Whereas, Pregnancy-related deaths doubled in the United States in the past 25 years;¹ and

Whereas, An estimated 700 women die of pregnancy-related causes each year in the US and another 65,000 have serious health complications; many of these deaths and complications can be prevented²; and

Whereas, Leading causes of maternal deaths include cardiovascular disease, cardiomyopathy, thromboembolism, obstetric hemorrhage, preeclampsia, sepsis, hypertension and obesity, and more recently, drug overdose and maternal suicide;³ and

Whereas, The US lags far behind all other industrialized countries and is the only high-resource country with a rising maternal mortality rate;⁴ and

Whereas, There are significant and widening disparities in maternal mortality and morbidity, disproportionately impacting black women in the US;⁵ and

Whereas, There is a need to redouble efforts to prevent maternal deaths and national initiatives are underway to mobilize clinical and public health resources to improve safety in obstetric care, including establishing and strengthening state Maternal Mortality Review Committees; and

Whereas, The Centers for Disease Control and Prevention and ACOG recommend that all states have an active Maternal Mortality Review Committee; and

Whereas, Maternal Mortality Review Committees conduct systematic, confidential analysis of the medical and non-medical circumstances of deaths that occur during pregnancy or up to one year after--for the purpose of taking action to reduce the risk of women dying from complications of pregnancy; and

Whereas, Maternal Mortality Review Committees make specific, data-driven recommendations, identifying gaps in services and systems to prevent future deaths and near-misses as well as strengths in the systems of care that should be supported or expanded; and

Whereas, Review Committees conduct their confidential interviews and analysis of birth and death certificates, autopsy, hospital ER, medical transport, social services, and mental health records and reports within a culture of promoting safety—not to assign blame; and

Whereas, Maternal health and mortality are important indicators of the quality of health care and are at the core of what it means to have healthy, vibrant communities; therefore be it

RESOLVED, That our American Medical Association support the important work of maternal mortality review committees (New HOD Policy); and be it further

RESOLVED, That our AMA support work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees (New HOD Policy); and be it further

RESOLVED, That our AMA support work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

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