

must be done; more coordination, more dedication and more dollars. This call to action comes not only from my background as a doctor and lawmaker. It is personal, too. About a century ago my dad's mother died in childbirth, casting a shadow over his long life and the lives of his siblings. The devastation caused by the unnecessary death of a mother and partner should not be any family's experience. A woman should not lose her life by *bringing* life into the world. With a firm agenda in mind and the funding to back it, we can move toward a day when almost no one

in the United States knows that kind of loss and heartbreak. **AJPH**

*J. Phillip Gingrey, MD*

#### CONFLICTS OF INTEREST

Ochsner Health System is a client of the District Policy Group.

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## Jewel Mullen Comments

 See also Morabia, p. 421, and Gingrey, p. 462.

The striking rise in US maternal mortality recently reported by the Centers for Disease Control and Prevention (CDC) makes a call to action logical and necessary. However, issuing such a call is not a novel act, and doing so has not been sufficient to achieve a lasting decrease in maternal deaths. Nor has it narrowed the persistent associated racial disparities in maternal deaths or prevented our national maternal mortality rate from sinking to the lowest rung among developed countries.

As early as 1987, at the first international Safe Motherhood Conference, former director general of the World Health Organization, Halfdan Mahler, issued a call to action urging governmental and private sector organizations to join a campaign to save women's lives. The goal was a 50% reduction in the number of maternal deaths worldwide by the year 2000.<sup>1</sup> Since that time, pregnancy-related maternal mortality has

decreased by more than 30% globally, whereas in the US it has more than doubled (from 7.2 to 16.9 deaths per 100 000 live births).<sup>2</sup> Both globally and nationally, the majority of maternal deaths are preventable. That reality, combined with worsening US outcomes, makes a call to action seem like a whisper. What women really need is a resounding demand for accountability that moves health care, public health, government, and other sectors from suggesting strategies necessary to prevent maternal deaths to consistently implementing and tracking them.

There are multiple examples of what connotes accountability for preventing maternal mortality. Leaders should promote the general welfare by upholding policies that mitigate inequities in access to safe, consistent, high-quality, evidence-based, and culturally and linguistically appropriate reproductive health care. Ensuring that all women

receive holistic interconception and prenatal services and standardized maternity care that includes management of chronic conditions is key to better outcomes. The constitutional obligation of achieving optimal health for all women must be a unifying, nonpartisan goal. If leaders adopt a “first do no harm” approach to reproductive health policy, their decisions will be driven by a commitment to women's safety and well-being, not political forces.

A second example of accountability is labeling preventable maternal deaths as “never events”—that is, dangerous errors that are preventable and should never occur—to eliminate them. Systems, teams,

and individuals need more real-time information to be proactive about rooting out the lapses in maternity care that are responsible for preventable deaths. The American College of Obstetricians and Gynecologists' recommendations on patient safety are such a nonpunitive, “just culture” framework that identifies and responds to staff who commit errors, risky actions, and recklessness.<sup>3</sup>

A third example of being accountable is accelerating solutions to maternal mortality disparities among African American and Native American/Alaska Native women. A woman's race and ethnicity are not causes, but racism that results in women's receipt of inferior medical treatment is one of them. The American College of Obstetricians and Gynecologists'

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*This comment was accepted January 15, 2020.*

*doi: 10.2105/AJPH.2020.305591*

**Note.** *Jewel M. Mullen contributed to this comment in her personal capacity. The views expressed are her own and do not necessarily represent the views of the Dell Medical School or the University of Texas.*

patient safety recommendations include improving physician–patient communications and partnerships. Similarly, the CDC suggests that identifying and addressing health care bias can nurture better relationships and improve maternal outcomes. It’s time to stop sugar-coating the word “racism” by invoking implicit and explicit bias instead. Naming racism is a step toward being intentional about undoing it to achieve equitable care.

Addressing racism promotes a justice culture in health care. So does effective public policy. Accountability for maternal mortality obliges us to build just and justice cultures. *AJPH*

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#### CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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