Maternal Mortality Legislation-HB 2573
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Megan McMahon MD

My name is Megan McMahon. I graduated medical school from Saint Louis University in Saint Louis, MO this past year. I moved to Kansas City, Kansas last year to start my residency in Obstetrics and Gynecology at the University of Kansas and I am honored to have the opportunity to advocate today on behalf of my patients and co-residents.

My first exposure to a maternal death was as a medical student. I showed up to the hospital early one morning and the night team was sitting there despondent. In a rural part of the state, a pregnant woman went into labor with no means of getting to the hospital on time. Her husband had come home from work and found her in the living room unconscious and covered in blood. She was life-flighted to the nearest tertiary care center, us, but had died before she arrived. It was a bad night.

Between 2003 and 2013, pregnancy related mortality has increased by 20% in the United States. We continue to see pregnancy related deaths at a higher rate than other developed countries. Why is this happening? As our medical knowledge grows by leaps and bounds, we should not be seeing this increase in maternal mortality. But that is not the case.

I was asked to share another story from a resident who could not be here today. A young woman was about 20 weeks pregnant and admitted for management of a sickle cell crisis. Her health quickly deteriorated and she was intubated. She suffered a massive stroke and would not wake up again. She passed away shortly after. It is still not fully clear why this happened.

The complexity surrounding pregnancy related deaths is immense. On a recent maternal mortality review the Centers for Disease Control found that the majority of deaths have 3-4 critical factors that lead to the final outcome. To fully understand and have an impact on pregnancy related deaths, it is critical to have a systematic, state wide approach to analyze potential causes and identify areas to implement change. Maternal mortality review boards are a proven method to do just that. The state of California, after implementing their maternal mortality review board, saw a decrease in their maternal mortality rate of 55%.

These deaths are preventable. We can reverse the upward trending of maternal mortality. We just need more data. We need maternal mortality review boards. The women who are dying are not the only ones who are suffering. These are young women who are expected to live for decades more. Who are expected to nurse their newborn child, teach them to read, help them grow strong and healthy. Instead, too many are dying before they get a chance to become mothers. This is a matter of public health. These are outcomes we can change. So I urge you to support the creation of maternal mortality review boards and support HB2573.

House Health and Human Services
Date:____________________
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