## COMMENT

# IGNORING THE CRIES OF BLACK MAMAS: LOOKING BEYOND TORT LAW TO ENSURE THAT BLACK MOTHERS ARE HEARD DURING CHILDBIRTH

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The image of an elated mother cradling her newborn while leaving the hospital is often the first image individuals envision when thinking about the beauty of childbirth. However, for many Black women, that picturesque scenario is not their reality. Black women are more likely to die of childbirth-related causes than white women, a disparity explained by systemic racism rooted in the medical industry.

While tort law is an arena where harmed mothers can seek justice, in reality, this method rarely leads to a finding in favor of the harmed mother and fails to address the reason why Black birthing women need to resort to tort law in the first place. Though this Comment does not discount the benefits of tort law, it calls on states to embrace a holistic view of childbirth that includes freestanding birth centers, midwives, and doula services. With individual states in control of the services covered by their respective Medicaid plans, states should ensure routes for freestanding birth center licensure and provide equal reimbursement rates for midwifery services. This reform will ensure that Black women are heard, empowered, and protected during childbirth.



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## INTRODUCTION

Simone Landrum was thrilled to discover that she was pregnant with a daughter.[1] However, Simone quickly realized that something was off: her hands, feet, and face were becoming increasingly more swollen.[2] Her doctors, whose services were covered by Medicaid, repeatedly brushed aside her complaints and instructed her to take more Tylenol.[3] As Simone's pregnancy progressed, she received test results indicating that she had elevated blood pressure, a sign that she had pre-eclampsia, which is dangerously high blood pressure during pregnancy.[4]

Simone's pain and fatigue intensified, and her doctors again brushed off her concerns and instructed her to "lie down—and calm down."[5] The pain that Simone experienced became so unbearable that there was no denying that something was terribly wrong. After arriving at the hospital by ambulance, she learned that her dangerously high blood pressure caused her placenta to separate from her uterine wall, an occurrence known as abruption.[6] Simone did not get to leave the hospital with her baby girl. Instead, she delivered a stillborn infant via C-section.[7]

1. Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. TIMES (Apr. 11, 2018), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html [https://perma.cc/P6LJ-VDXH].
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*

Throughout the pregnancy, Simone informed her doctors of her pain and symptoms yet faced routine dismissal of her pain by her providers.[8] Simone's doctors brushed off her pain and failed to inquire further into her case.[9] If Simone's doctors had acknowledged her pain and taken additional measures to look into her case, she may have left the hospital with a bouncing baby girl in tow.

Health disparities in maternal health outcomes are rooted in systemic racism, the effects of which are still present in the medical field. According to the Centers for Disease Control and Prevention, Black women are three times more likely to die of childbirth-related causes than their white peers.[10] Additionally, socioeconomic status does not shield Black women from fatal encounters with childbirth, which illustrates the severity and pervasiveness of the issue. Serena Williams's severe medical complications arising twenty-four hours after the birth of her daughter Olympia almost killed her.[11] Despite the financial resources and prominence of the tennis legend, Williams's story illustrates the pervasive issue of Black women experiencing delivery complications. Simply put, Black women must fight to be taken seriously about their bodies and their real experiences of pain.[12] The startling maternal mortality rate for Black women "is a reflection of how black women and their pain are ignored" by medical providers.[13]

The birth outcome disparities between Black women and their white peers illustrate that the medical industry desperately needs to undergo a paradigm shift. Thus, this Comment makes a critical assumption: by expanding Medicaid to implement a more comprehensive system, states could help eliminate the racial inequities that currently plague the medical system. Medicaid covers half of the births in the United States.[14] Therefore, if states lacking comprehensive Medicaid programs underwent expansion, the racial inequities present in the medical system could be

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8. *Id.*

9. *Id.*

10. Tonya Russell, *Racism in Care Leads to Health Disparities, Doctors and Other Experts Say as They Push for Change*, WASH. POST (July 11, 2020), https://www.washingtonpost.com/health/racism-in-care-leads-to-health-disparities-doctors-and-other-experts-say-as-they-push-for-change/2020/07/10/a1a1e40a-bb9e-11ea-80b9-40ece9a701dc_story.html [https://perma.cc/6E7C-Q6KN].

11. Serena Williams, Opinion, *What My Life-Threatening Experience Taught Me About Giving Birth*, CNN (Feb. 20, 2018), https://www.cnn.com/2018/02/20/opinions/protect-mother-pregnancy-williams-opinion [https://perma.cc/3YSC-4AQ8].

12. Alice Broster, *Why Are Black Mothers at More Risk of Dying?*, FORBES (July 22, 2020, 8:00 AM), https://www.forbes.com/sites/alicebroster/2020/07/22/why-are-black-mothers-at-more-risk-of-dying/#1ccf4ab314c9.

13. Russell, *supra* note 10.

14. Jamila K. Taylor, *Structural Racism and Maternal Health Among Black Women*, 48 J.L. MED. & ETHICS 506, 513 (2020).

reduced or eliminated.[15] Further, women receiving midwife and birth center care have better birth outcomes that are less costly than traditional birthing care.[16] With "the best outcomes for mothers and babies occur[ring] in states where all types of midwives are regulated and integrated into the health care system," states should recognize midwifery care as the legitimate form of care that it is.[17]

Accordingly, states should expand Medicaid to include the equal reimbursement rates of midwifery and doula services and provide licensure mechanisms for freestanding birth centers as a route to eliminate the disparate birth outcomes for Black women. Although tort law is one route to make harmed mothers whole again, medical malpractice suits targeting the harms that arise from childbirth often prioritize fetal harms over the harms suffered by mothers.[18] This often precludes a finding in favor of the mother.[19] Therefore, Medicaid expansion should include full reimbursement of doula and midwifery services as a proactive measure to reduce the harms that arise during childbirth, thereby eliminating the need for Black mothers to resort to tort litigation.

This Comment proposes measures that could help reduce the maternal mortality rate. Accordingly, Part I examines the implications of the transformation of childbirth into a medicalized event and the effects of racial discrimination, both of which are factors that explain the disparate birth outcomes for Black women. Part II summarizes the benefits of holistic birthing methods, which include midwifery and doula services, as well as freestanding birth centers. Part III then describes the midwifery model and the benefits of such an approach, as opposed to a physician-attended birth in the hospital setting, to counter the effects of societal racism and discrimination. Part IV illustrates the drawbacks of tort law in making harmed birthing women whole again and explores how a prevention-based approach could eliminate the need to resort to tort litigation altogether. Part V posits that the alteration of Medicaid to encompass the full range of ways by which midwifery and doula services are offered is the critical change needed to reverse the negative birth

15. *Id.*

16. Eva H. Allen & Sarah Benatar, *Maternity Care Financing: Challenges and Opportunities Highlighted by the COVID-19 Pandemic*, URB. INST. 7 (2020), https://www.urban.org/sites/default/files/publication/103127/maternity-care-financing-challenges-and-opportunities-highlighted-by-the-covid-19-pandemic_4.pdf [https://perma.cc/7YS6-GLT9].

17. Saraswathi Vedam, Kathrin Stoll, Marian MacDorman, Eugene Declercq, Renee Cramer, Melissa Cheyney, Timothy Fisher, Emma Butt, Y. Tony Yang & Holly Powell Kennedy, *Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes*, PLOS ONE, Feb. 21, 2018, at 12.

18. Jamie R. Abrams, *Distorted and Diminished Claims for Women*, 34 CARDOZO L. REV. 1955, 1959–60 (2013).

19. *Id.*

outcomes of Black women. Finally, Part VI concludes by urging policymakers to embrace holistic birth methods as a legitimate form of care to protect Black women during childbirth.

## I. HISTORY REPEATED: THE BLACK MATERNAL MORTALITY RATE EXPLAINED

Despite the sickening history of violence against Black women and men at the hands of state police officers, the institutions charged with protecting and serving are not the only entities with a history of violence against Black bodies.[20] In fact, the medical system also perpetrates violence, which is evidenced by the number of Black women who lose their lives or suffer from complications during birth at rates far higher than their white peers.[21] The systemic racism that manifests in the actions and inactions by hospital providers illustrates the need for states to embrace a holistic approach to birth, one that encompasses access to freestanding birth centers and the ability to obtain midwifery and doula services.

### *A. The Legacy of the Mistreatment of Black Women in America Persists in the Medical Industry Today*

The United States' history of slavery highlights the oppression and control of Black women.[22] This legacy persists in the medical system and manifests itself in the disparate health care treatment and outcomes of Black women.[23] The control slaveowners exerted over Black women often centered on Black women's ability to reproduce. Specifically, slaveowners coveted the increased fertility of enslaved women, as they could gain greater returns on women capable of conceiving.[24]

The interests slaveowners held in the fertility of their slaves often incentivized slaveowners to procure the help of medical professionals to assist in the reproductive health of their slaves.[25] With the emphasis on the fertility of the enslaved, a new era of experimentation and coerced

20. *See* Oliver Laughland, *US Police Have a History of Violence Against Black People. Will It Ever Stop?*, GUARDIAN (June 4, 2020), https://www.theguardian.com/us-news/2020/jun/04/american-police-violence-against-black-people [https://perma.cc/6MBH-7VXT] (discussing the acts of violence committed against Black people by law enforcement officers).

21. Abrams, *supra* note 18, at 1978–79.

22. Taylor, *supra* note 14, at 507.

23. Austin Frakt, *Bad Medicine: The Harm That Comes from Racism*, N.Y. TIMES: THEUPSHOT (July 8, 2020), https://www.nytimes.com/2020/01/13/upshot/bad-medicine-the-harm-that-comes-from-racism.html [https://perma.cc/2AN5-WHNR].

24. Taylor, *supra* note 14, at 507.

25. *Id.* at 508.

procedures left Black women powerless against the will of doctors.[26] The 1800s featured a slew of experimental procedures, most frequently performed without the aid of anesthetics.[27] Slaveowners interested in maximizing their returns and physicians concerned with advancing reproductive procedures operated to the benefit of each other.[28]

Though the American medical system no longer permits the inhumane procedures and treatment of Black women that were present in the 1800s, the legacy of slavery lives on in the current system. Thirty-two percent of Black women reported experiences of discrimination by their physicians.[29] Additionally, economic or social class does not immunize Black women from facing a higher risk of death from pregnancy-related causes when compared to their white peers.[30] In other words, neither money nor resources can guarantee a successful birth outcome for a Black woman. Despite the conspicuous absence of overt forms of racism—though such forms certainly do persist—the institutional characterization of Black women results in their dehumanization and the dismissal of their pain.[31] Further, when physicians are socially distant from their minority patients, the physicians may be more likely to find their Black patients' reports of pain as lacking credibility.[32]

In addition to the implicit biases some physicians may harbor toward their Black patients, Black patients are often victims of microaggressions, which contribute to Black patients' stress.[33] Microaggressions in the health

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26. *See id.* (explaining the methods of medical experimentation that enslaved women underwent). Black women also experience "medical-interaction induced trauma," which arises when patients do not feel heard by their physicians. Jameta Nicole Barlow, *Uncovering the Trauma Pregnant Black Women Experience in the U.S.*, HEALTHLINE (Dec. 3, 2020), https://www.healthline.com/health/black-women-pregnancy-trauma [https://perma.cc/89LS-8PL8].

27. Taylor, *supra* note 14, at 508.

28. HARRIET A. WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT 26 (2006).

29. Elizabeth Chuck, *How Training Doctors in Implicit Bias Could Save the Lives of Black Mother*s, NBC NEWS (May 11, 2018, 7:49 AM), https://www.nbcnews.com/news/us-news/how-training-doctors-implicit-bias-could-save-lives-black-mothers-n873036?icid=related [https://perma.cc/4RUZ-75FP].

30. Taylor, *supra* note 14, at 511.

31. *Id.*

32. *See* Joshua H. Tamayo-Sarver, Susan W. Hinze, Rita K. Cydulka & David W. Baker, *Racial and Ethnic Disparities in Emergency Department Analgesic Prescription*, 93 AM. J. PUB. HEALTH 2067, 2067 (2003), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448154/pdf/0932067.pdf [https://perma.cc/57S3-C2G3] (explaining why physicians are less likely to take minority patients' pain seriously when it comes to prescribing opioids).

33. Chuck, *supra* note 29; *see also* Daniel Cruz, Yubelky Rodriguez & Christina Mastropaolo, *Perceived Microaggressions in Health Care: A Measurement Study*, PLOS ONE, Feb. 5, 2019, at 1, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6363167/pdf/pone.0211620.pdf

care field occur when physicians marginalize people of color by engaging in "culturally insensitive interactions."[34] For example, a doctor's surprise over a Black patient's intellect or a Black patient facing belittlement by a doctor are correlated with pre-term birth.[35] Facing microaggressions in the health care field undermines patient-centered care, which is a critical element of physician care during childbirth.[36] Further, physicians who spend less time with their Black patients tend to make decisions on behalf of their patients, thus contributing to a reported lack of autonomy experienced by Black women in childbirth settings.[37]

Beyond what is known about the lived experiences of Black patients, the numbers and studies provide certainty and context to the disparities in childbirth outcomes among Black women. The pregnancy-related mortality rate for Black women is 3.2 times higher than for white women.[38] Additionally, Black women are more likely than white women to experience substandard quality of care in hospitals.[39] Due to the legacy of mistreatment and abuse by medical professionals, people of color harbor greater feelings of mistrust toward health care providers than their white peers.[40]

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[https://perma.cc/K9QZ-5K4J] (defining microaggressions as "behaviors that ambiguously disempower racial minorities," which often manifest as verbal or non-verbal messages directed at racial minorities).

34. Cruz, Rodriguez & Mastropaolo, *supra* note 33, at 2.

35. Hannah Yoder & Lynda R. Hardy, *Midwifery and Antenatal Care for Black Women: A Narrative Review*, SAGE OPEN, Jan.–Mar. 2018, at 3, https://journals.sagepub.com/doi/pdf/10.1177/2158244017752220 [https://perma.cc/PL4D-7UQ6].

36. Cruz, Rodriguez & Mastropaolo, *supra* note 33, at 3.

37. Chuck, *supra* note 29; *see also* Cruz, Rodriguez & Mastropaolo, *supra* note 33, at 2.

38. Emily E. Petersen, Nicole L. Davis, David Goodman, Shanna Cox, Carla Syverson, Kristi Seed, Carrie Shapiro-Mendoza, William M. Callaghan & Wanda Barfield, *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762, 762 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6835a3-H.pdf [https://perma.cc/R2ZP-HA2Q].

39. *Id.* at 764.

40. COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED. OF THE NAT'L. ACADS., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE 135 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003), https://www.ncbi.nlm.nih.gov/books/NBK220358/pdf/Bookshelf_NBK220358.pdf [https://perma.cc/JYZ6-UT8E]; *see also* COMM. ON ASSESSING HEALTH OUTCOMES BY BIRTH SETTINGS, NAT'L ACADS. OF SCIS., ENG'G, & MED., BIRTH SETTINGS IN AMERICA: OUTCOMES, QUALITY, ACCESS AND CHOICE 120 (Susan C. Scrimshaw & Emily P. Backes eds., 2020) [hereinafter BIRTH SETTINGS IN AMERICA] (explaining how the medical model has historically featured a distrust of Black women's competence).

### *B. The Limitations of Tort Law*

Tort law can be a useful mechanism to make harmed birthing women whole again; however, the tort system often fails Black birthing women. Because harms sustained during childbirth typically involve provider negligence, women can sue their doctors for the harms they experience during birth.[41] Although the tort framework's outward appearance suggests it is suited to handle the claims of harmed birthing women, the doctor is not concerned solely with the birthing mother but also owes a duty of care to the fetus.[42] The dualities of childbirth, which involve the best interests of the infant and the mother, manifest in tort law, with fetal harms dominating the harms sustained to the birthing mother.[43]

The framing of birthing mothers as the decision-makers often makes it more difficult for them to prevail. For example, birthing mothers may withdraw consent to a procedure after previously consenting to a procedure.[44] In such a situation, courts often consider whether the birthing woman made statements indicating the desire to cease the current course of treatment and whether viable medical alternatives to the current course of treatment existed.[45] However, due to the persistent institutional racism in the medical field, many Black women feel unheard by their doctors.[46] Thus, a Black woman could withdraw consent but be ignored. This prompts the question: How can she present evidence of being ignored to counteract the weight courts give to evidence of consent? This situation illustrates how medical malpractice suits are not always the best means for making Black mothers whole again.

## II. BEYOND THE HOSPITAL

Although physician-attended hospital births are the most popular birth method for American women, other birth methods may produce better birth outcomes for Black women.[47] The midwifery model is a vital

41. Abrams, *supra* note 18, at 1978–79; *see generally* Michele Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451 (2000).

42. Abrams, *supra* note 18, at 1960.

43. Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205, 1294 (1992).

44. *See Schreiber v. Physicians Ins. Co. of Wis.*, 588 N.W.2d 26, 26 (1999).

45. *See id.* at 31–32.

46. *See* Villarosa, *supra* note 1.

47. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 18 (citing Marian F. MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017*, 46 BIRTH 279, 280 (2019)) (explaining that 98.4 percent of births took place in hospitals in 2017, thereby making hospitals the most common place to give birth in the United States).

alternative to improve maternal birth outcomes,[48] particularly because women often report feeling "more in control" and empowered during their sessions with midwives.[49] The United States features three types of midwives: Certified Nurse Midwives (CNMs), Certified Midwives (CMs), and Certified Professional Midwives (CPMs).[50] Though CNMs and CMs work primarily in hospitals, they also can attend deliveries in birth centers and perform home births.[51] Additionally, doula services may help promote positive birth outcomes by reducing the amount of stress and eliminating the feelings of invisibility many Black women feel when working with physicians.[52] Further, doulas provide uniquely tailored care and serve as advocates and sources of emotional support for birthing women.[53] This type of care directly targets the gap between patients and their providers by way of doulas advocating on behalf of the birthing mother.[54]

### *A. A Holistic Approach*

Although only 0.52 percent of births take place in freestanding birth centers,[55] an increase in births taking place in these centers could alleviate the stress that Black women experience when giving birth in a hospital setting.[56] Freestanding birth centers typically use the midwifery model,

48. *See* Sarah Benatar, A. Bowen Garrett, Embry Howell & Ashley Palmer, *Midwifery Care at a Freestanding Birth Center: A Safe and Effective Alternative to Conventional Maternity Care*, 48 HEALTH SERVS. RSCH. 1750, 1763 (2013).

49. Yoder & Hardy, *supra* note 35, at 6.

50. "CPMs provide care only in birth centers and at home births, as they have not been granted hospital privileges in most areas." BIRTH SETTINGS IN AMERICA, *supra* note 40, at 66–67.

51. *Id.* at 67.

52. *See generally What Role Could Doulas Play in Addressing Black American Maternal Mortality?*, MATERNAL HEALTH TASK FORCE: BLOG (Apr. 28, 2020), https://www.mhtf.org/2020/04/28/what-role-could-doulas-play-in-addressing-black-american-maternal-mortality/ [https://perma.cc/72PU-ZADA].

53. *How Can Doulas Help Address Racial Disparities in Care?*, NAT'L HEALTH L. PROGRAM (Apr. 16, 2020), https://healthlaw.org/wp-content/uploads/2020/04/DoulasRacialDisparity_4.16.2020.pdf [https://perma.cc/R3R8-QHQV].

54. *What Role Could Doulas Play in Addressing Black American Maternal Mortality?*, *supra* note 52 ("One could posit that doulas serve as effective advocates for women who aren't believed to be in real pain and can therefore garner medical attention before a hemorrhage turns fatal[.] [H]owever, we have no evidence to conclude that deploying doulas would substantially reduce the risk of hemorrhage.").

55. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 46.

56. The United States features more than 384 freestanding birth centers in thirty-seven states and the District of Columbia. KITTY ERNST & KATE BAUER, AM. ASS'N OF BIRTH CTRS., BIRTH CENTERS IN THE UNITED STATES 11 (2020), https://cdn.ymaws.com/www.birthcenters.org/resource/collection/028792A7-808D-4BC7-9A0F-FB038B434B91/Birth_Centers_in_the_United_States__2020_.pdf [https://perma.cc/4VUS-KXG8].

which often includes a support staff consisting of registered nurses.[57] The birth centers often emulate the home setting and often feature nonmedical interventions.[58] Further, birth centers play a crucial role in better birth outcomes, making this setting one that could lend favorable results to Black women who feel neither safe nor heard in hospital settings.[59]

In light of the benefits that the midwifery model, doula care, and freestanding birth centers provide to Black women, states should shift their approaches to focus on prevention. Rather than utilizing a response approach to the harms suffered by Black women giving birth, the focus should be on preventative measures that reduce the need to resort to tort law. While Medicaid provides broad services ranging from preventative services and maternity care to family planning, the details of these services vary among the individual states.[60] The expansion of Medicaid in the states that currently do not provide expansive coverage of midwifery services—particularly midwife and doula services in freestanding birth centers—can reduce the disparate birth outcomes for Black women, thus reducing their need to seek redress against tortfeasors.[61] The type of care that many women seek, which is often characterized as a more holistic and individualized approach, falls squarely within the goals of the midwifery approach.[62] As such, midwifery-led care could eliminate some of the risks of harm Black women face when entering the hospital to give birth.

### *B. The Reality of Birth in the United States*

Currently, freestanding birth centers are not entirely integrated into the maternity care system in the United States, which makes it difficult for

57. *See* AM. ASS'N OF BIRTH CTRS., BIRTH CENTER DEFINITIONS 1, 9–10 (2016), https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/about_aabc_-_documents/Birth_Center_Definitions-12..pdf [https://perma.cc/E755-QVB8].

58. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 59.

59. Though some theorize that the midwifery method could be a suitable route for Black women, they also acknowledge the lack of data to conclusively support that hypothesis. Benatar, Garrett, Howell & Palmer, *supra* note 48, at 1763–64.

60. KFF, MEDICAID'S ROLE FOR WOMEN ACROSS THE LIFESPAN: CURRENT ISSUES AND THE IMPACT OF THE AFFORDABLE CARE ACT 3 (2012), http://files.kff.org/attachment/medicaid-role-for-women-across-the-lifespan-issue-brief [https://perma.cc/CZN5-FKUZ].

61. *See* BIRTH SETTINGS IN AMERICA, *supra* note 40, at 75. "In marginalized communities in the U.S., where the health system is often stretched thin, expanding access to midwives and increasing their responsibilities could be a feasible strategy for improving maternity care." UNIV. OF B.C. FAC. OF MED., *Midwifery Linked to Better Birth Outcomes in State-by-State "Report Card,"* UNIV. OF B.C. (Feb. 21, 2018), https://www.med.ubc.ca/news/midwifery-linked-to-better-birth-outcomes-in-state-by-state-report-card/ [https://perma.cc/QQ53-GEF6].

62. Yoder & Hardy, *supra* note 35, at 6 ("Women specifically mentioned feeling more in control and empowered in prenatal sessions with midwives.").

some women to obtain birth care in freestanding birth centers.[63] In states utilizing a more comprehensive Medicaid scheme, obtaining midwifery care in the home or in a freestanding birth center is more accessible to women of all means.[64] However, in states featuring a limited Medicaid scheme, out-of-hospital, midwife-attended births; obtaining a doula; and giving birth in freestanding birth centers remain inaccessible to many.[65] The out-of-pocket cost for doula care ranges from hundreds to several thousands of dollars, which poses a significant barrier to women who are on Medicaid.[66] Thus, in the states where Medicaid coverage for freestanding birth centers and midwife-attended births is lacking, the Medicaid schemes should be expanded. This Comment argues that the states featuring non-comprehensive Medicaid schemes should expand their programs to include services that can reduce the maternal mortality rate for Black women.

Medicaid is a jointly funded, state-federal health coverage program for individuals of low socioeconomic status.[67] To qualify for Medicaid coverage, one must fit into the category of individuals eligible for coverage and satisfy certain income criteria.[68] Specifically, being pregnant or being the mother of a child and falling within the eligible income bracket may qualify individuals for Medicaid coverage.[69] As such, Medicaid expansion is a critical route toward reducing the maternal mortality rate for Black women.

Though this Comment advocates for the expansion of Medicaid to include doula and midwifery services, the Affordable Care Act (ACA) has made several critical changes that may hinder this progression. In *National Federation of Independent Business v. Sebelius*,[70] the U.S. Supreme Court

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63. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 63–64.

64. *Id.* at 75.

65. *Id.*; *see generally* Emily Bobrow, *What It's Like to Be a Doula for Women of Color*, N.Y. MAG.: THE CUT (Aug. 28, 2018), https://www.thecut.com/2018/08/what-its-like-to-be-a-doula-for-women-of-color.html.

66. Doula fees vary; however, the average fee is around $1,000. Katy B. Kozhimannil, Laura B. Attanasio, Judy Jou, Lauren K. Joarnt, Pamela J. Johnson & Dwenda K. Gjerdingen, *Potential Benefits of Increased Access to Doula Support During Childbirth*, 20 AM. J. MANAGED CARE e340, e341 (2014). Doula services in New York City can range from $250 to $4000, depending on the experience level of the doula. Carolyn Adams, *New York Aims to Give Low-Income Pregnant Women Access to Doulas – but Some Say It's Not Enough*, NBC NEWS, (Feb. 27, 2019, 12:22 PM), https://www.nbcnews.com/news/nbcblk/new-york-aims-give-low-income-pregnant-women-access-doulas-n973671 [https://perma.cc/UMR2-7AQT].

67. *See* Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care*, 94 NEB. L. REV. 799, 824 (2016) (explaining that Medicaid provided more than 22.4 million women with coverage before the ACA expanded coverage).

68. KFF, *supra* note 60, at 1.

69. *Id.*

70. 567 U.S. 519 (2012).

found the ACA's Medicaid expansion mandate unduly coercive, ultimately holding that the decision to expand Medicaid schemes is properly left to the states.[71] Currently, twelve states have decided not to expand Medicaid,[72] thereby hindering the accessibility of midwifery and doula services in those states. The lack of uniformity under the ACA leads to variation in the extent to which certain services are covered under Medicaid.[73]

Further, the United States almost exclusively relies on medical specialists rather than certified midwives when providing maternity care to healthy women.[74] This trend must change, and midwifery services should become an accessible option for birth in addition to the risk-management and interventionist approach that characterizes hospital deliveries in the United States.[75] Although midwives and birth centers cannot erase the institutional racism present in the medical field, these actors and institutions can provide an individualized birth plan to birthing mothers while also advocating for Black mothers whose needs are often pushed away by doctors in the traditional hospital setting. Further, "where midwives are the first-line providers for healthy pregnant women . . . better health outcomes and lower maternity care costs" result.[76]

## III. SAVING BLACK MAMAS REQUIRES A SHIFT IN THE DELIVERY MODEL

The devastating stories of hurt forever etched into the minds of those who have lost loved ones during childbirth underscore the dire need to eliminate the current disparity in birth outcomes. Further, the medicalization of childbirth and the effects of societal discrimination result in worse outcomes for Black women. Although no policy or practice can erase the damage done to Black bodies, this Comment argues that alternative delivery models may be the solution to protecting Black birthing women.

71. *Id.* at 575–88 (holding that the ACA's Medicaid expansion mandate was unconstitutionally coercive).

72. *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (Oct. 8, 2021), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/8AQ4-Q2WP].

73. *See* Joelle Abramowitz, *The Effect of ACA State Medicaid Expansions on Medical Out-of-Pocket Expenditures*, 77 MED. CARE RSCH. & REV. 19 (2020).

74. *See* Kukura, *supra* note 67, at 811.

75. *See id.* at 851.

76. *Id.*

### *A. The Transformation of Childbirth into a Medicalized Event Coupled with Societal Discrimination Harms Black Women*

Although movie scenes of laboring women being rushed to the hospital reflect the modern prevalence of hospital births in the United States,[77] hospital births were not always the norm. During the colonial period up until the 1760s, friends and family would surround the birthing person while a midwife delivered the baby.[78] The transformation of childbirth into a medicalized event resulted in the preservation of life, particularly when complications arose.[79] However, in situations where no complications arise, the need for a childbirth fraught with procedures is often unnecessary.[80] Further, maternity experts argue that many medical interventions that are unnecessarily utilized during childbirth may increase the risks for both baby and mother alike.[81] Coupled with the societal racial discrimination that Black women face daily, giving birth in the hospital setting can result in dangerous, preventable outcomes.

The existing framework of birth as a medical event pushes Black women into the hospital, an institution built upon systemic racism.[82] Beginning in the eighteenth century, many white individuals characterized Black individuals as "mentally inferior, physically and culturally unevolved."[83] Further, the eugenics movement, which was the practice of population control and the encouragement of "good stock," subjected Black women to forced sterilizations.[84] The eugenics movement no longer defines the current era—though women of color still receive more

77. *See, e.g.*, WHAT TO EXPECT WHEN YOU'RE EXPECTING (Lionsgate 2012).

78. Maiken Scott, *How Did Birth Move from the Home to the Hospital, and Back Again?*, WHYY: THE PULSE (Dec. 13, 2013), https://whyy.org/segments/how-did-birth-move-from-the-home-to-the-hospital-and-back-again/ [https://perma.cc/6YNH-5Q93].

79. Richard Johanson, Mary Newburn & Alison Macfarlane, *Has the Medicalisation of Childbirth Gone Too Far?*, 324 BRIT. MED. J. 892, 892 (2002).

80. *Id.* at 893. The utilization of electronic fetal monitoring in the United States illustrates the pervasiveness of the medicalization of childbirth, particularly since evidence shows that this device "should be reserved for high risk pregnancies." *Id.*

81. CAL. HEALTH CARE FOUND., THE OVERMEDICALIZATION OF CHILDBIRTH (2018), https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothers2018Infographic.pdf [https://perma.cc/AM3Q-64PP]; *see also* BIRTH SETTINGS IN AMERICA, *supra* note 40, at 8.

82. Nina Martin & Renee Montagne, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 7, 2017, 7:51 PM), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why [https://perma.cc/7U7S-W6CL].

83. S. Plous & Tyrone Williams, *Racial Stereotypes from the Days of American Slavery: A Continuing Legacy*, 25 J. APPLIED SOC. PSYCH. 795, 795 (1995).

84. Danielle Thompson, *Midwives and Pregnant Women of Color: Why We Need to Understand Intersectional Changes in Midwifery to Reclaim Home Birth*, 6 COLUM. J. RACE & L. 27, 39 (2016).

sterilization counseling than white women—but the treatment that Black women face is a remnant of America's troubled history.[85]

The inequitable treatment in the hospital system stems from the fact that racial minority groups tend to receive lower-quality medical care than their white peers.[86] For example, medical providers often perceive certain minority groups as possessing a higher pain tolerance than white individuals.[87] This harmful stereotype explains why researchers have recorded numerous instances of pregnant Black women being ignored by their medical providers, being drug-tested without providing consent, or even being sutured without the aid of anesthetics.[88] Though one would think the medicalization of childbirth results in better birth outcomes, the opposite is often the case, particularly for Black women.[89]

### *B. The Effects of Societal Racism and Discrimination*

While the institutionalized racism embedded in the hospital industry contributes to the negative birth outcomes of Black women, the effects of societal racism and discrimination that Black women endure daily are epidemics in themselves. The effects of racism adversely affect pregnancy and cause negative birth outcomes due to an increase in chronic stress.[90] Moreover, women of color experience additional stressors such as economic stress, lack of childcare, and the costs of health care, which, when coupled with the stressors of enduring racism and discrimination, affect birth outcomes in ways that white women do not experience.[91]

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85. *Id.* at 42.

86. *See* BIRTH SETTINGS IN AMERICA, *supra* note 40, at 120 (explaining a survey reporting that one-third of women of color giving birth in the hospital context reported being mistreated by staff, while fewer than one-sixth of white women reported mistreatment); *see also* Martin & Montagne, *supra* note 82 ("In the more than 200 stories of African-American mothers that ProPublica and NPR have collected over the past year, the feeling of being devalued and disrespected by medical providers was a constant theme.").

87. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 120.

88. Rachel Scheier, *Black Women Turn to Midwives to Avoid COVID and 'Feel Cared For,'* CAL. HEALTHLINE (Sept. 16, 2020), https://californiahealthline.org/news/black-women-turn-to-midwives-to-avoid-covid-and-feel-cared-for/ [https://perma.cc/AHK5-WR9Y].

89. Although this Comment addresses the Black maternal mortality rate, the disparity between Black and white infant deaths shifted from enslaved infants dying at a rate 1.6 times higher than white infants to the Black infant mortality rate increasing to 2.3 times higher than non-Hispanic white babies in 2016. Deirdre Cooper Owens & Sharla M. Fett, *Black Maternal and Infant Health: Historical Legacies of Slavery*, 109 AM. J. PUB. HEALTH 1342, 1343 (2019).

90. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 121.

91. *Id.*

These stressors create a phenomenon known as "weathering,"[92] which provides a framework illustrating how women often experience worse health outcomes due to the impact of repeated lived experiences of "social, economic, or political exclusion."[93] The impact of lived racism not only affects self-esteem and feelings of confidence and value, but also takes hold of the body in ways that manifest through poor health behaviors, high pregnancy morbidity, and negative childbirth outcomes.[94] The combined effects of the medicalization of childbirth and societal racial discrimination leave Black women vulnerable to complications and mistreatment in the hospital. To reverse the state of health care as it exists, the first step is acknowledging the systemic racism that persists in the teaching methods of medical schools to further a system of health care that heals rather than harms.[95] Further, to improve birthing outcomes for Black women, society should acknowledge that hospitals are not the only settings in which women can give birth.

### *C. The Benefits of Doula and Midwifery Services*

The midwifery model is an underutilized alternative to a traditional hospital birth; however, the alternative should be the norm. The benefits of the midwifery model, which include reduced costs and high rates of positive birth outcomes, place Black women in a better position to feel heard by their providers.[96] Further, the midwifery model has resulted in lower rates of cesarean birth, preterm birth, and neonatal mortality, as well as higher rates of spontaneous vaginal birth.[97]

Far too often, Black women face barriers to obtaining midwifery and doula services, especially relative to white women.[98] The current picture

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92. The concept of weathering explains the potential for women of color to be more susceptible to stress compared to white women. Cheryl L. Giscombé & Marci Lobel, *Explaining Disproportionately High Rates of Adverse Birth Outcomes Among African Americans: The Impact of Stress, Racism, and Related Factors in Pregnancy*, 131 PSYCH. BULL. 662, 666 (2005).

93. *Id.* at 666–67 (quoting Arline T. Geronimus, *Understanding and Eliminating Racial Inequalities in Women's Health in the United States*, 56 J. AM. MED. WOMEN'S ASS'N 133, 133 (2001)).

94. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 121.

95. Medical students are "demanding that [medical] schools eliminate the use of race as a diagnostic tool, recognize how systemic racism harms patients and reckon with some of medicine's racist history." *See* Elizabeth Lawrence, *In Medical Schools, Students Seek Robust and Mandatory Anti-Racist Training*, WASH. POST (Nov. 8, 2020, 2:00 PM), https://www.washingtonpost.com/health/racism-medical-school-health-disparity/2020/11/06/6608aa7c-1d1f-11eb-90dd-abd0f7086a91_story.html [https://perma.cc/FX8Z-YWGN].

96. Kukura, *supra* note 67, at 852.

97. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 279.

98. Mickey Sperlich, Cynthia Gabriel & Julia Seng, *Where Do You Feel Safest? Demographic Factors and Place of Birth*, 62 J. MIDWIFERY & WOMEN'S HEALTH 88, 91

of the women who are unable to utilize midwifery services starkly contrasts with the demographic of women who once benefited from these services generations ago.[99] Black midwives were critical figures in society, many of whom walked miles to care for laboring women.[100] Lay practitioners who assisted during both labor and delivery—often affectionately known as "granny midwives"—served as prominent figures in the American South.[101] Granny midwives were an indispensable resource and source of support for Black laboring women, women who benefited from the midwives' traditional remedies brought to the States from African countries.[102]

Despite the vital role granny midwives played in the Black community, the medical profession as a whole harbored intolerance toward these midwives.[103] This intolerance led medical professionals to push granny midwives out of their field, evident by the way these professionals advocated for the elimination of granny midwives as the focal point of medical journals.[104] The lack of tolerance for granny midwives gave way to the passage of the Sheppard-Towner Act of 1921, which imposed new regulations on Black midwives.[105] Despite the odds stacked against Black women due to societal and institutionalized racism in the hospital setting, midwife-attended births may be the dose of medicine necessary to reverse the disparate birth outcomes that currently exist. The woman-centered philosophy of care upon which the midwifery model is based provides vital affirmation to women of color, which is critical in obtaining successful birth outcomes.[106]

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(2017). According to 2010 data, the nonhospital birth rate for white women is 1.75 percent compared with a rate of 0.48 percent for Black women. Thompson, *supra* note 84, at 43–44; *see also* BIRTH SETTINGS IN AMERICA, *supra* note 40, at 64.

99. Scheier, *supra* note 88.

100. *Id.* (explaining that Black midwives would also provide other nurturing services such as massaging the feet of laboring women, cooking, babysitting, or reading from the Bible).

101. Nina Renata Aron, *Meet the Unheralded Women Who Saved Mothers' Lives and Delivered Babies Before Modern Medicine*, TIMELINE (Jan. 11, 2018), https://timeline.com/granny-midwives-birthed-rural-babies-and-saved-lives-33f12601ba84 [https://perma.cc/567Z-Z4BP].

102. Alicia Bonaparte, The Persecution and Prosecution of Granny Midwives in South Carolina, 1900-1940, at 5–6 (Aug. 2007) (Ph.D. dissertation, Vanderbilt University) (ProQuest).

103. *Id.* at 13–14.

104. Aron, *supra* note 101; *see also* Bonaparte, *supra* note 102, at 13–14 (explaining that granny midwives who rejected the ways of white individuals or performed midwifery care with practices rooted in tradition were pushed out of birthing work altogether).

105. Yoder & Hardy, *supra* note 35, at 1.

106. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 122 ("[T]here is evidence to suggest that socially and financially disadvantaged women may thrive in midwifery models of care across all birth settings.").

## IV. TORT LAW IS INCAPABLE OF MAKING BLACK WOMEN WHOLE AGAIN

Although tort law can be a useful tool for women harmed during childbirth, the pursuit of tort claims, such as medical malpractice, often fails Black birthing women for two reasons. First, the duality of childbirth places the fetal harms over the harms experienced by the birthing mother and subordinates the harms of the mother;[107] and second, tension arises when determining whether to apply an objective or subjective standard of care. Thus, the result-oriented framework of tort law does little to address the root of the issue: the disparate birth outcomes for Black women.

### *A. The Duality of Childbirth Results in the Diminishment of Harms Experienced by Mothers*

Although medical malpractice suits are a way to seek relief from the courts, cases involving injuries arising during birth often lead to a duality that may preclude a finding in favor of the harmed mother.[108] Placing the primary focus on fetal harms results in the harms endured by the mother being either diminished or overlooked entirely.[109] This phenomenon, known as "fetal consequentialism," refers to the idea that the birth of a healthy baby outweighs the harm suffered by the mother during birth.[110] In fact, doctors recognize that they act in ways to minimize harm to the fetus, which often results in the needs of the birthing woman being pushed aside.[111] While a focus on the health of the fetus is an important and legitimate goal, that does not justify the subordination of the health of the mother.[112] For the past several centuries, harm to the fetus was considered "normal" and harm to the mother was almost expected.[113] Today, however,

107. *See* Abrams, *supra* note 18, at 1975 ("Maternal harms claims are rare and relatively nominal, whereas fetal harms are more common, yield large verdicts, are exceedingly emotionally compelling, and are extensively studied as a vehicle in tort reform.").

108. Although plaintiff's firms often advertise for fetal injury claims, the same cannot be said for harms sustained by the birthing mother, which illustrates the subordination of maternal harms to the harms of the fetus. Additionally, "[m]ore often, websites advertise for birthing harms cases, but exclusively describe claims relating to the child." *Id.* at 1983. This further demonstrates why harmed birthing mothers are unlikely to prevail on their tort claims.

109. *See id.*

110. Nadia N. Sawicki, *Fetal Consequentialism and Maternal Mortality*, PETRIE-FLOM CTR. AT HARV. L. SCH.: BILL OF HEALTH (May 16, 2017), https://blog.petrieflom.law.harvard.edu/2017/05/16/fetal-consequentialism-and-maternal-mortality/ [https://perma.cc/Z3L6-N3MB].

111. Abrams, *supra* note 18, at 1991.

112. *Id.* at 1981–83, 1983 n.180 (explaining that the primacy of fetal harms often results in a lax application of informed consent doctrine to the birthing woman).

113. *Id.* at 1993.

with the assistance of modernized health care, the emphasis is on the "perfect baby," which causes courts to inappropriately minimize the harms suffered by mothers.[114]

More specifically, the existence of a healthy baby often negates a finding that the birthing woman was harmed.[115] For example, in *Jefferson v. Griffin Spalding County Hospital Authority*,[116] the court ruled in favor of a hospital that authorized a cesarean despite the laboring woman's protestations.[117] In *Jefferson*, the mother refused to consent to a cesarean due to her religious beliefs, despite being informed that "[t]here [was] a 50 percent chance that [she would] die" if she were to give birth vaginally.[118] The court reasoned that "the intrusion . . . into the life of Jessie Mae Jefferson and her husband, John W. Jefferson, is outweighed by the duty of the State to protect a living, unborn human being from meeting his or her death."[119]

Although there are cases in which the court rules in favor of the mother's ability to dictate how her birth occurs despite the risks,[120] the existence of caselaw finding against the mother's exercise of choice illustrates the norm of fetal harms superseding the harms suffered by mothers.[121] The court often positions the fetus as the primary actor in such litigation by emphasizing the "sex, size, and health of the fetus."[122] Additionally, the court may attempt to critique the birthing mother and her personal tendencies or attributes to show that regardless of the physician's negligence, the same outcome would have resulted.[123] All of these maneuvers contribute to the subordination of the harms suffered by the mother, thus making it harder for harmed women to prevail in medical malpractice cases.

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114. *Id.*

115. *Id.* at 1986; *see, e.g.*, *Harrison v. United States*, 284 F.3d 293, 299–300 (1st Cir. 2002) (holding that the district court erred in weighing "the risks to the mother of a C-section, which the court found to be 'more than normally associated with the birth of a child,' against the risks to the child of a vaginal birth").

116. 274 S.E.2d 457 (Ga. 1981).

117. *Id.* at 459–60.

118. *Id.* at 459.

119. *Id.* at 460.

120. *See, e.g.*, *In re Baby Boy Doe v. Mother Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994) (holding that a woman's choice to refuse medical advice to obtain a cesarean must be honored, even if the choice may pose harm to the fetus).

121. *See, e.g.*, *Domann v. Vigil*, 261 F.3d 980, 984 (10th Cir. 2001) (denying a negligence claim against an obstetrician when the baby was born healthy but the mother was substantially harmed).

122. Abrams, *supra* note 18, at 1981.

123. *E.g.*, *White v. Edison*, 361 So. 2d 1292, 1296 (La. Ct. App. 1978).

### *B. The Framework of Tort Law Gives Way to the Inherent Tension Between Weighing Subjective and Objective Standards of Care*

Tort law largely centers on analyzing the standard of care, which is generally evaluated by assessing how a reasonable actor would behave in a particular situation.[124] In medical malpractice cases, courts typically evaluate how other competent doctors would reasonably act in the situation.[125] The court may also consider the reasonableness of the patient's actions, which gives way to troubling results, particularly if the plaintiff resists the direction of doctors.[126] Therefore, the tort framework may elevate the actions of doctors as reasonable while dismissing a woman's attempt to dictate her birth experience on her own terms.

However, this standard often presents issues, particularly when courts also consider the subjective, lived experiences of the harmed patient. *Schreiber v. Physicians Insurance Company of Wisconsin*[127] illustrates the subordination of the birthing woman's role in the labor process, which starkly contrasts with the elevation of the doctor's judgment.[128] In *Schreiber*, Janice Schreiber and her husband alleged that their doctor's refusal to perform a cesarean despite the mother's insistence violated the informed consent statute.[129] During the time of her pregnancy, medical research suggested that having a vaginal birth after cesarean (VBAC) was no more dangerous than birth by cesarean.[130] Janice's doctor recommended that they attempt a VBAC, to which Janice agreed under the belief that she could change her mind during labor and instead opt for a cesarean.[131] However, as her labor progressed, her doctor seemed to ignore her freedom of choice.[132] As Janice endured "unbearable" pain and urged her doctor to abandon the VBAC and instead undergo a cesarean, the doctor persistently pushed back on her request.[133] Due to further complications that arose during labor, the doctor performed an emergency cesarean, at which point the damage was too great—Janice's baby was born a quadriplegic.[134] The Wisconsin Supreme Court held that the doctor

124. RESTATEMENT (THIRD) OF TORTS § 3 (AM. L. INST. 2010).
125. Abrams, *supra* note 18, at 1986.
126. *Id.* at 1996.
127. 588 N.W.2d 26 (1999).
128. *See id.* 33–34; *see also* Abrams, *supra* note 18, at 1986.
129. *Schreiber*, 588 N.W.2d at 28–29.
130. *Id.* at 28.
131. *Id.*
132. *Id.* at 28–29.
133. *Id.*
134. *Id.* at 29.

violated the consent statute due to Janice's withdrawal of consent to the vaginal delivery when alternative avenues of medical treatment existed.[135]

Although the Wisconsin Supreme Court in *Schreiber* declined to apply the objective test, reasoning that an inquiry into what "the patient himself or herself want[s]" may "lead to absurd results,"[136] a different court may have taken a different approach. Specifically, the dissenting judge in the Wisconsin Court of Appeals' *Schreiber* decision wrestled with the objective and subjective standards in the case and ultimately concluded that the objective standard should prevail to give guidance to doctors.[137] The different approaches to cases of this nature illustrate the tension between the autonomy of the doctors and the harms suffered by the mother during birth.

### *C. The Consequences of Acting Against Medical Advice*

While the objective standard employed by the courts in medical malpractice cases poses difficulties for harmed mothers, exercising autonomy during labor may also hinder a mother's chance of prevailing. Despite the right to refuse medical treatment, when a woman goes against the mode of care prescribed by her doctors, she risks facing judgment and criticism in court, which also deters other women from voicing the types of birth experiences they envision.[138] When women act against the advice of their doctors, doctors tend to ignore the wishes of the patient and instead pursue a treatment that favors the fetus's interests.[139] As a result, a phenomenon known as "maternal-fetal" conflicts arises.[140] Further, patients who go against the mode of care prescribed by their doctors may be painted as acting "irrationally" or described as "making decisions in the abstract."[141] When lawyers define patients in this manner, jurors may be swayed to find that the patient was not acting reasonably, which could result in a verdict favoring the doctor.[142] The characterization of women who decide to exercise autonomy over their bodies despite contrary advice

135. *Id.* at 34–35 ("[W]e determine that Janice withdrew her consent to a vaginal delivery. Because alternative viable modes of medical treatment existed at that time, her withdrawal constituted a substantial change in circumstance obliging Figge under Wis. Stat. § 448.30 to conduct a new informed consent discussion and affording Janice the opportunity for a choice of treatment.").

136. *Id.* at 34.

137. *Schreiber v. Physicians Ins. Co. of Wis.*, 579 N.W.2d 730, 739 (Wis. Ct. App. 1998) (Myse, J., dissenting).

138. *See* Oberman, *supra* note 41, at 480–82.

139. *Id.* at 454.

140. *Id.* ("The construction of these conflicts as 'maternal-fetal,' or arising between pregnant women and their fetuses, begins when doctors project their own estimations of the optimal course of action onto their pregnant patients.").

141. Abrams, *supra* note 18, at 1994–95.

142. *See* Oberman, *supra* note 41, at 491.

by physicians should not result in a finding that the patient was unreasonable due to the doctrine of informed consent.[143]

## V. NON-COMPREHENSIVE MEDICAID PLANS HARM BLACK MAMAS

Tort law is not only an insufficient means of making Black women whole, but it also fails to address the crux of the Black maternal mortality rate. Thus, reforming how women obtain obstetric services may be the solution.[144] The vulnerability that Black women face while giving birth illustrates the urgent need to expand Medicaid plans to fully encompass how women can obtain midwife-attended births outside of the hospital. With Medicaid covering approximately fifty percent of births in the United States, Medicaid is a powerful tool to improve the birth outcomes of Black women in America.[145] This Comment argues for expanding Medicaid to include one hundred percent reimbursement rates for freestanding birth centers, midwifery services, and doula service coverage. This expansion could signal a shift to a more holistic view of childbirth that conceives of birth as more than a purely medical event.[146] Further, this shift would provide Black women the autonomy to choose their birth experience rather than being locked into a prescribed route of birth as dictated by many existing Medicaid plans, which far too often result in birth experiences fraught with interventions.[147]

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143. *Cf. Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (holding that individuals possess a right to refuse medical treatment under the Due Process Clause).

144. Although an award of damages, particularly for pain and suffering, can help ease the burdens of the harmed mother, this type of relief does not erase the experiences Black women face when medical providers fail to provide proper care. Further, no amount of money can erase the institutional racism that is present in the medical industry or eliminate the actions of doctors who fail to take seriously the pain expressed by their patients.

145. *Medicaid Coverage and Reimbursement*, AM. COLL. OF NURSE-MIDWIVES, https://www.midwife.org/Medicaid-Coverage-and-Reimbursement [https://perma.cc/QQ7A-A8DS] (last visited Oct. 9, 2021). While midwife reimbursement rates are not yet equitable, certified nurse-midwives receive 100% reimbursement rates under Medicare. *Equitable Medicare Reimbursement*, AM. COLL. OF NURSE-MIDWIVES, https://www.midwife.org/equitable-reimbursement [https://perma.cc/6GSA-PB22] (last visited Oct. 9, 2021) ("As of January 1, 2011, the CNM reimbursement rate increased from 65% to 100% of the Medicare Part B fee schedule."). Thus, individual states should follow suit and implement the same uniform reimbursement rates for both midwives and doula services under their respective Medicaid programs.

146. All states recognize and reimburse CNM and CM services at an equal or lower rate than physicians. However, the Medicaid programs of individual states vary regarding whether CPM services are covered. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 80.

147. *See* Benatar, Garrett, Howell & Palmer, *supra* note 48, at 1753 (hypothesizing that birth center delivery models may give rise to more culturally appropriate care and better birth outcomes).

### *A. The Lasting Impact of* National Federation of Independent Business v. Sebelius

The lack of uniformity regarding the states that recognize freestanding birth centers as health providers leads to unequal access to midwifery services across the country.[148] Further, despite the Supreme Court upholding the ACA, gaps in access to medical care continue to exist.[149] This can be attributed to the holding in *Sebelius*, in which the Court found Medicaid expansion unconstitutionally coercive to the states.[150] The Medicaid expansion envisioned under the ACA allowed Congress to induce participation in the program by threatening to pull all existing Medicaid funding if states did not comply.[151] As a result, Chief Justice Roberts analogized Congress's exercise of authority to the act of "placing a 'gun to the head' of the states," as states would have no other choice but to comply with the expansion.[152] Twenty-six states argued that the Medicaid expansion mandate was coercive, and for the first time, the Supreme Court accepted the "undue coercion argument."[153] Due to this holding, the services covered by Medicaid vastly differ from state to state, some of which do not include full coverage for out-of-hospital midwifery services.

### *B. The Status of Freestanding Birth Centers*

While the ACA requires reimbursement to birth centers, many of these centers still experience difficulties when attempting to accept patients on Medicaid.[154] And further, the variation in reimbursement rates for midwives working at freestanding birth centers leaves these centers ill-equipped to accept women as patients who are on Medicaid.[155] Birth centers are home-like facilities, centered on a wellness model of birth and

148. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 80. Section 2301 of the ACA only requires states to cover the costs of services at freestanding birth centers if the state licenses or recognizes the center under state law. *Id.*

149. *See id.*

150. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 575–88 (2012).

151. Jane Perkins, *Implications of the Supreme Court's ACA Medicaid Decision*, 41 J.L., MED. & ETHICS 77, 78 (Supp. 2013).

152. *Id.* (quoting *Sebelius*, 567 U.S. at 581).

153. *Id.* at 77.

154. Sarah Benatar, *Enhanced Medicaid Support for Out-of-Hospital Births Could Protect Moms and Babies and Reduce Hospital Strain*, URB. INST.: URBAN WIRE (Apr. 10, 2020), https://www.urban.org/urban-wire/enhanced-medicaid-support-out-hospital-births-could-protect-moms-and-babies-and-reduce-hospital-strain [https://perma.cc/MH78-2BWK].

155. JENNIFER E. MOORE, KAREN E. GEORGE, CHLOE BAKST & KAREN SHEA, INST. FOR MEDICAID INNOVATION, IMPROVING MATERNAL HEALTH ACCESS, COVERAGE AND OUTCOMES IN MEDICAID 42–43 (2020).

pregnancy.[156] As defined in the ACA, "freestanding birth center" means a health facility

> (i) that is not a hospital; (ii) where childbirth is planned to occur away from the pregnant woman's residence; (iii) that is licensed or otherwise approved by the State to provide prenatal labor delivery or postpartum care and other ambulatory services that are included in the plan; and (iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.[157]

Although freestanding birth centers are mandatory Medicaid benefits under Section 2301 of the ACA, that applies only to the extent that the state recognizes freestanding birth centers as providers under state law.[158] Nine states do not have regulations or do not recognize freestanding birth centers as providers, though some centers may still operate without licenses.[159] State licensure regulations of birth centers generally include a definitions section, staff requirements, fire and building codes, and explicit services that cannot be provided in the center.[160] Additionally, the inconsistent application of Section 2301 has resulted in licensed or recognized birth centers in some states that remain uncovered by Medicaid plans.[161]

The patchwork of states that do not have regulations for licensing birth centers results in inequities in who can access out-of-hospital births. Even in states where licensure for freestanding birth centers is available, limits on the total number of birth centers hinder the accessibility of this birthing option. This is the case in Illinois, "which allows up to 10 birth centers to be licensed by the Illinois Department of Public Health as birth center alternative health care delivery models."[162] The law specifies that four of the centers should be in Cook, DuPage, Kane, Lake, McHenry, and

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156. AM. ASS'N OF BIRTH CTRS., *supra* note 57, at 1 (Midwifery is the "exclusive model of care in a birth center.").

157. 42 U.S.C. § 1396d(*l*)(3)(B).

158. MOORE, GEORGE, BAKST & SHEA, *supra* note 155, at 29, 43.

159. Maine, Vermont, Virginia, North Carolina, Alabama, Michigan, Wisconsin, North Dakota, and Idaho do not have regulations for the licensure of birth centers. *Id.* at 42. Therefore, Medicaid benefits do not extend to cover the services provided in freestanding birth centers. *Id.* at 43.

160. *Birth Center Regulations*, AM. ASS'N OF BIRTH CTRS. (2016), https://www.birthcenters.org/page/bc_regulations [https://perma.cc/KMK2-MS5Z]; *see, e.g.*, 16 DEL. ADMIN. CODE § 4403 (2008); *see also* BIRTH SETTINGS IN AMERICA, *supra* note 40, at 80–82.

161. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 80.

162. *See* ILL. ADMIN. CODE tit. 77, §§ 265.1000–.1050 (2019) (defining birth center as "an alternative health care delivery model that is *exclusively dedicated to serving the childbirth-related needs of women and their newborns and has no more than 10 beds*").

Will Counties; one of the centers should be owned or operated by the hospital; and another should be "owned or operated by a federally qualified health center."[163] Despite the law providing for up to ten birthing centers, only two centers exist.[164] Some suggest that the reason for the low number of birth centers is due to the specific Illinois regulations to which birth centers must conform.[165] The lack of birth centers in Illinois demonstrates the *Goldilocks* phenomenon of certain states having so much regulation that birth centers are deterred from opening, which starkly contrasts with states such as Wisconsin and North Dakota, where no route exists for freestanding birth centers to gain state licensure.[166]

In the case of a birth center seeking licensure where state licensure is available, the facility must gain accreditation through the Commission for Accreditation of Birth Centers (CABC), which ensures the safety and quality of the care offered in the centers.[167] Furthermore, if the center seeks to accept health insurance, such as Medicaid payments, the center must then apply for service provider credentials.[168] The issue arises here—when states do not provide licensure requirements for freestanding birth centers, those centers are effectively shut out from receiving any Medicaid reimbursement, thus hindering the accessibility of this birth model.[169] In other words, a license to operate a birth center is required for a birth center to accept government-based health insurance plans, such as Medicaid.[170] As a result, obtaining a birth in freestanding birth centers remains inaccessible to Medicaid recipients, which further entrenches the dominance of hospital births for Black women.[171]

Although providing a route to freestanding birth center licensure is critical to improving access to out-of-hospital maternal care, even when states provide licensure, inaccessibility of care persists. In the majority of states that do provide licensing routes for freestanding birth centers, the reimbursement rates for midwives, particularly CPMs, are not equal to the

163. 210 ILL. COMP. STAT. 3/30 (2021).

164. Alison Bowen, *Chicago Still Doesn't Have Standalone Birthing Centers, Even as Options for Pregnant Women on the South and West Sides Are Dwindling*, CHI. TRIB. (Aug. 28, 2020), https://www.chicagotribune.com/living/health/ct-life-pregnant-south-west-sides-delivery-illinois-birthing-centers-20200828-cyax76bjozhi7beftnwnudcp2e-story.html.

165. *Id.*

166. Jill Alliman & Julia C. Phillippi, *Maternal Outcomes in Birth Centers: An Integrative Review of the Literature*, 61 J. MIDWIFERY & WOMEN'S HEALTH 21, 21 (2016) (explaining that North Dakota is the only state where birth centers are not a legal option for providing perinatal care).

167. MOORE, GEORGE, BAKST & SHEA, *supra* note 155, at 42–43.

168. *Id.*

169. *Id.* at 42.

170. *Id.* at 43.

171. Benatar, *supra* note 154.

reimbursement rates of doctors for the same services.[172] Medicaid payments for obstetric services can run as low as thirty percent of the rates of private insurance.[173] Additionally, in twenty-two states, CNMs "receive less than 100 percent of the fee as compared to physicians."[174] As a result, freestanding birth centers often focus on self-pay clients or private insurers and employer-sponsored insurance policies.[175] Further, the rates of compensation under Medicaid are not equal to those of physicians, which discourages midwives operating in freestanding birth centers from accepting patients on Medicaid.[176]

## VI. POLICYMAKERS MUST EMBRACE HOLISTIC BIRTH METHODS AS A LEGITIMATE FORM OF CARE

In light of the benefits arising from midwifery care, doula services, and freestanding birth centers,[177] policymakers should embrace this mode of care by ensuring that the services are accessible to all women. Policymakers in the nine states that currently do not have regulations regarding freestanding birth centers or that do not recognize freestanding birth centers as providers should pass legislation that recognizes the centers as such. This type of legislative change would make freestanding birth centers more accessible to women of color while providing a vital birth alternative, one that is separate from the hospital setting. Further, equalizing the reimbursement rate of midwives and the implementation of Medicaid coverage for doula services would eliminate the current financial barriers to holistic birthing methods that currently exist.

### *A. Improving Licensing for Freestanding Birth Centers*

Increased recognition and registration of freestanding birth centers will likely help Black women give birth in the centers under the midwifery model. While the benefits of freestanding birth centers include being a separate entity from hospitals, cost savings are an additional benefit.[178]

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172. *See id.*

173. MOORE, GEORGE, BAKST & SHEA, *supra* note 155, at 44.

174. *Id.* at 38.

175. *Id.* at 44 ("Since Medicaid payment . . . can be as low as 30 percent of commercial payment rates, the economics for low-volume centers with high personnel costs, malpractice insurance, and other operating and facility costs have driven freestanding birth centers to concentrate only on self-pay clients, or, if they do take health insurance payments, only employer-sponsored commercial payers, to remain solvent.").

176. *Id.* at 40.

177. *See generally* Scheier, *supra* note 88.

178. Embry Howell, Ashley Palmer, Sarah Benatar & Bowen Garrett, *Potential Medicaid Cost Savings from Maternity Care Based at a Freestanding Birth Center*, MEDICARE & MEDICAID RSCH. REV., 2014, at 2. *Supporting Access to Freestanding Birth*

Specifically, Idaho, Maine, Michigan, North Carolina, Vermont, and Wisconsin, which currently have no regulations regarding the licensure of birth centers,[179] should provide a means by which licensure can be obtained. While the American Association of Birth Centers sets national standards measuring the quality and safety of the services provided in freestanding birth centers,[180] even if a birth center is registered with the Association, the center remains ineligible for Medicaid reimbursements if the state does not provide a route for licensure.[181]

Medicaid expansion also faces resistance from legislators, the public, and, most vocally, hospitals.[182] The Centers for Medicare and Medicaid Services ("CMS") proposed paying the same rate for services at "off-campus hospital outpatient departments and independent doctors' offices," which could save Medicare an estimated $610 million.[183] CMS estimates that they were paying $75 to $85 more for the same services performed outpatient than those performed in hospitals or physician settings.[184] Hospitals, however, contend "that their higher reimbursement rates are needed to pay for expensive overhead costs."[185] The ability to receive higher payments allows hospitals to pay their physicians more, thus contributing to the decline of private and independent practices, such as freestanding birth centers.[186]

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*Centers Makes Sense*, AM. ASS'N OF BIRTH CTRS., https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/Strong_Start/Strong_Start_Resources_Files/Impact_Statement_-_Supportin.pdf [https://perma.cc/S2PP-24YQ] ("Medicaid can realize cost savings from 1) reducing the number of c-sections, 2) reducing costs of normal deliveries, and 3) reducing preterm births and other costly complications after delivery for both the mom and baby.") (last visited Oct. 29, 2021).

179. MOORE, GEORGE, BAKST & SHEA, *supra* note 155, at 42.

180. *National Standards for Birth Centers*, AM. ASS'N OF BIRTH CTRS. (2016), https://www.birthcenters.org/page/Standards [https://perma.cc/4PXK-H2X5].

181. MOORE, GEORGE, BAKST & SHEA, *supra* note 155, at 43.

182. Significant proponents of the combination of regulations on birth centers and complex restrictions on midwives are "powerful hospital and medical association lobbyists who use the rules to strangle potential competition." Lauren K. Hall, Opinion, *Unnecessary Risk: Women Need Safer Options than Giving Birth in Hospitals During Pandemic*, USA TODAY (Jan. 10, 2020, 6:00 PM), https://www.usatoday.com/story/opinion/2021/01/10/why-giving-birth-pandemic-riskier-than-should-column/6561318002/ [https://perma.cc/2NQ9-WUVX].

183. Alex Kacik, *Proposed Site-Neutral Payment Policy Sets the Stage for Battle Royale Between CMS, Hospitals*, MOD. HEALTHCARE: TRANSFORMATION HUB (July 26, 2018, 6:00 PM), https://www.modernhealthcare.com/article/20180726/TRANSFORMATION04/180729927/proposed-site-neutral-payment-policy-sets-the-stage-for-battle-royale-between-cms-hospitals [https://perma.cc/CTD2-DR6B].

184. *Id.*

185. *Id.*

186. *Id.* (explaining further that the high payments reduce competition between independent practices).

Many emphasize the problems that arise with the government paying for medical care.[187] Additionally, some argue that the incentives to cut costs will be eliminated because Medicaid providers know they will be reimbursed.[188] However, this concern can be addressed. Freestanding birth center recognition and regulation are estimated to save $1,163 per birth, or a total of $11.6 million per 10,000 births each year.[189] The savings that result from the use of freestanding birth centers rather than hospitals are attributed to the following: lower service costs of midwives;[190] lower rates of pre-term and early term births; and lower delivery costs.[191] As such, policymakers in the states that do not currently provide routes to state licensure for freestanding birth centers should pursue a licensing program that would result not only in cost savings, but also in improved birth outcomes.

### *B. Midwife and Doula Reimbursement*

The variation in the reimbursement rates for CNMs compared to physician reimbursement rates calls for an equalization of the playing field. Although twenty-nine states feature a one hundred percent reimbursement rate under Medicaid, the remaining twenty-one states do not.[192] It follows that legislators in the remaining twenty-one states must advocate for the expansion of Medicaid to include full reimbursement of these services. The re-framing of out-of-hospital, midwife-attended births as legitimate birth models could be instrumental in shifting the narrative that women must only give birth in hospital settings. Due to the institutionalized racism upon which hospitals were built,[193] the restructuring of Medicaid to fully encompass midwife-attended births can reverse the disparate birth outcomes for Black women.

Due to the inaccessibility of doula services, Medicaid expansion that includes reimbursement for doula services is a solution that ensures that

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187. *See* Jordan Roberts, *The Case Against Medicaid Expansion*, JOHN LOCKE FOUND. (Jan. 25, 2019), https://www.johnlocke.org/update/the-case-against-medicaid-expansion/ [https://perma.cc/S624-BE5C].

188. A major critique of Medicaid expansion is that the incentive to cut costs will be eliminated because Medicaid providers know they will be reimbursed. *Id.*

189. Howell, Palmer, Benatar & Garrett, *supra* note 178, at 1, 7 (referring to the difference between usual childbirth care and birth center care).

190. *Id.*; *see also* Allen & Benatar, *supra* note 16, at 7.

191. Howell, Palmer, Benatar & Garrett, *supra* note 178, at 7.

192. *Certified Nurse-Midwife and Certified Midwife Medicaid Reimbursement Rates*, AM. COLL. OF NURSE-MIDWIVES (2013), https://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000003374/Medicaid%20Reimbursement%20R
ates.%20September%202013.pdf.

193. Taylor, *supra* note 14, at 506–09.

Black mothers are heard and respected during birth.[194] Currently, Minnesota, New York, and Oregon are the only states that have extended Medicaid coverage to encompass doula services.[195] The remaining forty-seven states should follow suit and may find general guidance from New York's pilot program.[196] Guided by research indicating that doulas may have positive effects on maternal and infant health, New York's plan is a preventative and holistic-oriented birth approach that aims to "reduce racial disparities in health outcomes."[197] While New York has taken a step in the right direction—a step that the majority of states have not ventured to take—the reimbursement rates have been criticized as being too low.[198] Despite the push and pull of creating state Medicaid programs that encompass doula services while also attempting to reimburse doulas at appropriate rates, this should not deter states from expanding their current programs.

## CONCLUSION

The pain that Simone Landrum experienced from losing her baby girl during childbirth—a wholly preventable death—is just one example of the losses that arise unnecessarily during childbirth.[199] The disparities in birth outcomes for Black women illustrate the dire need for change that attacks the problem rather than an approach that targets the harms that result from inadequate care. Despite its abolition, the vestiges of slavery still linger in the health care system, manifesting in physicians' failure to take their Black patients seriously, the general distrust that Black individuals feel toward the health care system, and microaggressions that Black patients face from medical staff.[200] The medicalization of childbirth thrusts women of color into hospitals, the very institution that far too often perpetrates violence against Black bodies.

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194. *What Role Could Doulas Play in Addressing Black American Maternal Mortality?*, *supra* note 52.

195. BIRTH SETTINGS IN AMERICA, *supra* note 40, at 289.

196. *New York State Doula Pilot Program*, N.Y. STATE: DEP'T OF HEALTH (Sept. 2021), https://www.health.ny.gov/health_care/medicaid/redesign/doulapilot/index.htm [https://perma.cc/L6MJ-GY7B] ("Medicaid program to cover doula services for Medicaid fee-for-service and Medicaid Managed Care enrollees.").

197. *Id.*

198. Christina Gebel & Sarah Hodin, *Expanding Access to Doula Care: State of the Union*, MATERNAL HEALTH TASK FORCE: BLOG (Jan. 8, 2020), https://www.mhtf.org/2020/01/08/expanding-access-to-doula-care/ [https://perma.cc/85LU-7GS6]. Minnesota and Oregon, states that have expanded Medicaid to cover doula services, have also received similar criticism. *See also* Adams, *supra* note 66.

199. *See* Villarosa, *supra* note 1.

200. *See* Cruz, Rodriguez & Mastropaolo, *supra* note 33.

This Comment illustrates how all of these elements, when combined with the stress of being a Black woman in America, warrant a holistic view of childbirth that envisions birth as more than a purely medical event. Rather than relying on tort law, which is an important route to hold wrongdoers accountable, this Comment argues that the expansion of Medicaid to cover the services of CPMs at rates equal to physicians and reforming or creating routes to register and recognize freestanding birth centers would provide Black women with a birthing experience tailored to their individual needs. By advocating for a more holistic and accessible way to obtain out-of-hospital and midwife-attended births, Black women may be able to exert autonomy over their birth experience, which will begin the necessary movement toward eliminating the disparity in birth outcomes. While the changes this Comment proposes require fierce lobbying and grassroots efforts, in the interim, this Comment aims to generate discussions about the benefits that result from midwife and doula services, as well as freestanding birth centers.