

GUEST EDITORIAL

Go to Ruth's House: A Response to Infant Mortality*

If I could leave you with the single most important prescription to address the tragic and seemingly intransigent phenomenon known as infant mortality, it would be this: Go to Ruth's House. In due time, I will make plain for you the meaning of this poignant prescription. For the moment I want to briefly recount for you the long and laborious diagnostic process that leads me to this proposal for intervention.

In 1984 I was a neonatologist plying my trade in Pittsburgh, Pennsylvania, home of Magee Women's Hospital, one of this nation's largest obstetric delivery services and among the world's finest institutions for care and research in obstetrics and gynecology. In that year Pittsburgh held the dubious distinction of having the highest infant mortality rate among United States cities with a population greater than or equal to 250,000. Mayor Richard Caliguiri was busily steering Pittsburgh through its Renaissance from an industrial to a service-based economy.

Mayor Caliguiri asked himself: How do we account for this paradox? Arguably, health care services in Pittsburgh were among the best in the nation and the world yet our infant mortality rates, especially for women of color, were abysmal. In response to the conundrum Mayor Caliguiri convened a consortium of civic leaders, including journalists, educators, social scientists, and labor and business executives. I was one of two physicians appointed to the consortium.

This is what we learned in Pittsburgh: The paradox was more apparent than real. Healthy pregnancy outcomes have little to do with access to health care. Moreover, the consortium found that contrary to conventional wisdom, poor pregnancy outcomes could

not be attributed initially or primarily to ignorant, immoral, or irresponsible maternal behavior. I want to repeat that slowly, deliberately, and succinctly: Poor pregnancy outcomes and infant mortality are not a consequence of poor prenatal care or mothers behaving badly.

Fast forward 22 years to 2005. Under the auspices of the Joint Center for Political and Economic Studies, I had the privilege of convening a National Commission on Infant Mortality (1). Following the lead of Mayor Caliguiri, I recruited as commissioners, educators, a journalist, social scientists, nurses and physicians, and public policy experts. Distilling the essence of our lengthy deliberative process, the Commission set out to revisit and challenge conventional wisdom and offer an alternative analysis and perspective, including implications for care, research, and public policy to improve maternal health and reduce infant mortality (1).

In summary, the Commission discerned three sturdy and interwoven strands of ideology running throughout the history of gathering and interpreting infant mortality data. The first strand that most explicitly continues to inform public policy today is the notion that pregnancy is a pathological condition, or so nearly so that it requires medical supervision. The second strand lifted up for examination is distinctly misogynist and not so silently portrays women, especially women of color, as ignorant, immoral, and/or incompetent to the task of childbearing and childrearing. The third strand examined was the most subtle yet consistent and consistently ignored. That is, throughout the history of infant mortality studies an awareness is evident that toxic social relationships, social conditions, or both adversely affect maternal and child health.

In formulating a more comprehensive and complex perspective, the Commission turned to the concept of relationality. Relationality is a concept which asserts that human beings are by nature interdependent, relational beings. Anything that undermines the human

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experience of healthy relationships threatens growth and survival. As one of the Commissioners poignantly summarized our understanding of infant mortality, babies are dying because their mothers are dying. Their mothers are in dead relationships.

Now, lest your minds race to images and fantasies of the dysfunctional black family let me hasten to clarify that the relationships about which the Commission speaks include, but greatly transcend, domestic relationships. Indeed, it is the Commission's belief that domestic relationships are affected and infected by the culturally and socially toxic experiences of racism, misogyny and its attendant sexism, and income inequality that is itself a pale proxy for social inequalities more generally. These tears in the fabric of relationships are what make childbearing and child rearing such hazardous travails.

Said differently, infant mortality is a direct consequence of social injustices. As Bishop Sergio Carranza, of the Episcopal Church, states the case, "Justice is the social form of love" (2). I would add that injustice is the social form of fear. And no nation, no community, no family or child can grow, let alone survive, in the tainted soil of fear and in its social expression called injustice.

The policy recommendations set forth by the Commission are manifold and directly responsive to a call for social justice. I will briefly enumerate a few of those recommendations and invite your careful inspection and critique of the various publications memorializing the Commission's findings and recommendations (1).

Public Policy

- All public policy should include a "relational impact statement" similar in form to the economic and environmental impact statements now employed in policy analysis. Relational impact statements would include answers to questions such as the following: How will politically/economically disfranchised citizens be advantaged or disadvantaged by a policy? Have all stakeholders, especially the traditionally disfranchised, been afforded an opportunity for public hearing on the policy prospectively or retrospectively?
- At federal, state, and local levels of government, measures of economic progress must routinely include the Gini Coefficient or its equivalent measure to assess the degree of income inequality; the Human Development Index or its equivalent to measure progress in health, education, and purchasing power; and a Gender Development Index or its equivalent to measure the disparity in eco-

nomic and political development between men and women. (Note: The "Gini Coefficient" is a statistical measure of income or wealth inequality. A low value [at or near zero] means wealth is shared equitably; a high value [at or near 1] means a few are very wealthy and most are poor.)

Standards of Care

- Women should be provided with options for receiving maternity care. Among those options should be birthing centers wherein women design and determine the content of care and health care providers serve as consultants to childbearing women. Enhance efforts to promote and support breastfeeding, including efforts to resurrect and implement the U.S. Department of Health and Human Services Blueprint for Action on Breastfeeding (3). Request that the Joint Commission for the Accreditation of Health Care Organizations consider adding Baby Friendly Hospital status as a quality indicator for hospitals with obstetric and pediatric care services.

Research

- All research done in politically disaffected and economically disadvantaged communities should include participatory ethnographic methods. The federal government should give priority to such studies in determining grant awards.
- Institute periodic quality assurance oversight of research efforts to assure compliance with requirements for including the voices of "study subjects."

To get a greater intuitive grasp of the social justice agenda I have just articulated, I return to the prescription I offered at the beginning of the paper: Go to Ruth's House. Go to Ruth's House, sit in solidarity and break bread with Ruth's sisters. Ruth is Ruth Lubic, intrepid midwife extraordinaire. Ruth's sisters are the African American women with whom Ruth spent years cultivating a loving, mutually supportive relationship. Ruth's House is more accurately the Family Health and Birth Center that is the co-creation of Ruth and her sisters. The Center is located in Washington, DC, and has enjoyed enormous success in improving maternal and child health, reducing infant mortality, and inspiring hope in a community otherwise wracked with hopelessness.

If you want to see justice as the social form of love in action, go to Ruth's House. If you want to see children survive to see their first birthday in an otherwise toxic social milieu, go to Ruth's House. Go there and break bread with Ruth and her sisters. Listen to

them. Talk with them. Learn of their hopes and fears, their plans and practices. Learn from the stories they tell about themselves firsthand. You will learn far more from them than you can from the studies reported about them. Do not begin or end your quest to address the tragedy of infant mortality in a university or for-profit health care system. Go to Ruth's House.

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