wake Forest L. Rev. 445 (2006).

[53] Brue G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, Journal of Health and Social Behavior, 80 (1995); Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care* (2015); Dayna Bowen Matthew, *Just Health: Treating Structural Racism to Heal America* (2022).

[54] Throughout this text I will use the racial description Black rather than the nationality indicator African American. From my review of the data and texts included as sources, I have been unable to determine whether the Black patients and medical subjects did not have origins from other parts of the diaspora (e.g. South American, Caribbean, etc.). Use of African American would unintentionally equate all subjects with the common origin of the African continent whose ancestors arrived in North America via the trans-Atlantic slave trade, and I have not verified that to be an accurate descriptor.

of individuals and groups of patient populations.[55] Rather than social determinants of health, this article will instead focus on race-based historical events that created, solidified, or advanced inequitable healthcare outcomes as supported by legal institutions to illustrate the disparities still prevalent in our current healthcare delivery system and why health law should play a role in its remedy. The parallel development of medical advancements with the evolution of race-based discrimination serves as a microcosmic view of the foundational problems created and this paper offers a clinically informed legal solution to help address the deeply entrenched issue of inequitable outcomes for maternal health. Much of the legal scholarship has examined the events detailed in this article in an isolated vacuum with a desire to inform the legal profession and offer course correction on a singularly focused ill, but there is a lack of connective relation to the historical perspective which, in turn, encourages a piecemeal approach that has proven inadequate to-date. For example, medical experimentation[56] is often discussed in a context disconnected from employment-based discrimination[57] although the availability of healthcare services (including experimental treatment) and insurance coverage via employment are intertwined.[58] Since race-based partiality was the intent of the formation and design of the American healthcare system when chattel slavery was a significant component of the economy, the support of a multitude legal institutions in its establishment and maintenance was required. This paper will illustrate, via poignant points of our country's history, an explanation for the inadequacies of singularly focused solutions to disentangle the relationship between racist healthcare development and its modern-day outcomes.

Medical inequity persists in America, in part, due to the establishment (via drafting legislation, judicial decisions, and scholarly articles) of historical and modern legal precedent that perpetuates these outcomes. Those who have received legal education and training have an obligation to offer up insight and solutions to disassemble the mechanisms that enable race-based inequity rooted in the American healthcare system because our profession was instrumental in its creation and sustainability. This article seeks to unveil some widespread and seemingly disparate historical precedents related to medical research, the segregation of medical care for patients and training for practitioners, and the availability of health insurance coverage that have contributed to racial inequity in healthcare and prompt a broader conversation on the role of the law to work toward the disassembly of the portions of the healthcare delivery system that continue to bolster the disparities. Due to the role of our professional predecessors, legal institutions have an obligation to understand our historical role to effectively design wholistic and informed solutions to achieve impartiality for patient care and health outcomes. If we acknowledge and accept that American healthcare advanced and developed in tandem with purposeful race-based inequality, we can then focus on solutions to raze the interconnectivity between race

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[55] Frank Khalik & Alisa Lincoln, *Salus Populi*: Educating Judges on the Social Determinants of Health, 260 Journal of Legal Education, Volume 71, Number 2 (Winter 2002).

[56] Kenny, *supra* Note 36 at 12; Deleso Alford Washington, *Examining the "Stick" of Accreditation for Medical Schools Through Reproductive Justice Lens: A transformative Remedy for Teaching the Tuskegee Syphilis Study*, 26 J. Civ. Rts. & Econ. Dev. 153.

[57] Ronald L. Lewis, *Black Coal Miners in America: Race, Class, and Community Conflict, 1780-1980*, at 89 (1987).

[58] Madeline T. Morcelle, *Reforming Medicaid Coverage Toward Reproductive Justice*, 48 American Society of Law, Medicine & Ethics, 223 (2022).

and healthcare delivery in maternal care.

Part I of this article, *Building Blocks of American Race-Based Healthcare Inequity*, will discuss the early development of the American healthcare system and its coexistence with the establishment of a nation with a racial hierarchy. American medical professionalism and the establishment as a scientific field emerged alongside the widespread practice of enslavement of Black people in America, and thus it was impossible for the field to exist or develop without the societal ideas of racism and exclusion in the practice of medicine or treatment. Part II, *Frankenstein's Medicine: Experimentation, Eugenics & Treatment*, will highlight examples of inequity that impacted obstetrical health throughout the Colonial Period, in the Antebellum South, and during the Jim Crow Era following emancipation. The modernization of the healthcare system to one where practitioners increasingly provide services in hospital settings and push to learn from medical experimentation continued to incorporate racist attitudes and conduct of the larger society and were not appropriately addressed or eradicated following societal and medical integration. Part III, *The Birth of a Nation's Medical Insurance Industry*, will discuss the racial tensions as healthcare evolved payment mechanisms outside of direct cash payments from patients to healthcare providers. The health insurance industry emerged while tied to employment, which relied upon the existing race-based discriminations associated with labor in a country where slavery and professional exclusion were legally acceptable practices. In Part IV, *Potential for Comprehensive Solutions*, of the article I propose the alteration of current maternal safety bundles[59] to build upon these existing structures which authorize the collection of data and advocate for uniformity in obstetrical care practices to provide a legal solution that is historically informed and consistent with the self-interest of practitioners. My proposed alteration both furthers to goal for maternal healthcare equity as a connection with practitioner self-interest to make a workable solution anchored in an evidence-based clinical approach developed by medical practitioners.

I. BUILDING BLOCKS OF AMERICAN RACE-BASED HEALTHCARE INEQUITY

> *The work of dehumanization is to substantially and sufficiently distinguish oneself from another group of people, so that treatment that plainly would violate human decency if directed toward you becomes permissible, justified, or even desirable in light of the rationalization that the other group is nothing like you. If the other group is not human, then there is no need to treat its members as human.*[60]

A. Inferiority, an Exclusionary Bedrock

To evaluate the roots of purposefully discrimination in healthcare treatment in this country, we must go back to the infancy of the notion of the nation. A racial

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[59] Medicare and Medicaid Programs: Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals, 89 Fed. Reg. 59489 (July 22, 2024).

[60] Dayna Bowen Matthew. *Just Health: Treating Structural Racism to Heal America*, 58 (2022).

hierarchy[61] is among the foundational concepts within the creation of the American colonies, this ideology naturally translated to a difference between patient treatment and clinical services within the burgeoning American healthcare system. The enslavement and indentured servitude practices of European colonist [62] became enforceable within the bounds of the legal parameters established in the early creation of American jurisprudence.[63] Some of the original codified laws governing the colonies were contained in the Virginia Acts in the early eighteenth century included the legal solidification of inherited servitude for offspring,[64] which supports a theory that racial inequality was a primary societal concern addressed by colonists half a century before the Declaration of Independence was drafted.[65] Although indentured servants were not originally determined by race, there were even striations of servitude with Black indentured servants available for this life-long status and White servants exempt from this classification.[66] This foundational priority was thus recognized and upheld in the earliest iterations of the judicial system.[67] Courts continuously enforced the doctrine of inherited status of enslavement throughout the colonial period and after the founding of the United States of America.[68] The development of the practice of medicine happened alongside the widespread practice of enslavement and societal inequality.

In the early 1720s, the Smallpox virus was spreading internationally and

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[61] Entire races were prohibited from voting regardless of status as enslaved or free. General Assembly. ""An Act directing the trial of Slaves, committing capital crimes; and for the more effectual punishing conspiracies and insurrections of them; and for the better government of Negros, Mulattos, and Indians, bond or free" (1723)" Virginia Acts of 1723 Section XXII, pp 133-134.

[62] Early Colonial legislation established separate and distinct laws for people bound by indentured servitude and slavery. Warren M. Billings, *The Law of Servants and Slaves in Seventeenth-Century Virginia*, The Virginia Magazine of History and Biography, Vol 99 No 1, 45 (1991).

[63] William Goodell, *The American Slave Code in Theory and Justice; its Distinctive Features Shown by the Statutes, Judicial Decisions, & Illustrative Facts* (1853).

[64] General Assembly. "Negro womens (sic) children to serve according to the condition of the mother" Virginia Acts of 1662 Section XII, at 170.

[65] The Declaration of Independence was not adopted by the Continental Congress until July 4, 1776. National Archives, Declaration of Independence (1776), https://www.archives.gov/milestone-documents/declaration-of-independence (last visited on February 28, 2024).

[66] Bowen Matthew, *supra* Note 51 at 60.

[67] Howell v. Netherland, 1770 Va. LEXIS 1, *4-5 Samuel Howell, an indentured servant because his grandmother was white and his grandfather was black, argues the Virginia Act of 1723 should not apply to grandchildren. The court finds the Act of 1723 inapplicable and includes several quotes of the Virginia Act of 1705: "…c. 49. s. 18. 'If any woman servant shall have a bastard child, by a negro or mulatto, or if a free Christian white woman shall have such bastard child by a negro or mulatto; in both the said cases the churchwardens shall bind the said child to be a servant until it shall be of thirty-one years of age.' In other parts of the act, it is declared who shall be slaves, and what a manumission of them; from sect. 34. to 39. are regulations solely relative to slaves, among which is sect. 36. 'Baptism of slaves doth not exempt them from bondage; and all children shall be bond or free according to the condition of their mothers and the particular directions of this act.'…For having proved that servitude to be rightful, must be founded on either compact, or capture in war, he proceeds to shew that the children of the latter only follow the condition of the mother: for which he gives this reason, that the person and labor of the mother in a condition of perfect slavery, (as he supposes to be that of the captive in war) being the property of the master, it is impossible she should maintain it but with her master's goods; buy which he supposes a debt contracted from the infant to the master." Samuel Howell lost the case due to his inherited servitude. Samuel Howell was represented by future United States President, Thomas Jefferson. Thomas Jefferson's Argument in Howell v. Netherland (1770), Encyclopedia Virginia, Virginia Humanities, (07 Dec. 2020), https://encyclopediavirginia.org/primary-documents/thomas-jeffersons-argument-in-howell-v-netherland-1770/ (last visited January 17, 2024).

[68] Butler v. Boarman, 1 H. & McH. 371; Mahoney v. Ashton, 4 H. & McH. 295.

reached the metropolitan area of Boston, Massachusetts.[69] Although the process of acquired immunity had been documented and practiced in other parts of the world, variolation[70] (this would later evolve into the process of immunization) was an uncommon practice in the colonies.[71] During this time period, there were nearly forty-two thousand enslaved people living in the as-yet-unfounded United States of America.[72] As the medical community was gathering evidence and spreading knowledge about the practice of small pox inoculation, a minister in Boston Massachusetts confirmed efficacy of piercing small pox sores to inoculate healthy people to help them develop immunity. This minister, Cotton Mather, obtained this knowledge from an enslaved man named Onesimus[73] who was gifted to the minister by his parishioners in the early 1700s.[74] This method led to a wide-spread introduction of the procedure and this public health movement would later become the basis for George Washington's mandate to inoculate soldiers during the American Revolutionary War.[75] While unable to participate in the medical profession, Black people continually made significant contributions to the advancement of American healthcare. Medical knowledge was gained from people like Onesimus who willingly shared their unacknowledged expertise and from scores of known and many more unknown non-consenting patients whose contributions were forcibly obtained.[76]

B. Less of an Art, More of a Science

During the formative years of this nation, the profession and practice of medicine is likely unrecognizable to modern patients who are unfamiliar with its current evolutionary state. Circa the 1850s and 1860s, the practice of medicine begins to include an understanding of microscopic pathogens, preventative and interventionist management of overall health. This led to a scientific consensus that there is a link between specific diseases and microorganisms.[77] This connection is known as the "germ theory of disease" school of thought, which resulted in major advancements such

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[69] Brian D. Abramson et al., *Vaccine, Vaccination, and Immunization Law*, ch. 1, § 1.III.C. (2022) (ebook).

[70] The process of intentionally exposing healthy people to contagions to inoculate them against a more severe illness. *Id*.

[71] America founded with Declaration of Independence July 4, 1776 with the American Revolution fought from April 19, 1775 – September 3, 1783. 19 Stat. 216; 44 Pub. Res. 19; Demos v. Waddington, No. 03-489-S, 2004 U.S. Dist. LEXIS 654 (D.R.I. Jan. 20, 2004).

[72] This population increased by 60% by the end of the 1720s. J. David Hacker, *From '20. and odd' to 10 million: the growth of the slave population in the United States*, Slavery & Abolition, Vol 41 No 4, 840-855 (2020).

[73] Onesimus was gifted to Cotton Mather by his parishioners in 1707. Arthus Boylston, *The Origins of Inoculation*, 309 Journal of the Royal Society of Medicine, Volume 105, Issue 7 (July 28, 2012).

[74] The ability to give and received enslaved people as property was recognized and protected in the judicial system. Early colonial cases involved the resolution of disputes for the disposition of enslaved people or allocation of damages due to the loss of the value of those enslaved individuals. *See generally. Marston v. Parish*, 1730 Va. LEXIS 1; *Waddy v. Sturman*, 1731 Va. LEXIS 2 (Apr. 1, 1731).

[75] Boston National Historical Park, *Smallpox, Inoculation, and the Revolutionary War*, https://www.nps.gov/articles/000/smallpox-inoculation-revolutionary-war.htm (last accessed on March 4, 2024).

[76] L. Lewis Wall, *J. Marion Sims and the Vesicovaginal Fistula: Historical Understanding, Medical Ethics, and Modern Political Sensibilities*, 66 Issue 2, Volume 24 (March/April 2018).

[77] John Steele Gordon, *A Short History of American Medical Insurance*, Volume 47 Imprimis Issue 9 (September 2018).

as prevention of wound infection.[78]

In the United States, these medicinal marvels were unfolding in tandem with the trans-Atlantic slave trade. While the concept of bacteria and viruses were the direct causes for infections were taking hold in the development of modern medicine in 1860, there were approximately 4 million people enslaved in America.[79] During this era, care for enslaved people remained under the directive and non-regulation of slave-owners who could personally reject medical advancements and more costly treatment options while non-enslaved Black Americans could be denied care by facilities and practitioners based on their race. Physicians who were beginning to form professional training informed by scientific discovery were more likely to treat White Americans in more sanitary conditions.[80] It should be noted, that while the physicians treating White Americans were more likely to be informed by emerging professions standards, there were still many hurdles to clear for healthcare standardization.[81] "In 1850 the U.S. had 40,755 people calling themselves physicians…Few of this legion had formal medical education, and many were unabashed charlatans." [82] Society reinforced racial disparities in healthcare with the duality of these healthcare pathways and continued to interweave discriminatory treatment with scientific achievements.

With the passage of the 13th Amendment of the United States Constitution in 1865 to formally abolish slavery,[83] came an era of codified and *de facto* race-based discrimination with the purpose of keeping Black and White populations separated with limited instances of interaction without regard to emancipation status widely known as "Jim Crow."[84] This societal separation was, of course, recognized and enforced by the Supreme Court in the landmark decision of Plessy v. Ferguson which permitted "separate but equal accommodations" and those living within jurisdictions that enacted these rules were stripped of personal discretion to violate these regulations.[85] The end of slavery did not result in equal access to healthcare or universal ethical conduct within the healthcare system. Additionally, Jim Crow regulations required clinicians to use the substandard practices, locations, and medications as determined by racist ideologies commonly practiced or codified in the jurisdiction. Jim Crow discrimination was enmeshed within the fabric of American lifestyles, including the way in which individuals and groups sought and paid for healthcare.

The development of the germ theory accompanied the initial wave of the

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[78] *Id*.
[79] Khushbu Shah and Juweek Adolphe, *400 years since slavery: a timeline of American history*, The Guardian (August 16, 2019).
[80] Kenny, *supra* Note 36 pp 9 – 17.
[81] Whitfield J. Bell Jr., *A Portrait of the Colonial Physician,* Volume 44 Bulletin of the History of Medicine Number 6, 497 (November – December 1970).
[82] Gordon, *supra* Note 68.
[83] National Archives, 13th Amendment to the U.S. Constitution: Abolition of Slavery (1865), https://www.archives.gov/milestone-documents/13th-amendment#:~:text=Passed%20by%20Congress%20on%20January,slavery%20in%20the%20United%20States. (last accessed February 28, 2024).
[84] *303 Creative LLC v. Elenis*, 600 U.S. 570, 143 S. Ct. 2298 (2023).
[85] *Plessy v. Ferguson*, 163 U.S. 537, 16 S. Ct. 1138 (1896). The separate but equal doctrine would not be overturned until 1954 with the Brown v. Board of Education decision. *Brown v. Board of Education*, 347 U.S. 483, 74 S. Ct. 686 (1954).

transition[86] of the of the primary site of care for acute treatment from the home of the patients to a hospital setting. This advancement meant the cost to render care in a hospital increased healthcare expenditures for patients.[87] At the beginning of the twentieth century, the conundrum of additional cost with the shirking availability of nonhospital-based care[88] created an opportunity to innovate while in the climate of Jim Crow enforcement. Since this transformation coincided with legally enforceable racism, the advent of the American health insurance industry and societally acceptable Jim Crow norms resulted in an interknit relationship between the two further discussed in Section II of this article.

II. FRANKENSTEIN'S MEDICINE: EXPERIMENTATION, EUGENICS & TREATMENT

> *The systematic, institutionalized denial of reproductive freedom has uniquely marked Black women's history in America.*[89]

The care provided from the American Colonial Period and continuing thereafter included a fundamental attitude within the medical profession that Black people were physiologically and biological so dissimilar from White people, that medical advice and treatment had to be provided on the basis of these differences and under a separate set of conditions.[90] For centuries medical practice incorporated the ideas that Black people did not experience pain as acutely as White people.[91] This beliefs naturally lead to the desire to perform medical experiments on enslaved people in an attempt to substantiate the assertion and simultaneously advance medical knowledge for non-Black patients in direct contradiction to this inherent hierarchy claim.[92] The explicit acknowledgement of inferiority of Black people extended beyond the status of enslavement and was enforced within our legal system.[93] Legal support for this viewpoint, enabled other areas of society including healthcare delivery to continue with inequity as a foundational tenant to its existence. While enslaved, the care or absence of such for Black people was subject to the conditions and oversight of the owner of an enslaved person.[94] Enslavers provided medical care for the enslaved in various degrees and in different settings, including slave hospitals.[95] Fitness for manual labor tasks rather than healthy lifestyle would have been the focus of care (when allowed) for enslaved people[96] "Most slave hospitals in the American South, especially those with commercial and experimental roles, did not operate simply to provide patients with comfort, warmth, and light; rather they functioned as mechanisms for the maintenance,

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[86] *See* Barbara Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1865 – 1925*, Chapter 3 (2005).
[87] Gordon, *supra* Note 68.
[88] *Id*.
[89] Dorothy Roberts. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 4 (1997).
[90] Kenny, *supra* Note 36.
[91] Hannah-Jones, *supra* Note 5, at 318.
[92] Todd L. Savitt, *The Use of Blacks for Medical Experimentation and Demonstration in the Old South*, 48 The Journal of Southern History, 331 (August 1982).
[93] Collins v. Hall, 1 Del. Cas. 652 (Sup. Ct. 1793). A case in which Levin Thompson, a Black man who was born free with free parents in Maryland, was unable to serve as a judicial witness because he was deemed inferior and without significant rights by the court.
[94] Young v. Forgey, 5 Tenn. 9 (May 1, 1817).
[95] Kenny, *supra* Note 36.
[96] *See* Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (2006).

restoration, insurance, and enhancement of commercial value for the objectified chattel they housed, as well as to provide spaces in which southern doctors could develop their knowledge, raise their profile, and sharpen their professional skills."[97]

Even with documented contributions noted herein to medical advancement by Black people in America, racist discrimination often barred their contemporaneous acknowledgement or actively prohibited their official recognition. The first Black doctor in the United States opened his medical practice in 1839, but Dr. James McCune Smith could not obtain his medical degree in America.[98] Due to the ferocity of America's commitment to race-based inequality, Dr. McCune Smith was forced to earn his degree from the University of Glasgow in Scotland after he was denied the opportunity to attend in his country of birth.[99] Restrictions to development and training opportunities for Black healthcare professionals increased the likelihood that Black patient populations would encounter clinicians unwilling to treat them or increased the possibility that when treated they would receive inferior care. Dr. McCune Smith's achievements are in spite of and in defiance to all the American societal and legal barriers to success, others who lacked this same access were locked out of any viable pathway to formal medical education and training. This absence of Black practitioners meant medical care for Black patients was often rendered by practitioners who fervently believed these patients had physical and mental inferiorities.

Alongside the brutalism of American chattel slavery, scientific advancements were developing the nascent understanding that underlies our current system of the practice of medicine. Medical experimentation continued to develop as a necessary and respected form of the proliferation of scientific innovation.[100] One group subjected to forced experimentation were enslaved women who suffered from vesicovaginal fistulas[101] in the 1840s who were operated on, without anesthesia, by J. Marion Sims who received the moniker "The father of gynecology" for his surgical advancements in this area of medical practice.[102] Although the use of anesthesia was rare during this time for all patient populations, the forced procedures that were repeated on the same patients to create a new surgical approach is considered inhuman and barbaric by today's medical standards. There is a valid argument that the treatment would have been viewed at least unfavorably at that time, which is why the medical subjects were enslaved women and girls.[103]A statue depicting three of Sims's involuntary test subjects, enslaved girls Anarcha, Lucy, and Betsey, titled Mothers of Gynecology has been

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[97] Kenny, *supra* Note 36.

[98] Neil Krishan Aggarwal, *The Legacy of James McCune Smith, MD – The First US Black Physician*, The Arts and Medicine, November 29, 2021, https://jamanetwork.com/journals/jama/fullarticle/2786889, (last accessed on March 4, 2024).

[99] Bryan Greene, *America's First Black Physician Sought to Heal a Nation's Persistent Illness: An activist, writer, doctor and intellectual, James McCune Smith, born enslaved, directed his talents to the eradication of slavery*, Smithsonian Magazine, February 26, 2021, https://www.smithsonianmag.com/history/james-mccune-smith-america-first-black-physician-180977110/ (last accessed August 5, 2024).

[100] *See* Harriet A. Washington, *supra* Note 87.

[101] Vesicovaginal fistula is an abnormal opening between the bladder and the vagina that results in continuous and unremitting urinary incontinence, often resulting after a difficult birth with women who have nutritional deficiencies. Michael Stamatakos, Constantina Sargedi, Theodora Stasinou, & Konstantinos Kontzoglou, *Vesicovaginal Fistula: Diagnosis and Management*, 76 Indian Journal of Surgery 2, 131 (April 2014).

[102] Wall, *supra* Note 67.

[103] Washington, *supra* Note 87 at Part I Chapter 2.

erected in Montgomery, Alabama in acknowledgement of their contributions to this field.[104] While Sims documented his surgical experiments over a five-year period, it is only conclusively stated that Anarcha (who was subjected to 30 operations in a three year period)[105] received successful surgical treatment at the end of the trial. It is unclear if the other enslaved women ever received the corrective surgery once the approach and suture material were proven safe enough for White women.[106]

Not unlike the early development of gynecological medicine,[107] the specialty of gynecology continued to utilize nonconsenting Black women as subjects.[108] Widespread sterilization practices, often colloquially referred to as a "Mississippi appendectomy" [109] due to their frequent occurrence for poor Black women, implemented eugenic practices[110] and permitted inexperienced doctors the opportunity to learn how to perform the procedure.[111] In addition to medically unnecessary forced surgical sterilizations, passive eugenics and infertility were also permitted with other types medical experimentation. One of the most infamous clinical trials[112] occurring from 1932 through 1972, was the U.S. Public Health Service Syphilis Study at Tuskegee, Alabama,[113] which observed the progression of untreated syphilis.[114] Researchers designed an observational study for hundreds of Black male participants infected with syphilis.[115] These participants were not offered clinically appropriate treatment even though the correct treatment became widely available during the course of the study and were instead given non-treating injections.[116] The race and socioeconomic status of the medical study subjects supported the medical community's false inferiority view[117] of those patients. As a result of the inaction of those involved

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[104] Safiya Charles, *Event Honors Enslaved Women Subject to Gynecological Experiments in Alabama*, Southern Poverty Law Center (March 1, 2024) available electronically at https://www.splcenter.org/news/2024/03/01/event-honors-mothers-of-gynecology (last visited August 18, 2024).

[105] Joel D. Howell, *Understanding Black Distrust of Medicine*, Findings Magazine, University of Michigan School of Public Health (Spring 2021).

[106] *Id*.

[107] *See* Dineo Khabele, Kevin Holcomb, Ngina K. Connors & Linda Bradley, *A Perspective on James Marion Sims, MD, and Antiblack Racism in Obstetrics and Gynecology*, Volume 28 Journal of Minimally Invasive Gynecology Issue 2, 153 (February 2021).

[108] *See* Lutz Kaelber, *Eugenics: Compulsory Sterilization in 50 American States*, 2012 Social Science History Association presentation, available electronically at https://www.uvm.edu/%7Elkaelber/eugenics/ (last visited on August 9, 2024).

[109] Rebecca Skloot. *The Immortal Life of Henrietta Lacks*, 50 (2010).

[110] Bowen Matthew, *supra* Note 51 pp 122 – 123.

[111] Skloot, *supra* Note 100 at 50.

[112] James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (1993), 91.

[113] The study was named "The Tuskegee Study of Untreated Syphilis in the Male Negro." R.A. Vonderlehr, Taliaferro Clark, O.C. Wenger & J.R. Heller, Untreated Syphilis in the Male Negro: A Comparative Study of Treated and Untreated Cases, 107 JAMA 856-60 (1936). See Centers for Disease Control and Prevention, U.S. Public Health Service Syphilis Study at Tuskegee, available at http://www.cdc.gov/tuskegee/timeline.htm.

[114] Deleso Alford Washington, *Examining the "Stick" of Accreditation for Medical Schools Through Reproductive Justice Lens: A transformative Remedy for Teaching the Tuskegee Syphilis Study*, 26 J. Civ. Rts. & Econ. Dev. 153.

[115] Syphilis is a sexually transmitted disease that can cause health effects when it goes untreated and can be passed to unborn children by an infected pregnant person, infections in utero can result in an increased risk of stillbirth delivery or infant death. Centers for Disease Control and Prevention. https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm (last accessed March 14, 2024).

[116] 260 Conn. 785.

[117] Washington, *supra* Note 87.

in the conduct and oversight of the study, the males observed (along with the women and children excluded from the selection criteria who were infected by the study participants) experienced unnecessary disease progression and death within their families and communities.[118] We have an opportunity to examine "the biomedical significance of overlooking the women directly impacted from the study, both in the past and today."[119] Even though researchers excluded women from this experiment, their absence reveals the insignificance with which Black women were viewed by the medical profession in the observation of healthcare consequences and study.[120]

Dubiously structured medical tests were not limited to groups of similarly situated patient populations, some experimentation was limited to a single subject. Henrietta Lacks went to Johns Hopkins Hospital[121] in 1951 for cervical cancer surgery, and without her informed consent[122] the doctors involved in her surgery harvested her cancerous cells for medical research. The consent she signed was so lacking in detail, that Lacks did not realize the surgery left her unable to have more children.[123] It would not have been uncommon for a patient to lack informed consent for a procedure because the federal rules standardizing this requirement for medical research on human subjects[124] were not formalized until decades after this encounter,[125] but the concept to continuously inform a research subject of the proposed course of action, rationale for the clinical approach, and potential consequence[126] could have occurred if the medical staff had been willing.[127] Lacks became an unwitting, and long-time unrecognized,[128] contributor to one of the most impactful and wide-ranging set of global medical advancements.[129] Her harvested cells, coined HeLa cells by medical researchers,[130] led to a plethora of medical advancements. "[T]he polio vaccine, gene mapping, and in

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[118] Washington, *supra* Note 105.
[119] *Id* at 163.
[120] *Id* at 153.
[121] Johns Hopkins was the only major hospital in the area that treated Black patients, but the treatment was rendered in segregated wards. Skloot, *supra* Note at 15.
[122] Henrietta Lacks signed a general consent statement for treatment of her cervical cancer, but not for the subsequent experimentation with the use of the cells removed during her surgery. *Id* at 31.
[123] Skloot, *supra* Note at 47.
[124] 45 C.F.R § 46.116
[125] Public Law 93-348 § 202(a)(1)(B)(iv) (July 12, 1974) available electronically at https://www.govinfo.gov/content/pkg/STATUTE-88/pdf/STATUTE-88-Pg342.pdf (last accessed on August 18, 2024).
[126] *See* Washington, *supra* Note 87 at Chapter 2.
[127] Contemporarily, informed consent is not immune from societal pressures based on some internalized bias of physicians when considering women's healthcare decision-making process. *See* Amelia Landenberger, *Flattening Breast Cancer by Removing the Breasts: Protecting a Woman's Right to Choose Reconstruction of an Aesthetic Flat Chest after a Mastectomy*, 25 GEO. J. GENDER & L. 1197 at 1213 (Spring 2024).
[128] *See* Skloot, *supra* Note 100 at 4, pp 105 – 109.
[129] Law360 A LexisNexis Company, 5 Major Drug and Device Developments of 2022, January 6, 2023, https://plus.lexis.com/api/permalink/456d1a4a-90da-477f-988f-61575c7eaa8a/?context=1530671.
[130] Skloot, *supra* Note 100 pp 1 – 2, 37.

vitro fertilization" are among the most notable developments.[131] The profitability of Lacks's cells spurred medical dynasties and built infrastructure,[132] while she was buried in an unmarked grave[133] with her surviving family members impoverished.[134] Lacks's biological material was valued, but her humanity was discarded throughout her course of treatment and the postmortem cellular research conducted by countless academics and professionals. Not until decades after Lacks's death would we see a significant increase of federal regulation of medical research[135], which occurred shortly after the federal government began to supplement healthcare costs[136] for individuals to address continually rising expenses for patients who lacked private health insurance.

III. THE BIRTH OF A NATION'S MEDICAL INSURANCE INDUSTRY

> *[The] industrial sickness funds…formed the basis of the American system of associating health insurance benefits with the workplace. Because of such institutions Americans began to connect health insurance with their employer.*[137]

Among some of the early advancements in American healthcare, was the centralized delivery of medical care in a hospital setting. Operations began at a New York facility, which was the first hospital within the colonies beginning its operations in 1658. This facility treated soldiers and Black people enslaved in the service of the Dutch West Indian Company.[138] It would take time for the concept of hospital-based care to gain its foothold but even in the Philadelphia area, an early adapter of hospital-

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[131] Mary Anne Pazanowski, *Henrietta Lacks' Family Settles Lawsuit Over Use of Famed Cells*, Bloomberg Law, August 1, 2023, https://www.bloomberglaw.com/product/blaw/bloomberglawnews/bloomberg-law-news/X2BRVDKG000000?bc=W1siU2VhcmNoICYgQnJvd3NlIiwiaHR0cHM6Ly93d3cuYmxvb21iZXJnbGF3LmNvbS9wcm9kdWN0L2JsYXcvc2VhcmNoL3Jlc3VsdHMvN2NkYzBkMzFjYjAxMTZhNzEwODk3NzM0NjEwYjkzNGMiXV0--915c82a02dd7568b6fcede94f44e5d03e6bc27f8&criteria_id=7cdc0d31cb0116a710897734610b934c&search32=Mf-JIRP3MXHf_qQcsvgsgg%3D%3DNPqBIMGOR4CoGDLumUAMnlulCx68I9Q99VKRdY4A-P3yCTwrbTPx0l8ODfdFyz5sWqGlmq6sCvnjFa-kTqgMRG-Ut8_rPxlnZ1BFZ9AVsDHKbfRW3nENaOMs7EwrtaSu-PbiRuxmnyjrmj_Brh4Mee6bx8wPrRhI_uoiWel9lJ0%3D.

[132] Shortly after Lacks's death, a HeLa factory was built to produce cells to produce polio vaccines. Skloot, *supra* Note 100 at 91.

[133] *Id* at 121.

[134] *See Id.*

[135] *See* Pub. L. No. 93-348 § 202(a)(1)(B)(iv) (July 12, 1974) available electronically at https://www.govinfo.gov/content/pkg/STATUTE-88/pdf/STATUTE-88-Pg342.pdf (last accessed on August 18, 2024).

[136] Medicare, a health insurance program primarily for the elderly, and Medicaid, a health insurance program for people with limited income, were signed into law in 1965. Pub. L. No. 89-97 Social Security Amendments of 1965 (July 30, 1965).

[137] John E. Murray, *Origins of American health Insurance: A History of Industrial Sickness Funds*, 6 (2007). Although two types of industrial sickness funds (establishment funds and labor union funds) emerged and eventually evolved into the health insurance benefits more recognizable in this paper, I have conflated these two types of fundings into the single category of employer-provided health insurance due to their similar origins. *Id*.

[138] John E. Ransom, *The Beginnings of Hospitals in the United States*, Vol 13 Bulletin of the History of Medicine No. 5, 514, 521 (May 1943).

based care,[139] it would be centuries before a hospital for Black patients, unassociated with a relationship to a prominent captor, Douglass Hospital to begin operations. Douglass Hospital was established to address the segregated care delivered by the existing healthcare system when it was founded in Philadelphia in 1895. Douglass Hospital served as a facility to train Black physicians and nurses who were often prohibited from training at other facilities that treated White patients.[140] It would require much more progress to establish regulations related to medical best practices, licensure,[141] and professional ethics and expectations. These norms which developed the standard of care for the medical profession evolved alongside the legal acknowledgment and enforcement of the false assumption that Black people were interior to their White counterparts.[142] Outside of the original colonial territories, healthcare for the enslaved population in the southern region was offered through a variety of delivery systems, including, plantation hospitals, medical school hospitals, private infirmaries, and commercial hospitals.[143] It is of note that care provided to enslaved people in buildings that bore one of these labels could be more accurately described as out buildings or shacks and not consistent with the concept of a hospital setting for White patients.[144]

In the 1920s, employer-provided health insurance emerged independent of charitable and religious support[145] to address the cost concerns of workers who received treatment in hospitals.[146] A collective of approximately 1,500 schoolteachers in the Dallas, Texas area created a symbiotic relationship with Baylor University Hospital, this group paid an annual premium of six dollars in exchange for up to twenty-one days of hospital care at Baylor University Hospital.[147] Hospitals could attract better-trained personnel and provide more advanced courses of treatment than home visit physicians who were limited to tools which were mobile and limited by transportation hurdles.[148] Located in Texas, Baylor University Hospital was designated as a hospital for White patients where Black physicians were prohibited from the practice of medicine, serving in any staff role, and which only had minimal access for treatment of Black patients.[149] Insurance tied to labor,[150] which was already a deeply

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[139] William H. Williams, PhD, *The Early Days of Ango-America's First Hospital: The Pennsylvania Hospital, 1751-1775*, JAMA, Vol 220 No 1, 115 (1972).

[140]Russell F. Minton, M.D., *The History of Mercy-Douglass Hospital*, Vol 43 Journal of the National Medical Association No 3, 153 (May 1951).

[141] The Act of February 26, 1824 (Ohio), deprived persons who were not members of medical societies, nor licensed, from the aid of the law in the collection of their debts (e.g. voiding contract, imposing a fine for practicing medicine for pay). Nichols v. Poulson, 6 Ohio 305, 305 (1834).

[142] "Negro medicine" developed as a specialty based on this assumption. *See* Kenny, *supra* Note 36 at 12.

[143] Kenny, *supra* Note 36.

[144] Washington, *supra* Note 87 at Part I.

[145] Mann Wall, *supra* Note 77.

[146] Gordon, *supra* Note 68.

[147] Gordon, *supra* Note 68.

[148] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (2023).

[149] The predecessor for Baylor University Hospital, Texas Baptists Memorial Sanatorium, did have 250 beds with 1 reserved from Black patients as of records from October 1909, but it is unclear how many Black patients were admitted or treated there. Notably, Black patients had to have their physicians transfer their care to a White physician due to the prohibition on joining the medical staff. Lauren Fine MD, *We are our history: Baylor University Medical Center and Black physicians in Dallas*, v.37(2) Proc (Bayl Univ Med Cent) eCollection 2004 185, February 8, 2024, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10857562/ last accessed March 13, 2024.

[150] Ulrich Bonnell Phillips, *American Negro Slavery*, Chapter XIX Business Aspects of Slavery (1918).

segregated practice continuing after the abolition of slavery,[151] further coalesced the likelihood that mistreatment of Black patients would continue. Black people who resided in Dallas were more likely to receive treatment at a facility like Bluitt Sanatorium, which was more of an amalgamation of a Black professional office building with patient care on the top floor than a formal hospital environment.[152] As with the coupling of Jim Crow laws in response to emancipation, so too came the rise of Ku Klux Klan membership in Dallas in the 1920s as Black medical and other professionals attempted to gain a foothold in the area. Around the time of the Bluitt Sanatorium's opening, which was needed in response to the segregation enforced at Baylor University Hospital, the local Ku Klux Klan membership expanded and is estimated to have been the highest per capita membership of any US city with one-third of all eligible men in Dallas obtaining membership.[153] Not only were Black patients severely limited from receiving the care now pioneered by the region, they were also intimidated from legal recourse if their access to or use of the available care was hampered by the actions of the Ku Klux Klan.[154]

Also at the dawn of the twentieth century, in the Pacific Northwest area of the country the link between health and employment status was developing with the creation of Blue Shield.[155] Healthy workers are able to continue to perform services for their employer, so owners of logging operations and mines created a plan to pay both individual physicians and groups of practitioners a monthly fee to provide treatment on a *pro re nata* basis.[156] While discrimination in the region may not have been an exact

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[151] Ruqaiijah Yearby, Brietta Clark & José F. Figueroa, *Structural Racism in Historical and Modern US Health Care Policy*, Volume 41 Health Affairs Issue 2: Racism & Health, 157, at 188 (February 2022) available electronically at https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.01466 last accessed August 9, 2024.

[152]"The facility provided medical care for inpatients as well as office and clinic space for Dr. Bluitt and several other local African American physicians. The basement had a 'cleaning establishment' run by Bluitt's nephew, the second floor contained Dr. Bluitt's office as well as a dental office and an attorney's office, and the top floor was used for patient care." Lauren Fine, MD, We are our history: Baylor University Medical Center and Black physicians in Dallas, v.37(2) Proc (Bayl Univ Med Cent) eCollection 2004 185, February 8, 2024, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10857562/ last accessed March 13, 2024. (Includes a reference to and quote from - Solamillo S. Dallas Landmark Commission landmark nomination form: Bluitt's Sanitarium. Dallascityhall.com. https://dallascityhall.com/departments/sustainabledevelopment/historicpreservation/HP%20Documents/Landmark%20Structures/Bluitt%20Sanitarium%20Landmark%20Nomination.pdf (Accessed September 27, 2023).

[153] Lauren Fine, MD, We are our history: Baylor University Medical Center and Black physicians in Dallas, v.37(2) Proc (Bayl Univ Med Cent) eCollection 2004 185, February 8, 2024, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10857562/ last accessed March 13, 2024.

[154] With such an expansive membership base, locating non-members to serve on a jury for any action would have been difficult, and pursuing action included the knowledge that the sheriff, police commissioner, district attorney, and police chief were all members of this group. Lauren Fine, MD, We are our history: Baylor University Medical Center and Black physicians in Dallas, v.37(2) Proc (Bayl Univ Med Cent) eCollection 2004 185, February 8, 2024, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10857562/ (last accessed March 13, 2024).

[155] Blue Shield began as a California Physician Service plan in 1939 where the plan sent payments directly to the patients who were then responsible for payment to the physician. Michael A. Morrisey, *Health Insurance*, (2008) at 8.

[156] https://www.bcbs.com/about-us/industry-pioneer last accessed 2/27/2024.

equivalent to the experience in the South,[157] one source of racial tension was the intentional recruitment of Black workers to circumvent White workers engaged in employment strikes in the mining industry.[158] Utilizing labor disputes as a means to sow discord between White striking-workers and Black strike-breaking laborers, these conditions fostered untenable working conditions for Black employees after a strike. In addition to a tense work environment, such conditions could also result in denial of treatment by physicians who participated in the health insurance plan and whose medical livelihood was dependent upon the industry for which they provided treatment. Black people residing in the area at the time were discouraged from political participation [159] or conflict with the White population, and with so few Black inhabitants the ability to stand up against or ignore this tacit directive could have led to increased personal vulnerability. [160] Worker exploitation and striation equated to talented and well-trained physicians becoming selective about who received a steady income to ensure the health and welfare of White workers, with the remaining medical community free to refuse care to Black patients who had little social or political capital[161] to demand access to quality healthcare treatment. With the brief overview of the originating relationship between healthcare development and legal institutions described herein, although tattered and worn by centuries of progress you can still view the remaining threads of the intended inequity. There are pathways to rind the fabric that contains the pattern, to move forward to finally close the gap in maternal health outcomes and improve the chances for healthy pregnancy and delivery for all patients in this country.

IV. POTENTIAL FOR COMPREHENSIVE SOLUTIONS

> *We already know why women are dying, and we already know how to save them. In this way, the tragedy of maternal mortality in the United States is not a problem of information; it is a problem of political will.*[162]

We can never fully calculate the depth of the contributions to medical advancements by Black Americans, either by intellectual contributions or forceful clinical experimentation. Limited by literacy prohibitions and mischaracterizations by researchers; accuracy, transparency and prevalence of medical racism in the creation of the American healthcare system will remain somewhat opaque. As a result of historical knowledge gaps and differing clinical approaches by providers, our current attempts to yield more favorable and equitable outcomes emphasizes evidence-based solutions

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[157] Although protected from the possibility of enslavement, Black residents were still restricted or excluded from societal participation. *See* Leon F. Litwack, *North of Slavery, The Negro in the Free States, 1790-1860*, pp 69 – 74 (1965).

[158] Lewis, *supra* Note 48 at 89.

[159] In the establishment of Oregon Territory government, voting was limited to white males. Stella E. Pearce, *Suffrage in the Pacific Northwest: Old Oregon and Washington*, Vol. 3 The Washington Historical Quarterly No. 2, 106 at 107 (April 1912).

[160] Center for the Study of the Pacific Northwest, *Lesson Twenty-One: African Americans in the Modern Northwest*, https://www.washington.edu/uwired/outreach/cspn/Website/Classroom%20Materials/Pacific%20Northwest%20History/Lessons/Lesson%2021/21.html last accessed 3/1/2024.

[161] Quintard Taylor, *Slaves and Free Men: Blacks in the Oregon Country, 1840*-1860, Vol. 83 Oregon Historical Quarterly No. 2, 153 pp 156 – 157.

[162] Bridges, *supra* Note 9.

which require more extensive data and documentation.[163]

The U.S. Department of Health and Human Services utilizes the Centers for Medicare and Medicaid Services (CMS) to regulate provider and reimbursement rules for patients enrolled in these healthcare payment programs.[164] While private payers and providers play a significant role in healthcare delivery, the regulations and norms by CMS oft times shape the approach used by the private sector.[165] Where the CMS rules lead after public commentary periods and the apparatus of the federal government for implementation and enforcement, the private sector actors tend to follow.[166] Consequently, utilizing CMS quality tools which measure healthcare processes and patient outcomes[167] can shift the healthcare landscape to advance maternal equitable outcomes.

Currently, we incentivize healthcare providers who participate in Medicare, an insurance program administered by CMS,[168] with monetary payments tied to the achievement of healthcare quality metrics. This Quality Payment Program (QPP)[169] is one of CMS's efforts to improve quality but has failed to close the gap in health outcomes between different groups, or to improve the overall maternal mortality statistics as a developed nation.[170] These types of programs aim to implement comprehensive, data-driven, and systematic approaches to maintain and improve safety and quality in healthcare. Rather than over-pivoting on the admirable cause to collect additional data points, we can take advantage of this legal framework to bridge the gap between existing data to achieve the desired outcomes.

In 2023, U.S. Senator Cory Booker of New Jersey and U.S. Representative Lauren Underwood of Illinois re-introduced the Black Maternal Health Momnibus Act (Momnibus Act) in the 118th Congress after similar legislation failed to gain traction in both chambers of the 116th and 117th Congress.[171] With its failure to pass either chamber of the legislature, we must find ways to utilize other mechanisms to accomplish maternal health equity objectives. The Biden-Harris Administration's focus on improving maternal health equity included an approach to harvest the power of

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[163] Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Evidence-based best practices for hospitals in managing obstetric emergencies and other key contributors to maternal health disparities*, Ref: QSO-22-05-Hospitals (ADVISORY) (December 7, 2021) available electronically at https://www.cms.gov/files/document/qso-22-05-hospitals.pdf.

[164] The Medicare Act of 1965 established the Medicare and Medicaid programs and CMS was established as a subagency of the Department of Health and Human Services by the Reorganization Order of 1977. 79 Stat. 1432. 91 Stat. 29.

[165] Brietta R. Clark, et al., Health Law: Cases, Materials and Problems 596 (9th ed. 2022).

[166] Stanley B. Jones, *Medicare Influence on Private Insurance: Good or Ill?*, Vol. 18 Health Care Financing Review No. 2, 153 (Winter 1996).

[167] 42 CFR § 510.400(g).

[168] 42 CFR § 405.201.

[169] The Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015, 129 Stat. 87.

[170][170] World Health Organization, UNICEF, United Nations Population Fund & The World Bank, *Trends in Maternal Mortality: 2000 to 2020* (2023).

[171] The Momnibus Act is a combination of thirteen congressional bills "[t]o end preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States, and for other purposes." Title VI of the Momnibus Act, Data to Save Moms, includes a review of current data collection with the aim to modify and refine its efficacy. Black Maternal Health Momnibus Act, H.R.3305 & S.1606, 118th Cong.

maternal data collection and leverage[172] the refinement of "maternal safety bundles" after they were implemented in California and internationally.[173] The clinically-based maternal safety bundles have been developed by the Alliance for Innovation on Maternal Health and developed in accordance with the clinical conditions of pregnant patients to deliver consistent care utilizing a five-prong process, referred to as the "Five Rs."[174] Upon implementation of these evidence-based clinical interventions, reduction in preventable maternal mortality attributable to obstetric hemorrhage, severe hypertension in pregnancy, and non-medically indicated cesarean section deliveries occurs. [175] Current maternal safety bundles are divided into 5 categories for simultaneous implementation to improve outcomes: Readiness; Recognition & Prevention; Response; Reporting and Systems Learning; and Respectful, Equitable, and Supportive Care.[176] The first four "Rs" of the safety bundles were originally included, and the category for Respectful, Equitable, and Supportive Care was added in 2022.[177] "Each of these steps should integrate equity, which means taking deliberate steps to value each mother's life equally, appreciating the impact of historical trauma and institutional racism along with patient and community perspectives."[178]

Brief Description of the Five Rs

1. Readiness – Every Care Setting: A guideline to develop standard protocols based on the patient's condition that includes timely evaluation and an escalation plan.

2. Recognition & Prevention – Every Patient: A call to review a 12-month patient documentation history to screen for additional risks and provide patient education.

3. Response – Every Event: A directive to utilize the standardized protocols and checklists to evaluate current symptoms with postpartum follow-up and ongoing support.

4. Reporting and Systems Learning – Every Unit: A call to establish and interdisciplinary care team to receive expert feedback and incorporate population disparities into the clinical review.

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[172] The White House, *White House Blueprint for Addressing the Maternal Health Crisis* (2022) available electronically at https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf.
[173] Jennifer M. Banayan & Barbara M. Scavone, *National Partnership for Maternal Safety: Maternal Safety Bundles*, Vol. 7 Obstetric Anesthesia, 67 (February 10, 2017).
[174] Health Resources and Services Administration of the U.S. Department of Health and Human Services, American College of Obstetricians and Gynecologists & Alliance for Innovation on Maternal Health, *Patient Safety Bundle* (2022).
[175] Medicare and Medicaid Programs: Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals, 89 Fed. Reg. 59489 (July 22, 2024).
[176] The 2022 American College of Obstetrics and Gynecologists, *Severe Hypertension in Pregnancy Safety Bundle (2022)*, Alliance for Innovation on Maternal Health (2022).
[177] Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Evidence-based best practices for hospitals in managing obstetric emergencies and other key contributors to maternal health disparities*, Ref: QSO-22-05-Hospitals (ADVISORY) (December 7, 2021) available electronically at https://www.cms.gov/files/document/qso-22-05-hospitals.pdf.
[178] Marla Shauer, Amy Nichols, & Audrey Lyndon, *Maternal Safety*, Department of Health & Human Services, Agency for Healthcare Research and Quality (2024).

5. Respectful, Equitable, and Supportive Care – Every Unit/Provider/Team Member: Encouragement to incorporate the patient in the decision-making process with the care team to establish patient trust and confidence.

When performed collectively, these categories have improved maternal clinical outcomes, but there is no universal adoption of these clinical standards even though this approach is supported by the American College of Obstetricians and Gynecologists (ACOG).[179] ACOG is the largest professional organization for obstetricians and gynecologists in the United States.[180] I offer for consideration the addition of a sixth R to the maternal safety bundles, "Record the Rationale," to improve the likelihood that medical professionals will consistently implement and thoroughly adhere to the guideline contained within the safety bundles. Part of the strength, and concurrent potential shortcoming, of the maternal safety bundles is the ability to modify or disregard them based on the clinical judgement of the practitioner. This flexibility allows the clinical staff to adjust their response based on their professional experience and situational differences but also allows the opportunity for implicit bias to continue to impact outcomes.

A "Record the Rationale" component would allow medical professionals to exercise the elasticity necessary in the exercise of their independent judgment, with the legal obligation to record within the patient's medical record their reasoning when they either fail to implement a safety bundle or deviate from one or more of the existing five Rs. Mandating a notation in the patient's record will serve as a consideration for clinicians who wish to stray from an emerging national standard of care for streamlined obstetrical practice. Unlike the payment of additional funds to clinicians via the bifurcated Quality Payment Program administered by CMS which issues funds via the Merit-Based Incentive Payment System (MIPS) or Advanced Alternative Payment Model (APM),[181] the sixth R ("Record the Rationale") would incentivize the course of action by non-monetary means. Rather than paying clinicians who supply eligible data under the MIPS criteria or providing increased reimbursement percentage amounts with patient risk pools for APM participation, the "Record the Rationale" component would instead factor into medical malpractice insurance premium pricing, licensure actions, medical facility privileging, insurer network credentialing, and malpractice litigation due diligence. This allows the provider's self-preservation interest to coincide with the government's equity objectives.

As a long-term outlook, practitioners, legal academics, and lawmakers should support the passage of complex maternal equity legislation, like the Momnibus Act to purposefully and systematically undo the damage legally permitted to establish and continue the maternal inequity still evidenced today. Legislation, such as the Momnibus Act, could advance the objectives included in this article and remove additional barriers to equity. In the interim, the modification of non-binding rules like the maternal health bundles to include a compliance component with chart notation is immediately adoptable and within the scope of practice for obstetric clinicians without becoming overly burdensome to a specialty already implementing this practice who have an

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[179] Caitlin Baptiste MD and Mary E. D'Alton MD, *Applying Patient Safety to Reduce Maternal Mortality*, Vol. 46 Obstetrics and Gynecology Clinics of North America Issue 2, 353 (June 2019)
[180] Michael J. Myers, *ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?*, 49 S.D. L. Rev. 526 (2004).
[181] 42 C.F.R. §414(O).

existing legal obligation to notate patient charts and to make those notes accessible to patients.[182] Health professionals relied upon the protection of legal institutions to perpetuate racist practices, contemporary legal apparatuses can work in collaboration with medical experts to strengthen efforts that address disparities while contextualizing historical factors. The implementation of clinical tools established and supported by clinicians with legal guidance to modify the five Rs to incorporate Record the Rationale is a pathway for healthcare legal professionals and scholars to positively impact patient outcomes without the need for immediate legislative action and can continue in the event executive branch's support for such endeavors shifts or lacks financial support via federal grants or reimbursement mechanisms.

A colleague, who does not practice healthcare law, was concerned about a potential chilling effect on practitioners who would leave the field or emerging professionals who would shy away from obstetrics in healthcare facilities that implemented Record the Rationale practices. The concern about the impact on the medical provider's decision to practice is real[183] and a valid point of consideration. However, I contend that inaction to curb avoidable maternal fatalities due to a fear of potential clinical objection is an insufficient argument against implementation. Medical care already includes a complex and layered ecosystem of federal and state regulations, professional licensure review, employer guidelines, and medical malpractice policy considerations. A non-legislative course of action which was developed by clinical experts that align with the practitioner's self-interest is a better tool than one solely designed by legal experts who may lack the technical and scientific expertise to accomplish the outcomes proven by the established five Rs of the maternal safety bundles. This approach bridges the gap between legal analysis and scientific expertise to accomplish the common desired result of reduced maternal health inequity.

CONCLUSION

We cannot solve the contemporary concern about the maternal health crisis in America without acknowledging and confronting the legal legacy of permitting our healthcare delivery system to emerge and continue with interwoven components of the deplorable racist ideologies that permeated society at-large. Current medical practices and legislative solutions that are singly focused cannot address a centuries-long problem that was knitted into every aspect of our nation, and in turn our healthcare and legal institutions. Historical accountability, starting from the earliest iterations of the professional practice of medicine through time to include the payment mechanisms currently functioning in the twenty-first century, is necessary to adequately redress the wrongdoings of the past. It is only with this lens that we can properly course-correct for the underlying origins for this ongoing medical injustice. When advancing or advocating for legal solutions, those positions require historical framing.

In our more recent reflections on the realities of maternal healthcare inequity, we have stitched together our modern understanding of medical benevolence with past

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[182] 42 C.F.R. §41, 413 & 495.

[183] Julie Rovner and Rachana Pradhan, *Medical residents are starting to avoid state with abortion bans, data shows*, NPR (May 9, 2024) available electronically at https://www.npr.org/sections/health-shots/2024/05/09/1250057657/medical-residents-starting-avoid-states-abortion-bans (last visited January 24, 2025).

atrocities.[184] Unfortunately, this conduct was permitted without shame and with the tacit or explicit consent of medical[185] and legal institutions.[186] "Access to health care depends on finding providers who are willing and able to treat you. But some people are refused medical care or given inadequate treatment for economic and social reasons unrelated to medical need."[187] One way for legal professionals to contribute to the ongoing efforts to achieve maternal healthcare equity is to coordinate our efforts with clinical approaches and resources to create a cohesive legal and healthcare delivery model. American medical professionalism and its establishment as a scientific field emerged alongside the practice of chattel slavery, and thus it was impossible for the field to exist without the societal ideas of racism and exclusion of people medical treatment. As the practice of medicine developed and modernized, the healthcare system incorporated the racist attitudes and conduct of the larger American society, these were not eradicated with societal and medical racial integration. As legal institutions shift focus toward health justice and equity,[188] we can propose solutions that are historically informed and in conjunction with the practitioners who develop clinical guidelines while legal institutions continue to respect practitioner autonomy to achieve our goal of maternal healthcare equity.

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[184] Gretchen Long. *Doctoring Freedom: The Politics of African American Medical Care in Slavery and Emancipation* (2012).
[185] Robert B. Baker, PhD, *History of Medicine: The American Medical Association and Race*, Vol. 16 Virtual Mentor: American Medical Association Journal of Ethics No. 6 479 (June 2014).
[186] Alyson Reed, *Women's Healthcare Disparities and Discrimination*, 4 C.R.J. 42 (1999)
[187] Brietta R. Clark, et al., Health Law: Cases, Materials and Problems 285 (9th ed. 2022).
[188] Fuse Brown, *supra* Note 40.