Testimony Before the
House Committee on Health Care regarding Support for HB 4133
Presented by Marguerite P. Cohen, M.D.
on behalf of the Oregon Medical Association
February 9th, 2018

Chairman Greenlick, members of the committee, thank you for the opportunity to testify today.

My name is Dr. Marguerite Cohen, and I am a member of the Oregon Medical Association and the Legislative Chair for the Oregon Section and District VIII of the American College of Obstetricians and Gynecologists. I specialize in Obstetrics and Gynecology, and I work at as a clinic physician at Kaiser Permanente and as an OB Hospitalist at Providence St. Vincent Hospital in Southwest Portland. I help to care for high risk maternity patients with medical complications of pregnancy such as high blood pressure, diabetes, preterm labor, narcotic addiction and obesity.

The maternal mortality rate, or MMR, is defined as the number of maternal deaths which occur per 100,000 live births. In the United States in 1930 the MMR was about 600/100,000 live births, and over the next twenty years it declined to about 50/100,000. That slow and steady decline continued until 1990 when the rate began to rise. The United States is the only highly industrialized country in which the maternal death rate is rising and has the highest maternal death rate of any developed country. From 2000 to 2014 it increased by about 25% and is now 21.4/100,000 live births. But even more concerning is the fact that the MMR is three to four times higher for African Americans, Native Americans and Alaska Natives than it is for Caucasians, Hispanics and Asian Americans.

The causes of these disparities are not well understood, but are likely related to social, economic, cultural, medical issues and a combination of other factors. Rural Americans are also at higher risk for complications of pregnancy and childbirth. Leading causes of maternal deaths include heart disease such as a heart attack or heart failure, a stroke from high blood pressure, severe bleeding, serious infection and blood clots in the lung. Today, more pregnant women in the U.S. have chronic health conditions such as hypertension, substance abuse and diabetes than in the past. Many are overweight or obese, and they are older

Oregon needs more data to understand why these disparities exist in a state which has focused on improving health care access and outcomes. For every maternal death, it is estimated that there are more than 50 cases of severe morbidity— very serious complications which are considered “near misses” in which death was averted. These also need to be studied.

34 other states have established Maternal Mortality Review Committees which look at each maternal death and try to determine exactly what happened and why. The Centers for Disease Control and the American College of Obstetricians and Gynecologists recommend that every state have an active, confidential Maternal Mortality Review Committee that uses standardized, uniform data collection and reporting tools.

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HB 4133 would establish a Maternal Mortality and Morbidity Review Committee in the Oregon Health Authority. The committee would provide specific, data-driven recommendations to prevent future maternal deaths. They would examine the medical and non-medical circumstances of deaths that occur during pregnancy up to one year after delivery. They would review medical records, birth and death certificates, autopsy reports, hospital emergency room records, medical transport, social services and mental health records and reports.

With a better understanding of the causes of maternal death in our state, groups such as the Oregon Perinatal Collaborative may be able to help implement recommendations that can help improve management of high risk situations such as hemorrhage and hypertension. The reduction of preventable maternal morbidity and mortality will improve health outcomes for both mothers and infants and is critical to the promotion of the health of our families. Oregon's vision for the future should be that no family or community suffers a loss of a mother due to a preventable pregnancy-related death. The Oregon Legislature should authorize the creation of a Maternal Mortality Review Committee for our state so that every Oregon family knows we are doing everything we can to make childbirth safer for every mother.

I would like to thank you once again for the opportunity to address the committee regarding this very important topic, and I am happy to answer any of your questions.

The Oregon Medical Association serves and supports over 8,000 physicians, physician assistants and student members in their efforts to improve the health of all Oregonians. Additional information can be found at www.theOMA.org.

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