**Episode 59: Maternal Mortality – Part 2**

Dr. Joe Chappelle: Hello everyone, and welcome back. I’m Joe Chappelle and you’re listening to Episode 59 of the OB/GYN Podcast. First off, sorry for the delay in getting episodes out. This time of year is always busy with our resident research projects wrapping up, and I got a little behind. But I do have some great episodes coming out over the next few weeks plus some more interviews from the National Perinatal Association meeting back in April. Today’s episode is a conversation I had with Dr. Heather Link back in May about U.S. policy initiatives around maternal mortality. Dr. Link is always fascinating to talk to, and I hope you enjoy it as much as I did. So, let’s get started with Episode 59: Maternal Mortality – Part 2.

Alright, hello everyone. I’m here with Heather Link, an MFM fellow, soon to be graduating MFM fellow. And today we’re going to talk about some maternal mortality in the U.S. Welcome back, Heather.

Dr. Heather Link: Thank you so much. Happy to be here.

Dr. Joe Chappelle: Maternal mortality is not a new subject. Heather did a great talk for us back in January, I think, about global maternal mortality and the differences in different places, which was great. But today, I really wanted to focus on U.S. maternal mortality. And really, this came up because of a proposal by one of the democratic candidates for president, we’ll get into that in a minute. But it made me start thinking about this more and how, without the right data and the right people, who are giving advice to politicians, sometimes we end up with not the right solution. In fact, maybe the wrong solution. So, before I get there, I mean, everyone knows maternal mortality is bad in the U.S. and it’s going up. It’s one of the highest in developed countries. The most recent, 2014 data from the CDC shows that 18 per 100,000 live births, that’s maternal mortality. And starting in 1997, that was 7.2. So, in only 30 years we’ve more than doubled the maternal mortality rate. That’s pretty impressive.

H: In a not great way, that would be impressive. But yeah, definitely. I think we’re looking on newer info to come from the CDC. But I think the latest numbers are probably going to be even higher than that unfortunately. And I think one of the things that brings a lot of maternal mortality to the attention of the press lately has been the racial disparity that we have here in pregnancy-related mortality. So, deaths for white women is 12.4 per 100,000. But that jumps all the way to 40 per 100,000 for women of color, specifically Black women in the U.S. So, we’re looking at a 3 to 4 higher risk of dying for Black women as compared to white women here in the U.S. Which is a national disgrace and something that we really need to pay more attention to, and luckily is getting more attention as people are becoming more aware of this and working on improving things.

Dr. Joe Chappelle: Absolutely. Those numbers, 12 and 40 are ridiculous. And you might think, 12 per 100,000 is not that bad, and overall, 12 per 100,000 is a pretty low number. Even 40 per 100,000 is a very low number. But the problem here is that most of these deaths are preventable. People don’t have to die. If you’re looking at, I don’t know, mortality from cancer or something that you can’t really control, maybe that’s not so bad. But with something that’s preventable like wearing seatbelts in cars to prevent fatalities, why are we not doing something about it? And people- that’s where this drive comes from. People want to do something about it.

Just to further expand on what you’re talking about, looking at maternal morbidity, which obviously is a lot more prevalent than maternal mortality, and so it’ll be easier to focus your attention on, the overall maternal morbidity rate in the U.S. is about 25 per 1,000. And that’s broken down by race as well. An article from Howell et al. in 2016 from the Green Journal, they found that Black women had a much higher rate of maternal morbidity than White women. And also, interestingly, it had had to do with where they delivered. So, Black women who delivered in a predominantly Black hospital had worse outcomes than those who delivered in a predominantly White hospital. And so, I’ll give you some numbers there. Overall it was 18.8 per 1,000 versus 13.3 per 1,000 Black versus White. And then for just the Black women it was 17.3 versus 16.5 versus 13.5 based on mostly Black, moderately Black or limited Black population within that hospital.

So, you can see that it’s not just being Black, it’s where you’ll deliver being Black that is the issue. And here’s a quote just from the end here: Most Black deliveries occur in concentrated set of hospitals. So, 75% of Black deliveries occurred in this higher and medium Black serving hospitals. And these hospitals have a higher rate of severe maternal morbidity rates. Targeting quality improvement in these hospitals is probably what we should do if we want to fix this. Because it’s really just a few hospitals that are driving a lot of this maternal morbidity and therefore, presumably, mortality. I don’t know if you have any thoughts on that, Heather.

Dr. Heather Link: Yeah. I think that targeted improvement is definitely something that hospitals and care providers are looking to address. In addition to being where you locate, I think another thing to address that’s important is sometimes people look at race in the U.S. and think that that is just a marker for socioeconomic status, and say that the driver here is not race as much as it’s poverty. And I think that we actually do have data for maternal mortality that looks at socioeconomic status of these women who are dying and is able to parse out the fact that a college educated African American woman has a greater risk of dying in childbirth than a White woman who hasn’t finished high school.

Dr. Joe Chappelle: Yeah.

Dr. Heather Link: And that is something that, while it makes people uncomfortable, it’s an important part of the discussion to have, because it’s not fair to just say, okay well, maybe that we’re just seeing concentrations of poor health because of poverty, which we do see with health conditions, but that isn’t something here. And it would be inappropriate to just rest on that and say that the solutions we need, need to address just these poverty issues. The solutions do, there are issues with access to care and access to follow up and stuff but are unique to people of limited socioeconomic conditions. But that isn’t’ the be-all and end-all for why we see this difference in the U.S.

Dr. Joe Chappelle: Absolutely. I didn’t mention it, but what makes those numbers I just read of even more stark is that those are actually controlled for socioeconomic status. The unadjusted data is even worse.

Dr. Heather Link: Yes.

Dr. Joe Chappelle: So that was just being Black and delivering in a Black hospital. Nothing to do with your socioeconomic or education status or anything else. So even setting all that aside is still, like you said, is still worse. So, what do we do about this? First thing I want to ask is what are the drivers of maternal morbidity and mortality? I think you mentioned one of them which is important, which is access. It affects so many things. But if you don’t have access to an Ob/Gyn, or we’ll step back for a second, access to a primary care doctor before you get pregnant, you’re more likely to go into pregnancy sicker or not present to your 20-weeks or whatever it may be. And especially in states that don’t have that access because they didn’t expand Medicaid, or whatever, that may be an issue.

Dr. Heather Link: Yes. Access is an important issue. I think one of the- something that’s important to consider in this discussion is we will talk about these drivers of care, but this is an area where we need more data. There is no one identifiable reason for why maternal mortality continues to rise in the U.S. as compared to every other high-income country. And part of the reason that we can’t answer that question is because we don’t collect good data. Of the recent CDC press release they put out with their vital statistics earlier just this month, looking at changing pregnancy-related death and strategies for prevention, they were able to look at maternal mortality review committees from the states where each committee broke down all the deaths that happened within their state, within a certain period of time to investigate whether those deaths were in any way preventable and steps that could be made to help educate their physicians and help contribute to this problem. But I want to say that only 13 states contributed that information to the CDC so that they were able to use within their publication to summarize this. So, we have a very disjointed system within the U.S. where the data isn’t all collected, we don’t have it together and so, even the recommendations we have are kind of based on half-truths and half information.

Certainly, we have an issue with access to obstetric care in this country. There is a crisis in world healthcare settings. I can speak for my part of New York State, which is in the western part of the state, where you cannot have a VBAC or attempt a TOLAC in much of the surrounding counties outside the two major cities in this part of the state. And so, there are hospitals there where you can access care, but you can’t attempt to have a vaginal delivery after a c-section, so that’s going to contribute to your rising caesarean section rates if you don’t have any access within those areas. The downstream effects of that are further c-sections for those moms with future pregnancies, increased risk of venous thromboembolism. Those patients with cardiac disease are at an additional risk after having a c-section. And so not having access because you don’t have providers is an issue. Not having access because you can’t try to have a vaginal delivery is an issue. And then, not being able to access your postpartum care to follow up on how you’re doing is something that really is an issue that we’re trying to work out. So, in the latest CDC numbers that they put out, over like 30% of all these pregnancy-related deaths are happening in the postpartum period. And so, if someone doesn’t have a primary care physician to get to, can’t get in with the cardiologist, can’t get back to their Ob/Gyn for an appointment, and whether that is because there is no one in the area or because they don’t have the financial means to arrange that and childcare or time off from their work because we don’t have paid maternity leave, all of those things are going to contribute to why these women are falling through the cracks.

Dr. Joe Chappelle: I think you made a lot of good points there. Interestingly, the National Perinatal Association meeting I was at in April, and there are some episodes coming out about some interviews there, one of the interviews coming up is from a doctor from Idaho who was talking about this rural healthcare problem that they have there. And yeah, it’s an issue with providers. It’s also an issue with consultants. And it’s an issue of if you do have a sick mom, how do you get her to higher care when it’s through the mountains and there’s ten feet of snow? So, you’re right. There’s geographic issues, there’s insurance issues.

But one of the things that, going back to your data that you were talking about… We talk about universal healthcare a lot recently. A lot of the democratic candidates are talking about wanting to do that. But I think there’s a difference between universal healthcare and a universal health system. And most of the other developed countries in this world have a universal health system, where it’s a national health system. Where the hospitals use the same EMRs, they use the same data registry, and you can therefore make it much more standardized to get that data back out of those institutions. Whereas in the U.S., even if we go to universal healthcare, we’re still- all the hospitals are independent, they use different systems, how do you get them to talk? The states are different, we collect data at a state level, not a national level. So, there’s other things besides just having everyone access to care that is important to a healthcare system. And I think it’s probably going to be a long time before we have – probably never – something like that in the U.S. just because of the way our country is structured with state independence. Anyway, that got me thinking about the differences between those two terms.

Dr. Heather Link: Yeah. Thank you. I mean, it’s not a coincidence that the best data that looks at maternal cause of death comes out of systems like they U.K. and their confidential inquiry system or some of the other European countries that have a universal healthcare system where they can track that data and they can really follow up on those deaths. I agree with you, it will be a while, if ever, that we move to a more comprehensive system in the U.S. I think that the recent legislation that was passed at the end of December last year to help set aside funding for maternal mortality review committees is going to at least make a little bit of progress on that at the state level. So, the states will be able to apply to the CDC for funding that has been set aside to help them set up their committee and get it going. It’s one thing to just say, okay, we want to have a committee. It’s another thing to collect all that data, deidentify all that data, bring together all of the people on your committee to meet to review the data, even though most people do this in their free time, it’s still getting that information together, making sure that it’s deidentified, physically bringing people to one spot so they can have these meetings can be a financial barrier. And so, this is something that states will be able to apply to the CDC for.

And, I don’t know all the details, but my assumption would be that if the CDC is going to give you money to do this, they probably want to see the data that you have after. So, kind of, carrot-and-stick thing there that hopefully will bring more information in to the CDC so that we can track these women and we can really do a better job of finding out what’s causing these deaths now and then what has been deemed preventable and how can we help continue to address this. And I think we said that probably, it’s thought that about 50% of all these pregnancy-related deaths happening in the U.S. right now are preventable. So, that’s about 7’ to 800 women a year total who are dying in the U.S. with half of those being thought to be preventable when they go through a review.

Dr. Joe Chappelle: Yeah. That kind of dovetails into my next thing on my list which is resources. Why are some hospitals better than others? And some of that comes down to- and I’m not talking just money, but money is part of it. But it’s also the quality and the number of providers or nurses that you have, it is the quality and presence of training. And all that stuff costs money. It is the support from the hospital that women’s and maternal health is important. Because, honestly, most hospitals that do 4,000 deliveries a year, just based on the numbers, they’re not going to have that many maternal mortalities. So, each individual hospital, maybe every five or six years or ten years, whatever it is, will have a maternal death. And that usually mobilizes people for a year or two and then it dies back off again. So, a lot of hospitals don’t put a lot of money into labor and delivery because they get the money no matter what. There’s no real reason to improve it because the outcomes that we’re talking about are so rare at a hospital level. I thankfully work in a place where the hospital is very, very invested in women’s care. Probably mostly because it feeds the NICU and that makes a lot of money for the hospital, but that’s alright. But they give us a lot of resources, in both time, education and money in order to do all these things.

And the other thing for resources, I was reading an investigative journalist’s piece about maternal mortality and one of the stories they told was a woman with preeclampsia on postpartum. The nurse called the resident and said, “hey, her pressure’s high.” He said, “okay, I’ll get there. She’s on my list. I have 20 other patients to come see.” And by the time he got there, she had a stroke and died. I’m not saying that to blame the resident. I don’t know the story. Maybe the resident didn’t do the right thing. But also, when we put people in a situation where they’re taking care of 20 or 30 or 40 people, mistakes will happen eventually. I think we’ve all seen that in our training. If you had gotten there 10 minutes later or an hour later, maybe it would’ve been different when you got there. But sometimes- most of the time we just get lucky, because the human body is pretty resilient. But every once in a while, you’re not going to get lucky. But anyway, how do you take places that rely on cheap resident labor to keep the hospital functioning and how do you do that and make it safe? So, I don’t know. These are my thoughts on resources.

Dr. Heather Link: No, I think that those are all excellent thoughts and kind of really capture for some of us exactly what’s going on when we’re thinking about how to address this issue. In terms of resources, I would direct people to looking at the Alliance for Innovation in Maternal Health so the AIM protocols. This is a program that falls under the Council on Patient Safety in Women’s Health. ACOG is a partner for this. But it is an alliance that exists to promote consistent and safe maternity care with the goal of reducing maternal mortality and severe maternal morbidity. And so, states that sign on to AIM or hospitals that sign on to AIM protocols get the support. They have the bundles of care. They have- for addressing specific obstetric conditions that come up quickly. So they have safety bundles with action measures that your hospital can take and then can adapt to their resource setting to deal with obstetric hemorrhage, severe hypertension, the prevention of VTEs, reducing the primary caesarean birth rate, reduction in peripartum racial disparities and postpartum care and access.

And so, if that hospital had had an obstetric severe hypertension bundle it’s possible that when the resident said- or any provider was like “I can’t get to this patient now,” there would’ve been a protocol in place for the nurse to escalate that, for a medication to be started immediately for them to be transferred over. We know that we’re all fallible but having safety protocols can help standardize some of this care to help prevent things that could be missed. An example of excellent use of safety bundles has been the California Maternity Quality Care Collaborative, CMQCC. And they rolled out an obstetric hemorrhage toolkit and bundles back… probably between 2014 and 2016 and they reduced their morbidity by obstetric hemorrhage by over 20%. And so, it doesn’t have to be the same bundle in each hospital. Perhaps the hospital that only does 30 deliveries a year has a different need than the hospital that does 3,000 deliveries a year. In fact, I assume that they would.

Dr. Joe Chappelle: Yes.

Dr. Heather Link: But what this does is it helps hospitals and healthcare systems put together a basic understanding and a checklist and toolkit for them for what they need to do and what they need to have available so that they can function well in an obstetric emergency. And it takes a little bit of the subjectiveness outside of care so that there isn’t room for someone to just kind of look at that patient and be like “Oh, well, you know she has high blood pressure to begin with, so she can just kind of ride this one out.” Like, no? She’s now on our hypertensive protocol and we’re going to do X, Y and Z.

Dr. Joe Chappelle: I think that you, again, it’s like you’re reading my mind. Because the next thing I want to talk about is the difference between money and- I guess money is the resource, but money and resources. So, this all started from Elizabeth Warren who was giving a talk a couple of weeks ago, probably a month ago now. And I’m just going to read you the quote that got me- I’ll call it upset. So, she said, “the hospitals are just going to get a lump of money, and if they bring down the maternal mortality rates then they get a bonus, and if they don’t, they’re going to the money back away from them. I want to see hospitals to see it as their responsibility to address this problem head on and make it a first priority. And the best way to do that is to use money to make it happen.”

I, personally, and I can’t wait to hear your opinion, but I personally can’t think of a worse way of going about it. First of all, money doesn’t solve everything. I mean, there is money… like you were talking about, there are things that cost money like doing quality assurance and reviewing maternal morbidity and mortality, those are important things that do cost some money. But also, you could give the worst hospital in the country a million dollars a year to fix this and it probably wouldn’t change that much because you also need the other resources. You need the talent to do the training, you need the guidelines and the resources. And we are developing some of those. The Safe Motherhood initiative, ACOG do have a lot of these bundles out there now that you can use. But just throwing money at it doesn’t work. And then, on the other side, if you have a place that’s doing bad, that’s not doing well with maternal mortality, how does taking money away from them make it better? All you’re going to end up doing is either shutting down the hospital or making it worse. So, I don’t know, I got really frustrated about it. I’d love to hear your thoughts,

Dr. Heather Link: Yeah. I think you’ve summed up the thoughts of a lot of obstetric providers when they saw that. I love Elizabeth Warren. I think that she brings really innovative ideas. Her proposal for universal childcare was just so exciting… But I think she missed the mark on this one. And, yes, it does not make sense to take resources away from hospitals that need more and places that are doing poorly. I think she approached this with a very kind of, Elizabeth Warren-y lens to this. She’s an economist, she looks at systems like that and I think… she used to have the Consumer Financial Protection Bureau and… yeah. When the bank is misbehaving, yeah, give the bank a fine. But healthcare doesn’t work that way. And I think she definitely missed the mark on that. I do think that if you read her op-ed for essence, where she really kind of lays out more in detail how she envisions her plan for maternal mortality to go, it is much more thoughtful and much more nuanced. But I don’t think that her tweets were helpful about just holding providers accountable and that somehow, that women are dying because we’re just not taking care of them is kind of the unsaid thing at the end of that, I think that her quote that you read is… along those same lines. So, her op-ed where she really went through things, I think is much better. And we can put a link to that with this website so people can read it themselves. But it was unfortunate. I do believe that a group of motivated women physicians had reached out to her and was actually able to have a meeting with some of the staff members from the campaign to deliver a letter with people’s concerns and got what they felt was a positive reaction and feedback and thoughtful discussion from that.

So, my hope is that we will see more from her and maybe a more thoughtful approach to this. It was also a little confusing because I feel like a lot of obstetric care is bundled. And I didn’t- I was wondering if there is a secret payer system that I’m not aware of where everyone’s just billing everything independently. And… it’s bundled care as it is. And I think some of that speaks to maybe a lack of knowledge on the campaign’s part about how women’s healthcare is delivered. And we all know that we make as much in the global bundle as the anesthesiologist who puts in the epidural. There are layers of problems with how care is handled, and reimbursement works for obstetricians. But I don’t think that just taking money away, as if that’s the issue... I’m glad that she highlighted the issues of racial disparity that we have and the fact that it’s- racism is a problem and that we need to work on this. And that chronic exposure to racism is well, a very difficult thing to measure is probably playing a very significant part in why women of color have worse outcomes that others. But I think, yes, she missed the mark a little bit on this.

Dr. Joe Chappelle: Fair enough. Yeah. Alright. So, in the remaining five or ten minutes I kind of want to talk about- I want to fix this ourselves. We’re going to come up with a plan to fix maternal mortality in the U.S. in the next five minutes, alright?

Dr. Heather Link: Oooh. Okay. Great.

Dr. Joe Chappelle: Perfect. Alright. So, here are my thoughts on this. And you are much more in this world than I am, so I’m interested to hear what you think. But, number one is doing what the CDC is already doing, which essentially is saying we will give you money to actually look at what you’re doing and find out why women are dying or why women are suffering and report that back to us, but also for yourself. And we will pay you to do that, because it’s important work to be done that takes time. That’s number one. Number two is kind of what the SMI and ACOG, SMFM are already doing, but it’s more of these bundles. More of these guidelines so that a hospital that wants to do this has the resources that they can use to do it. Going along with that, and I don’t know exactly how to do this part, but maybe experts that- consultants I suppose, that can go to hospitals and help initiate some of these. Because if you don’t know how to initiate new guidelines and bundles, it can be difficult. Especially in the hospitals that are not used to them. And then the third part, and this goes back to the value-based care that is already coming out via this compensation that is coming out already from Medicare. Which is to say, yes, okay, so if your maternal mortality is in the lowest, the bottom 50%, you will get a 5% or a 10% increase in your global fee for both the hospital and the provider. So, yes, now there’s an incentive from a hospital-based point of view, provider maybe not so much, but in the hospital point of view, it’s alright, yeah, so if I have this I know I’m going to get an extra $3 million out of insurance to do this. Okay, well, hey, maybe that’s worth it now. And maybe I can use that money back into resources to make the places better. Now, taking money away obviously doesn’t really work, I don’t think.

So, that’s kind of my thoughts as you have to tackle a few problems. You have to tackle people looking at it, getting data. You have to tackle education and training and bundles. And then you have to tackle the resource part of it. And part of it is say, yeah, if you do a good job, we will give you more money, which then is a virtuous cycle of feeding back into maternal mortality. It’s much more complicated than all that, but those are my three, off the top of my head, thoughts.

Dr. Heather Link: I love all of those thoughts. I think I would piggyback on that a little bit, is expanding that idea of the consultants, to really enhancing our community partnerships with organizations like Black Mommas Matter, Moms Rising… learning from women who have experienced severe maternal morbidity or families of women who passed away in childbirth, like what their perception of their care was, where they felt the care could’ve been different. Really dealing with the fact that some of these differences are dealing with intrinsic biases that we have as providers where we are not treating every patient the same. And I think that has to play a role into fixing the system here, especially for women of color. So, building up with those organizations. For living in a world with unlimited money… it should be easier to get to postpartum visits, it should… you know, if the reason you are not getting to it is because you don’t have childcare and you don’t have support and you don’t have a ride there, maybe we could use that extra money that you’re saying your hospital will get through being good to put it towards a cab service and a daycare onsite. Make it so that women can come and see the provider when they need to. If, like a third of these deaths are happening in this postpartum period and we know that 50% of women don’t even show up for their postpartum visit, we have to make it easier to do part of that.

There’s a discussion going on about expanding Medicaid up to one year postpartum, I think there’s a few politicians who introduced that with some of the maternal health bills that are going through. I think that that is a great idea. If you live in a state that hasn’t expanded Medicaid, if you can’t get in in those six weeks, you’re on the chop and block to get out. So, I think that that would help with things. I think if you’re going to do that, you’re going to have to really rethink the global and how you’re going to bill for that because it’s… We want to continue to take care of women, but if you’re seeing someone every month for 12 months after they’ve had their baby, there has to be a financial reimbursement so that that physician can continue to do that and operate and provide care in a safe manner to both that patient and all their other patients. Let’s see… what else? I’m a data nerd so I just want better data. Just give me… give me better data so we can make better decisions.

Dr. Joe Chappelle: Yeah, I think you make a good point there about the postpartum stuff, and again, at the National Perinatal Association, which, over the next few weeks we’ll be hearing this stuff, they talked a lot about the fourth trimester. In fact, next April in Denver, their whole conference is about the fourth trimester. But we’re doing something at Stony Brook where we’re trying to do for all the women with preeclampsia to get cardiac follow up. Because we know they’re at risk for later issues, and then also in subsequent pregnancies. So, there’s a lot there you can do to get them ready for their next pregnancy or for the rest of her life. But we run into the same problem. Medicaid is done at six months- I mean, at six weeks. So, what do we do? And so, we’re running into that exact same problem now. Hopefully, if we can stretch it out to a year, we’ll be able to take better care of these women. But there are so many things, diabetes and preeclampsia are probably the two biggest ones, that women just disappear afterwards. And you know they’re going to come back six, nine, a year later and they’ll be pregnant again, with an A1C of 8 and hypertension. So, we’re only setting ourselves up for bad outcomes down the road there. And you’re absolutely right. One of the things you could do with all that extra money is those postpartum visits. ACOG now wants us to do multiple visits in that postpartum period, but it doesn’t have to be providers. So, nurses or whoever else can go out to the house, you go out two days after they leave the hospital. You go out two weeks later to check on them again. And then you see them for their postpartum visit. Like, there are so many steps in there, but they cost money. And that’s when it starts getting into the heavy pay for this and where does it go?

Dr. Heather Link: We haven’t gone into this, but obviously the elephant in the room is making sure that the women who are pregnant and carrying a child to term are the women who are in the best health, and those who want to be. And I think that’s an entirely different podcast in itself, but we’re seeing trickle-down effects from the fact that it’s harder to access terminations, and it’s harder to access good contraception in some of our states. And people who are starting pregnancy sicker continuing their pregnancy that maybe they wouldn’t have had. And it shouldn’t be surprising to anyone that our health outcomes are reflecting that.

Dr. Joe Chappelle: Yeah. I mean, even if you want to set abortion aside for a moment, one of the primary providers of prenatal care to poor women in this country is Planned Parenthood. And with all the decrease in funding and the attempts, and attempts, and attempts, and some successes to gut Planned Parenthood, you’re not just getting rid of terminations, you’re getting rid of actual good prenatal care for women who don’t have access anywhere else, or have to drive 100 miles to get there. So, I think you’re absolutely right. All this stuff comes back around together. And you’re right, we have, and we could spend another whole episode talking about – and probably will – about the recent laws passed about termination in several states. But we’ll save that for another episode.

So, I think we did it. I think we solved maternal mortality in the U.S. so I’m very happy about that. Thank you very much for helping me do that. No, but seriously, I mean, there is a ton, a ton of work here to be done from… guidelines, from… an advocacy point of view, from even your own hospital. So, yeah, Heather and I will get together, we’ll put some resources into the show notes if you guys want to go see what you can do at your hospital, you can do that. If you want to support ACOG and its advocacy, you could do that. If you want to get involved with SMI and work on bundles, you can do that. And we’ll put all the stuff in there. But it really takes all of us working together, and women who are interested in women’s healthcare and women to work together to try to solve this. Because if we don’t, then, probably like the rest of history, women will keep being ignored as they die. And that’s what we don’t want anymore. I don’t know, any final thoughts, Heather?

Dr. Heather Link: No, I think you wrapped it up nicely.

Dr. Joe Chappelle: Alright, well, Dr. Link, thank you so much for being on today and a pre-congratulations on your graduation. And I hope to hear you back soon.

Dr. Heather Link: Thank you so much.