After a 40-year absence, it is perhaps fitting that the renowned pianist Leon Fleisher would choose for his return to recording two-handed pieces, Bach’s “Sheep May Safely Graze.” Written as a birthday celebration piece for the German prince Duke Christian of Saxe-Weissenfels, the aria comes from the hunting cantata “Was mir behagt, ist nur die muntre Jagd” (“What really pleases me is the lively hunt”). For Fleisher, the recording on the album “Two Hands” is the result of a frustrating search through Western, Eastern and non-traditional medicine to find a cure for an involuntary curling of the fingers of his right hand (focal dystonia). Treatment finally came in the form of botulinum toxin (Botox) injections, which enabled his right hand to play again.

Fleisher’s tale of loss and salvation is a familiar parable. Yet as we think about our own daily existence and that of our Society for Obstetric Anesthesia and Perinatology, we may be too comfortable in embracing routine patterns. Although the practice of obstetric anesthesia, with its perpetual infusion of novel ideas and practices, is perceived as a maelstrom of change, both individual practitioners and our Society can be confined by fossilized patterns. How is SOAP doing, and should we be on the hunt for change?

SOAP’s Current Status
Our latest Annual Meeting (“Creating a Safer Practice Environment”) in Washington, D.C., with more than 700 attendees, was a vibrant representation of our Society. Terrific presentations with relevant clinical correlations, wonderful research, relationship-building sessions with our colleagues from the Obstetric Anesthesia Society of Asia and Oceania (OASAO) and the North American Society of Obstetric Medicine (NASOM), exceptional resident participation, dynamic pre-meeting programs, and fun social events fraught with new and seasoned friends and colleagues, were all palpable expressions of our SOAP family. I can’t thank meeting host Bob Gaiser, Executive Director Jill Mlodoch,
Craig M. Palmer, M.D.
Chair, ASA Committee on Obstetric Anesthesia

“The American Society of Anesthesiologists is… an association of physicians organized to raise and maintain the standards of the medical practice of anesthesiology and improve the care of the patient.”

This statement greets any visitor to the homepage of the American Society of Anesthesiologists (ASA) Web site; though, as anesthesiologists, we usually know what we are looking for on the site and do not spend much time reading things like mission statements and mottoes. It is useful from time to time to stop and remember what the real purposes of our organizations and societies are. The mission of SOAP is similar, but subtly different: “The mission of this Society is to improve the pregnancy-related outcomes of women and neonates through the support of obstetric anesthesiology research, the provision of education to its members, other providers, and pregnant women, and the promotion of excellence in clinical anesthetic care.” Both organizations clearly strive to raise the level and standard of care for all our patients.

A recent publication in the journal Health Services Research (2009; 44:464-482) studied a database of discharge diagnosis codes and concluded that parturients are just as safe delivering their infants in facilities staffed by CRNAs as in those staffed by anesthesiologists. In reality, the data and analysis supported no such conclusion, and the publication of the article represents an abject failure of the peer-review process, at least as we, as anesthesiologists, understand it.

Health Services Research (HSR) is published by the Health Research and Education Trust, which is a tax-exempt affiliate of the American Hospital Association (AHA). The Trust was born in 1944 when the AHA’s House of Delegates passed a resolution calling on federal and state governments to fund hospital construction and health care costs. HSR’s goal is to be “…the preferred forum for health services researchers, managers, policymakers, providers, and students…” Providers, such as us, are well down on that list; a perusal of the editorial board and recent publications reveals that this journal, and the authors who publish here, strive to direct the debate about health care reform in the U.S.

The authors of this article are both prominent Ph.D. nurses, but neither has any experience or expertise in the delivery of anesthesia. The closest either has ever likely come to an obstetric anesthetic is their long-standing grant funding from the American Association of Nurse Anesthe-

tists (AANA). Indeed, even before the article made it into print, the lead author was quoted on the front page of the AANA Newsletter saying, “Outcomes of this study may serve as a guide to policy makers who use results of studies such as this when considering allocation of resources or regulation [italics mine].” The release of this article, just weeks before the AANA’s annual legislative conference in Washington, D.C., was clearly orchestrated as an attempt to influence those who will be dictating the future of health care in the U.S. under the new Administration.

This study is not about improving patient safety or quality of care; it is simply an attempt to expand the scope of nurse anesthesia practice through regulatory and legislative channels, something the AANA cannot accomplish on merit through education, training or even post-graduate research. A more detailed analysis of the study’s findings can be found in the “Members Only” section of the ASA Web site under “ASA Member News.”

The ASA remains firm in protecting the field of obstetric anesthesia as the practice of medicine, not a mere acquired technical skill. It is not just sticking a needle in a parturient and injecting the “usual” drugs; it requires the expertise, knowledge base and judgment a physician provides. My former chair, Burnell Brown, used to tell me about a difference between obstetric care in the U.K. and the U.S.: “In the U.K., they are fine with letting a midwife deliver your baby, but they would never consider letting a nurse give you anesthesia.” In this area, I think they have it right...

I am proud of the contributions made by ASA and SOAP members to the decline in maternal mortality and morbidity of the past several decades and the vast improvement in analgesic techniques and their safety. Let us not allow our inattention or indifference to lead to the decline of this, the oldest subspecialty in anesthesiology.

Speaking of the future of health care, as you read this, the U.S. Senate is debating reform proposals, and one of the ideas being seriously considered is to provide a “public option” for health care, based on Medicare payment rates. Most of you are surely aware that reimbursement rates for anesthesia services under Medicare are abysmally low, averaging roughly 33 percent of what private insurers pay for anesthesia services (according to the U.S. Government Accountability Office. Further, physician participation would be mandatory.

If you believe, as I do, that such a plan would cripple our specialty, it is imperative that you make your voice heard to your elected representatives. ASA members can send an e-mail to their senators through a link on the ASA Web site – click on the “Alert” dated June 2, 2009. If we do not stand up for our specialty, it may cease to be one.
The goals of the SOAP Research Committee are, rather obviously, to “promote research and progress and in obstetric anesthesia and perinatology” and to “promote the training of individuals to perform research in obstetric anesthesia and perinatology.” The major current responsibilities of the Research Committee are to review and score abstracts submitted for the Annual Meeting to evaluate requests for scientific/clinical surveys of SOAP members, to organize a “Research Hour” session at each Annual Meeting, and most ambitiously (and not yet even remotely accomplished), to develop a multicenter research network capable of initiating and performing clinical studies in obstetric anesthesia. This will require two things that are usually in very short supply: ideas and funding. The Committee is currently composed of 17 members, meeting each year at the SOAP Annual Meeting, and at the ASA Annual Meeting.

Abstract Submission/Grading

For the 2009 meeting, we reviewed approximately 120 research abstracts and sent about 120 case report abstracts to the Education Committee for review, since these are more educational in nature. Having the Education Committee handle case reports allowed more individuals to review each research abstract, presumably resulting in more uniform scoring for submitted abstracts. Next year, we hope to have eight committee members review each research submission, which should result in much fairer, more uniform grading than in past years where two or four members scored each submission. In general, membership feedback about the abstract submission process has been positive, with some inevitable complaints and suggestions, and we are quite interested in constructive feedback about how the system is working and ways to improve it.

Resident membership

In 2007, we started a program aimed at increasing resident involvement with the committee and, it is hoped, with research in the future. These individuals will be nominated by the Resident Affairs Committee (formerly the Ad Hoc Committee on Resident Membership) and serve for two years. If you are (or know) an appropriate resident candidate, please contact the Resident Affairs Committee, chaired by Paloma Toledo, M.D., p-toledo@md.northwestern.edu.

Research Funding

We expect that SOAP will soon officially announce a research grant program utilizing some of the funds that Gertie Marx left to SOAP for this purpose. While final funding decisions and levels will be up to the Board, the Research Committee will assume an advisory role, much like an NIH study section, in rating/scoring research proposals.

Please feel free to contact me with any comments/questions at any time at rms7@columbia.edu.

Now Is the Opportunity You’ve Been Waiting For!!!!

Is your home cluttered with clean “old” SOAP T-shirts? Does your bookshelf contain old obstetric anesthesia texts that you can’t throw away?

The SOAP Legacy Task Force is looking for SOAP paraphernalia and historical items pertinent to OB anesthesia to be stored at the Wood Library-Museum of Anesthesiology.

Please contact the Legacy Task Force if you have anything of value:
E-mail: jdouglas@cw.bc.ca or vasdev.gurinder@mayo.edu
In March 2009, SOAP members were asked to complete an online survey related to practice management. The following data are compiled from 264 responses (30 percent of all U.S. members). Table 1 summarizes practice type, anesthesia personnel utilized and coverage models. Overall, our survey responses reflect practices in hospitals with larger delivery numbers (75 percent of responses came from hospitals with >2,000 deliveries/year) than those in a 2005 Obstetric Anesthesia Workforce Survey of the United States by Bucklin (72 percent of those responses came from hospitals with <1,500 deliveries).

Our respondents were equally divided between academic and private practice for larger services, and predominately private practice for smaller units. The 2005 report noted that 33 percent of hospitals with 1,500 or more deliveries had anesthesia residency programs and that hospitals with less than 1,500 deliveries had a higher proportion of certified registered nurse anesthetist (CRNA) independent practice (15 percent for hospitals with 500-1,499 deliveries, 34 percent for hospitals with 100-500 deliveries). In our survey, the CRNA-only model was noted <2 percent of the time, probably because the vast majority of our respondents were physicians and less than 8 percent of the practices had <1,000 deliveries. We report similar levels of in-house coverage for larger units (>80 percent) but higher levels for smaller units (35 percent) versus the 2005 report (3-20 percent). Of note, a surprisingly high percentage of respondents from large units reported involvement with neonatal resuscitation when providing anesthesia care for the mother because other providers skilled in neonatal resuscitation were not routinely available.

Chart 1 summarizes billing methods for labor analgesia. Nearly all respondents use one of four methods suggested by the American Society of Anesthesiologists (ASA). The most common method was base units plus time units (insertion through delivery) with a capped fee. Thirty to 50 percent of respondents reported that they received financial assistance from their hospital for covering labor and delivery [Table 1]. For those who reported assistance, most received a direct stipend. Only 5 percent of respondents reported hospital supplemental reimbursement for being on “standby” for vaginal birth after cesarean (VBAC) services and 7 percent billed for being on “standby” for VBAC when not giving an anesthetic.

Chart 2 summarizes responses on billing for epidural blood patch placement, neuraxial opioid administration, pre-delivery consultation, labor and delivery (L&D) nurse anesthesia-related practices, and anesthesia cart security. Nearly 67 percent of respondents bill for an epidural blood patch if it is related to anesthesia; nearly all bill for a patch required to treat another provider’s dural puncture headache. While 33 percent bill for single-shot opioid administration after cesarean delivery, 26 percent bill for a pre-delivery consult prior to admission to L&D.

Greater than 80 percent of hospital practices allow L&D nurses to remove epidural catheters, but fewer allow nurse adjustment of epidural pump infusion rates. Additionally, 32 percent of our respondents were not aware of the pos-

**TABLE 1:**

<table>
<thead>
<tr>
<th>Deliveries Per year</th>
<th>Practice Type</th>
<th>M.D. only Practice (includes Residents)</th>
<th>M.D. only Places Block: CRNA Manages</th>
<th>All Providers Place Block: M.D. Supervises</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1000 (N=21)</td>
<td>2/21 (9.5%)</td>
<td>13/21 (62%)</td>
<td>2/21 (9.5%)</td>
<td>6/21 (28.6%)</td>
</tr>
<tr>
<td>1000 – 2000 (N=42)</td>
<td>14/42 (33.3%)</td>
<td>26/41 (63.4%)</td>
<td>1/21 (4.8%)</td>
<td>12/21 (57.1%)</td>
</tr>
<tr>
<td>2001 – 3000 (N=55)</td>
<td>20/40 (50%)</td>
<td>34/54 (63%)</td>
<td>6/54 (11%)</td>
<td>15/54 (27.8%)</td>
</tr>
<tr>
<td>&gt; 3000 (N=146)</td>
<td>60/118 (51%)</td>
<td>70/145 (48.2%)</td>
<td>21/145 (14.5%)</td>
<td>48/145 (33.1%)</td>
</tr>
</tbody>
</table>

Number under delivery range is the number who responded to any question. Fraction in all other cells is: [(Response) ÷ (Number who responded to that question)] and (Percentage who responded to that question).
tion statements written by AWHONN, which many units use as a standard for L&D nurse practice.

Most respondents lock their carts in delivery rooms when not present, and 35 percent reported that a locked cart had interfered with care at least once in an emergency. In response to the ASA concerns for access to resuscitation drugs and the need to set up anesthesia carts in preparation for use in the operating room or labor and delivery unit, the Centers for Medicare & Medicaid Services has announced changes in its policy allowing non-controlled anesthesia medications to be in a “secure area” when anesthesia personnel are not present, not necessarily in a locked cart. The intent of this change and examples of appropriate policies can be found in the January 2007 ASA NEWSLETTER article “Anesthesia Carts: New Federal Regulation Aligns With ASA Policy.”

Many thanks to all of you who responded to our survey. The committee requests that you submit questions or suggestions for future surveys (send to: Curtis.L.Baysinger@vanderbilt.edu). Thanks to the committee members for their efforts in preparing the survey questions and for helping to draft this report.


References:

<table>
<thead>
<tr>
<th>CRNA only Model</th>
<th>Dedicated Coverage (Separate from O.R.)</th>
<th>24/7 in House?</th>
<th>Hospital Support</th>
<th>Resuscitate the Newborn</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>9/20 (45%)</td>
<td>7/20 (35%)</td>
<td>8/20 (40%)</td>
<td>1/17 (5.9%)</td>
</tr>
<tr>
<td>2/41 (4.9%)</td>
<td>25/41 (60.9%)</td>
<td>20/41 (48.7%)</td>
<td>8/27 (29.6%)</td>
<td>5/27 (18.5%)</td>
</tr>
<tr>
<td>0</td>
<td>49/54 (90.7%)</td>
<td>44/54 (81.5%)</td>
<td>19/38 (50%)</td>
<td>3/45 (6.6%)</td>
</tr>
<tr>
<td>3/145 (2%)</td>
<td>139/145 (95.8%)</td>
<td>129/145 (88.9%)</td>
<td>48/112 (42.8%)</td>
<td>16/109 (14.7%)</td>
</tr>
</tbody>
</table>
Robert McKay, M.D., Steps Down as Editor of Obstetric Anesthesia Digest

In January 2009, Robert S.F. McKay, M.D., stepped down as editor-in-chief of Obstetric Anesthesia Digest (OAD), ending a 16-year tenure in that position and a 23-year period of editorship with the journal. Started 28 years ago by Dr. Gertie Marx, the Digest has provided a means for the obstetric anesthesia community to review recent significant developments in obstetric anesthesia-analgesia and care of the mother and infant. Dr. McKay has continued that mission by overseeing large increases in content, reviewing multiple journals, working with contributing editors, and, recently, fostering the Digest's online access through Lippincott Williams & Wilkins, where more than 5,000 online visits occur monthly. For nearly 20 years, Dr. McKay formatted and typeset each quarterly issue himself. During his tenure as editor-in-chief, Dr. McKay was responsible for ensuring the high quality of OAD's article abstractions and editorial comments. In his March 2009 editorial message to the readers, editors and publisher of OAD, Dr. McKay thanked all of them for their efforts. We owe Dr. McKay our thanks for his achievements in providing us with a valuable tool that has kept us abreast of changes in our field. Dr. McKay will continue to serve OAD as a contributing editor.

Treasurer's Report Summer 2009

As my first point of order in this, my final Treasurer's report for SOAP, I would like to announce my successor, John Sullivan, M.D., M.B.A., of Northwestern University. He will be taking over from this point on. Traditionally, the new treasurer writes this report, but I asked to do so for the following reasons. Not only have we transitioned to ASA management during this past term, the ASA itself has undergone its own internal transition to better meet the needs of the membership. As a result, there are many new faces in place in many departments, including finance. To better assist in the transition to Dr. Sullivan at a time when the ASA financial department is also getting settled with new talent, I felt it would be best if I completed my tenure by writing this report in order to hand over a clean slate and smooth the transition.

<table>
<thead>
<tr>
<th>Revenue</th>
<th>FY07+Transition Months</th>
<th>FY08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dues</td>
<td>$115,341</td>
<td>$99,058</td>
</tr>
<tr>
<td>Annual Meeting</td>
<td>$305,397</td>
<td>$324,076</td>
</tr>
<tr>
<td>Interest &amp; Dividend Income</td>
<td>$53,639</td>
<td>$19,086</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$564,702</strong></td>
<td><strong>$482,870</strong></td>
</tr>
</tbody>
</table>

Membership dues remain the primary source of SOAP's operational revenue. Although it is anticipated that the Annual Meeting will turn a profit, we do not budget that expectation so that dues income is expected to cover all operational expenses. Additionally, we cannot use income we generate from our investments, with the one exception being our Schwab reserve account. The SOAP Board approved a dues raise to meet our increasing operational expenses. It went into effect this January. This dues raise will not be reflected in this year's report covering FY08, but rather will be apparent in next year's report.
Whether an investor or not, it’s hard for anyone to not be aware of the economy over the past year. Our investment portfolio was diminished primarily in the category of unrealized income. That means our stock values dropped. As a result, interest earned on that stock dropped as well. The following table summarizes FY07 plus the two transition months and FY08. Please note that the three categories listed will not add up to the actual total revenue because there are other smaller contributions included.

<table>
<thead>
<tr>
<th>ANNUAL MEETING</th>
<th>FY07 (Banff)</th>
<th>FY08 (Chicago)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>$305,397</td>
<td>$324,076</td>
</tr>
<tr>
<td>Expenses</td>
<td>$283,020</td>
<td>$325,897</td>
</tr>
<tr>
<td>Gain/(Loss)</td>
<td>$22,377</td>
<td>($179)</td>
</tr>
</tbody>
</table>

Our 2007 annual meeting in Banff, Canada, was a record-breaker for attendance. Then the 2008 Chicago annual meeting attracted an even larger meeting attendance. This was great news. However, our original contract for hotel space and services for the Chicago meeting did not anticipate the larger registration. Additionally, the Chicago hotel business is unionized with a union labor pricing structure. As a result, we had to pay top dollar for several services that went beyond our contract numbers. This cut sharply into our bottom line. The following table reports the two meetings for which we have complete information.

<table>
<thead>
<tr>
<th>INVESTMENTS</th>
<th>FY07</th>
<th>Nov/Dec07</th>
<th>FY08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Value</td>
<td>$1,034,813</td>
<td>$1,009,192</td>
<td>$820,802</td>
</tr>
<tr>
<td>Investment Income</td>
<td>$91,990</td>
<td>$31,523.40</td>
<td></td>
</tr>
</tbody>
</table>

$1,403,970. Currently, they are $1,902,169. Although part of that is due to revenue from the annual meeting with few expenses paid yet, the dues increase has gone far to shore up our operational bottom line. Another happy occurrence is that the Gertie Marx Trust has deposited $39,658 into the investment account.

**Summary**

Fiscal Year 2008 was a lean year for three reasons that, although independent of each other, simultaneously impacted our bottom line. First, our operating expenses crept up to nearly reach our operating revenue. To address this, the Board had to raise dues. It should be noted that the last dues raise was eight years ago, and the raise instituted by the Board kept SOAP competitive with other similar societies. With current strategic plans being developed, SOAP’s Board is exploring other means of increasing revenue so that the full burden of the Society’s operating cost does not fall completely on membership revenue. Secondly, although Chicago was a huge success, it was also hugely expensive. That was due in part to the fact that Chicago’s hotel business is unionized and necessary labor for our meeting demanded union-level pay. But, also, our practice of choosing meeting sites four years in advance outpaces our ability to adjust hotel contracts without incurring penalties. This has been a topic of discussion for the Board. Finally, the economy and resulting stock market plunge hurt our unrealized gains; but we have still fared far better than most, with growth likely in the near future.

Moving forward, the Board has received a clarification from the trustees of the Gertie Marx Trust that the annual payments from her trust do not have to be put aside but may be used to fund research and educational grants. Thus, it is possible to initiate the new Gertie Marx Grant in 2010 as the annual payments from the trust will supply enough to make that possible.

Finally, it has been a privilege and an honor to serve you as your treasurer. I have always kept in mind that it is because you choose to be a member of this Society, and perhaps donate to OAPEF, that these two entities exist, and that how the money is spent should always be in the best interest of the membership and in the fulfillment of the Society’s mission. I look forward to being of further service to you in the years to come.
The 41st SOAP Annual Meeting, held at the Renaissance Washington, D.C. Hotel on April 29 to May 3, 2009, attracted a record number of more than 730 eager attendees.

Pre-meeting activities on April 29 included a very popular Obstetric Anesthesia Crisis Simulation Course, in which enthusiastic faculty exercised their acting skills to put forth four realistic obstetric-emergency scenarios that tested the participants’ team-based approach to problem solving. Concomitantly, those beginning their research careers received invaluable advice from research veterans regarding everything from NIH funding through manuscript review in the research/grantsmanship/study design seminar.

That afternoon, SOAP and the Obstetric Anesthesia Society of Asia and Oceania (OASAO) jointly produced an eclectic symposium discussing novel and international obstetric anesthesia techniques and challenges.

Wednesday evening, SOAP participants had the opportunity to mingle with the rich and famous (or reasonable facsimiles thereof) at the Welcome Reception at Madame Tussauds Wax Museum. The wine-and-dessert evening gave attendees the chance to meet friends – both old and new – before the official start of the Annual Meeting on Thursday.

SOAP President Linda S. Polley, M.D. (University of Michigan), and Program Chair/SOAP President-Elect Lawrence C. Tsen, M.D. (Brigham and Women’s Hospital) opened the meeting Thursday morning, along with Meeting Host Robert R. Gaiser, M.D. (University of Pennsylvania) and American Society of Anesthesiologists (ASA) President Roger A. Moore, M.D. (Deborah Heart and Lung Center).

The meeting’s theme, “Creating a Safer Practice Environment,” was well-represented by the first event, the Gertie Marx Research competition, open to residents, fellows and medical students performing independent research [Table 1]. Of the five outstanding presenters, Arvind Palanisamy, M.D. won the competition with his abstract on the effects of isoflurane on embryonic progenitor cells.

Dr. Tsen then presented the Distinguished Service Award to Sanjay Datta, M.B. (Brigham and Women’s Hospital)

### Table 1: SOAP Award Winners 2009

<table>
<thead>
<tr>
<th>Winner</th>
<th>Affiliation</th>
<th>Abstract Title</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Distinguished Service Award</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanjay Datta, M.B.</td>
<td>Brigham &amp; Women’s Hospital, Boston</td>
<td></td>
</tr>
<tr>
<td><strong>Teacher of the Year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medge Owen, M.D.</td>
<td>Wake Forest University School of Medicine, Winston-Salem, NC</td>
<td></td>
</tr>
<tr>
<td><strong>Gertie Marx Research Competition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st</td>
<td>Arvind Palanisamy, M.B.B.S., M.D.</td>
<td>Isoflurane inhibits allopregnanolone-induced proliferation of embryonic neural stem/progenitor cells in vitro</td>
</tr>
<tr>
<td>2nd</td>
<td>Lindsay M. Atkinson, M.D.</td>
<td>Intrathecal bupivacaine requirements in morbidly obese patients undergoing cesarean delivery</td>
</tr>
<tr>
<td>3rd</td>
<td>Anna Chaplin, B.Sc.</td>
<td>Up-down determination of the ED90 of oxytocin infusions for the prevention of postpartum uterine atony in parturients undergoing cesarean delivery</td>
</tr>
<tr>
<td><strong>Frederick P. Zuspan Award</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrinalini Balki, M.D.</td>
<td>University of Toronto</td>
<td>Oxytocin pre-exposure of pregnant rat myometrium reduces the efficacy of oxytocin but not ergonovine or carboprost</td>
</tr>
<tr>
<td><strong>SOAP 2009 Best Paper</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patricia M. Lavand’homme, M.D., Ph.D.</td>
<td>St. Luc Hospital, Brussels, Belgium</td>
<td>Evaluation of oral pregabalin as an adjuvant to epidural analgesia for late termination of pregnancy</td>
</tr>
<tr>
<td><strong>Research in Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manuel C. Vallejo, M.D., D.M.D.</td>
<td>University of Pittsburgh</td>
<td>Ultrasound-guided transversus abdominus plane blocks for postoperative analgesia following cesarean delivery</td>
</tr>
</tbody>
</table>
for his unique contributions and dedication to the field of obstetric anesthesiology.

Sleep-expert Charles A. Czeisler, M.D., Ph.D. (Brigham and Women’s Hospital) intrigued meeting-goers with the thought-provoking lecture “Work, Sleep Hours, and Patient Safety,” immediately followed by a rousing SOAP tradition: the Pro/Con debate. Dr. Gaiser (pro) and Phillip E. Hess, M.D. (con) took opposite positions on the topic “Attending Obstetric Anesthesia Call Should Be Restricted to No More Than 15 Consecutive Hours.”

The afternoon session included a discussion of the benefits of using protocols to improve patient safety, five oral presentations, and the SOAP business meeting.

Friday kicked off with five more oral presentations, followed by two informative lectures regarding risk management in obstetric anesthesiology. The first, presented by Sheila E. Cohen, M.B., Ch.B., F.R.C.A. (Stanford University), discussed the pros and cons of several different informed-consent options; and the second, presented by Cynthia A. Wong, M.D. (Northwestern University), discussed complications of neuraxial techniques and patient follow-up, including the concept of disclosure.

Coffee with exhibitors was followed by Yaakov Beilin, M.D. (Mount Sinai School of Medicine), who admirably organized and reviewed 85 posters in the first of the poster sessions.

The first of three “What’s New?” lectures was presented by Michal Elowitz, M.D., whose “What’s New in Obstetrics?” lecture provided the latest data on our increasing population of parturients with repaired congenital heart disease.

The afternoon was filled concomitantly by the Residents’ Forum of oral presentations [Table 2] and a discussion led by several members of the ASA Practice Advisory Committee on Infectious Complications of Neuraxial Techniques regarding the draft of the proposed new practice advisory.

Saturday’s meeting opened with the fit and energized participating in the Wellness Run/Walk at Rock Creek Park. Everyone was a “winner” this year, experiencing the joy of a great cardio workout. Those desiring a mental, rather than physical, workout attended the Breakfast With the Experts, where obstetric anesthesia experts shared their experiences with participants during discussion of a high-risk case.

A Panel Discussion then highlighted two drug categories associated with obstetric anesthesia risk: anticoagulants and neuraxial opioids. Alexander J. Butwick, M.B., B.S. (Stanford University) furnished attendees with an update on anticoagulation and neuraxial techniques, including a discussion of post-caesarean deep-vein-thrombosis prophylaxis. Brendan Carvalho, M.B., B.Ch., F.R.C.A. (Stanford University) reviewed the risk of respiratory depression with neuraxial opioids, featuring the new ASA guidelines.

Typically, the highlight of the SOAP Meeting is the Gerard W. Ostheimer Lecture, and 2009 was no exception, with John T. Sullivan, M.D., M.B.A. (Northwestern University) presenting “What’s New in Obstetric Anesthesia?” Traditionally, the lecturer catalogs and presents obstetric, anesthetic, pediatric and other literature pertaining to obstetric anesthesia published in the previous calendar year. Dr. Sullivan marvelously presented the highlights from 2008 and provided a syllabus of more than 930 pertinent articles.

An excellent second review of 84 posters by Roshan Fernando, M.B., Ch.B. (Royal Free Hospital – London Un-

### Table 2: Resident Forum Winners in Alphabetical Order, SOAP 2009

<table>
<thead>
<tr>
<th>Winner</th>
<th>Institution</th>
<th>Abstract Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laurie A. Chalifoux, M.D.</td>
<td>Northwestern University, Chicago</td>
<td>Persistent CN VI palsy after inadvertent dural puncture</td>
</tr>
<tr>
<td>ThuyAnh A. Nguyen, M.D.</td>
<td>Case Western Reserve University Hospital, Cleveland</td>
<td>Management of pulmonary embolus and DIC after a dilation and evacuation</td>
</tr>
<tr>
<td>Angel M. Martino-Horrall, M.D.</td>
<td>University of Michigan, Ann Arbor, MI</td>
<td>A case of central hypoventilation in a pregnant patient</td>
</tr>
<tr>
<td>Brian Paitsel, M.D.</td>
<td>Wake Forest University School of Medicine, Winston-Salem, NC</td>
<td>Relation between combined spinal epidural characteristics and spinal epidural labor analgesia outcomes – a daily problem/decision encountered by OB anesthesiologists that has not been answered previously</td>
</tr>
<tr>
<td>Patrick C. Thornton, M.B., F.C.A.R.C.S.I.</td>
<td>BC Women's Hospital, Vancouver, British Columbia</td>
<td>Evaluation of obstructive sleep apnea in a pregnant population and its correlation with maternal airway</td>
</tr>
<tr>
<td>Dirk Varelmann, M.D., DESA</td>
<td>Brigham &amp; Women’s Hospital, Boston</td>
<td>Nocebo-induced hyperalgesia during local anesthetic injection</td>
</tr>
</tbody>
</table>
University of Kentucky College of Medicine Anesthesiologists are sometimes confronted with challenging issues concerning informed consent of the parturient. Difficulty in obtaining consent sometimes occurs when a procedure is not necessary for preservation of life, but is likely to provide significant benefit, and at the same time has potential risks that cannot be precisely predicted. Of course, the patient must be involved in the decision. The goal of this article, through a general discussion of informed consent in the context of a clinical case, is to provide the reader with an improved understanding of ethical and legal principles involved in informed consent. Issues regarding maternal versus fetal benefit, while important, are beyond the scope of this article.

**Case Presentation**: A woman presents at 38 weeks gestation for labor induction due to HELLP syndrome. Her platelet count is 75,000. The obstetrician asks the anesthesiologist to discuss labor analgesia options with the patient before induction begins. The anesthesiologist has a thorough discussion with the patient, explaining both neuraxial analgesia techniques and systemic opioids. The risks and benefits, including epidural hematoma with neuraxial procedures and neonatal depression with systemic opioids, are discussed. The anesthesiologist also discusses the risks associated with general anesthesia should an emergency cesarean delivery be required without an epidural catheter in place. The anesthesiologist then asks the patient which analgesia technique she prefers. Rather than giving an answer, she asks, “Why am I being asked to make this decision? You are the doctor. You should decide.” It seems as though the patient is asking to relinquish her right to autonomy.

Autonomy is the basic ethical principle upon which informed consent is based and connotes the patient’s right to make her own decisions concerning her health care without being coerced by others. Before one can proceed in the scenario described above, one must understand the components involved in the process of informed consent from the standpoint of an ethicist. First, the patient must have the capacity to make a decision. Since this patient appears to have an understanding of the discussion and has not yet received any medications that would affect her decision-making capacity, this requirement for informed consent has been met. The second component in the process has to do with the patient acting in a voluntary fashion (i.e., her actions are the product of a conscious choice and independent will). Unless the anesthesiologist manipulated or distorted the facts during the discussion of analgesic options in an attempt to coerce the patient to choose a particular technique, the patient seems able to act voluntarily. In fact, one could argue that she is voluntarily requesting that the anesthesiologist choose the analgesic technique.

**Disclosure** is a third component of the informed consent process. This requires open communication between the physician and the patient and is fundamental to respecting a patient’s autonomy. The difficult aspect of disclosure is deciding how much information to disclose, especially in terms of risks. From an ethical standpoint, the ideal approach is to tailor the degree of disclosure to the specific patient. For instance, one would provide more details of the risks of endotracheal intubation to a professional opera singer than to other patients. This approach to disclosure is called the subjective person standard. Unfortunately, the subjective person standard is not generally accepted by the legal community because no objective criteria exist as to what should be disclosed. In most states, the legal requirement for informed consent involves the reasonable person standard. Under this standard, the amount of information disclosed is that which a “reasonable” person would consider necessary to make an informed decision. In a few states, the professional practice standard is utilized for defining legal informed consent. By this standard, the amount of information disclosed is based on what would typically be disclosed by members of the local anesthesia community. The largest problem with disclosure in the informed consent process is that sometimes the legally accepted extent of disclosure may not be sufficient from the ethical perspective, and sometimes the ethically preferred method may be inadequate legally. In the case presented above, the anesthesiologist appears to have met both ethical and legal requirements regarding disclosure.

**Recommendation**, another component of informed consent, could be crucial in the scenario described. In the current health care environment, patients are urged to take an active role in their health care decisions, and therefore, some anesthesiologists mistakenly believe that they should only describe to the patient the anesthetic options available and let the patient decide without offering an opinion as to which technique is preferable. In fact, the anesthesiologist has an ethical obligation to provide an opinion as to which procedure he recommends as well as an explanation for this recommendation. It is also
acceptable to use persuasion when explaining to the patient why a particular procedure is preferred. However, manipulation or coercion, in which the information presented to support the physician’s opinion is exaggerated or biased in an attempt to get the patient to choose the anesthesiologist’s preferred technique, is inappropriate. Without the recommendation component of informed consent, many patients may feel uncomfortable or even incapable of making a decision concerning their care and might feel a need to relinquish their autonomy, leaving the decision-making solely to the physician. In the scenario above, the patient’s response appears consistent with such a situation. By providing and fully explaining a recommendation for treatment, the anesthesiologist is likely to be more successful in his attempts to involve the patient in the decision-making process regarding her anesthesia care.

Another important component of informed consent is gauging patient understanding. Although one can never be certain that a patient fully understands a medical procedure, its indications, and the risks and benefits involved, it is the anesthesiologist’s responsibility to present the important information to the patient in a way that is understandable to a layperson. Patient understanding may be facilitated by not overloading the patient with nonessential details and being willing and available to answer the patient’s questions. The recommendation and understanding components then lead to this important aspect of informed consent: the making of an informed decision by the patient. In the scenario described above, it would be desirable for the patient to participate in the decision-making process. However, the degree of patient involvement will vary significantly with several factors, including such things as cultural norms and level of education. The anesthesiologist should tailor the extent of physician involvement in the decision-making process to the individual patient. The anesthesiologist should also understand that if all of the components of the informed consent process have occurred, it is acceptable for the patient to decide that she wants the physician to make the decisions concerning anesthetic management.

The final component of informed consent is autonomous authorization. This involves the patient authorizing the anesthesiologist to proceed with the procedure that was chosen, whether the decision was made by the patient or the physician. Autonomous authorization signifies the patient expressing her right to self-determination and thus is the basis of informed consent.

In addition to ethical principles, clinicians must also realize there is a legal requirement for informed consent. Court cases have set the precedent that physicians must discuss the risks, benefits and alternatives of a proposed medical procedure. Legal cases have also addressed what information needs to be disclosed and defined the reasonable person and professional practice standards discussed above. While differences exist between the ethical and legal aspects of informed consent, in most situations if all of the components of informed consent associated with the ethical concept are met, the anesthesiologist should feel confident that the legal requirements have also been satisfied. It is important from the legal aspect of informed consent that documentation occurs. This can take the form of a note in the medical record or the use of a standardized consent form. It seems that an increasing number of institutions and anesthesiology groups require a separate anesthesia consent form; however, not all health care facilities or anesthesiologists have adopted this approach, and a well-written note documenting the informed consent process remains legally acceptable.

Although the patient in the scenario described was not yet experiencing labor pain, the controversy regarding the validity of informed consent in a laboring parturient remains discussion. Some professional ethicists have argued that women in labor cannot truly give informed consent. Because of the severe pain the woman is experiencing, they have questioned whether she is capable of understanding the information being presented to her about the proposed anesthetic procedure. They have also expressed concerns about the effect of labor pain on the patient’s ability to act in a voluntary fashion, arguing that the pain may interfere with her ability to truly voluntarily consent to anything. In contrast, some anesthesiologists have suggested that until a woman has actually experienced the pain of labor, she cannot be truly informed as to whether she needs or desires labor analgesia. In a 2002 survey of SOAP members, the majority of the 448 respondents (68 percent) believed that women in active labor were able to give informed consent for neuraxial labor analgesia. In the American Society of Anesthesiologists Syllabus on Ethics also states that laboring parturients are able to give informed consent. In legal cases where informed consent for epidural labor analgesia has been questioned, the courts have ruled that the woman’s cooperation with the epidural procedure implied that she accepted the procedure and the risks associated with it.

In conclusion, it is important that anesthesiologists understand the process of informed consent and its ethi-
Pioneer’s Corner:
Philip Raikes Bromage: Pioneer of Epidural Labor Analgesia

Whose name do you most associate with epidural analgesia? If this question was asked during the last half of the 20th century, most anesthesiologists would have given the name of Philip Bromage.

Born in England in 1920, as a boy he attended the Benedictine Ampleforth College, which emphasized spirituality, Spartan discipline, intellectual rigor and sport. Philip graduated in medicine at St. Thomas’ Hospital in London in 1944 and then served in the navy in Asia for two years. After the war, Philip began a career in anesthesiology. Appointment to a consultant post in Chichester coincided with an explosion of his interest in epidural anesthesia and analgesia. He was fortunate to work with surgeons who encouraged him and tolerated a change from the routine. In 1954, while working in this milieu far from academic centers, he published a monograph “Spinal Epidural Analgesia,” and this work brought him international attention.

In 1956, Philip joined the McGill Department of Anesthesia in Montreal, and he became chairman in 1970. He then moved to Duke University (1977-81) and subsequently the University of Colorado (1981-85). After this, he spent some time in Saudi Arabia and then Wilmington, and finally, he enjoyed a much-deserved retirement.

Philip’s research explored many aspects of regional anesthesia, including the spread of epidural drugs, carbonation of lidocaine, and the rostral spread of intrathecal narcotics. While at McGill, he studied pain with Ronald Melzack. Today, he is most remembered for the Bromage Score of lower-extremity motor weakness. In 1978, he published his outstanding single-authored textbook Epidural Analgesia, which is well worth reading today. Toward the end of his career, Philip focused on safety issues in regional anesthesia.

Like all great scientists, Philip has a boundless curiosity and an urge to find solutions to problems. His enthusiasm is infectious and attracted students from all over the world. He possesses great gifts, including a masterful command of the English language. All his work is superbly written, and lectures were given in mellifluous tones, reminiscent of BBC newscasts of the 1940s. Never afraid to fight his own corner, he enjoyed an academic verbal tussle. As a physician, he impressed patients with his elegant appearance and impeccable manners. He set up an obstetric epidural analgesia service at McGill soon after he arrived and became an international ambassador for this technique. For this and other work, he has received many honors, including the first gold medal of the British Obstetric Anaesthetists’ Association.

Philip has three children. His wife Meg is known for her wit, vivacity and kindness. She also played an important role in Philip’s professional life, typing and editing all his manuscripts. While at McGill, Philip and Meg bought a farm in Vermont where they generously entertained members of the anesthesia department on a regular basis. These were happy times and allowed Philip to indulge his taste for skiing and the outdoor life. Philip now lives in retirement in his beloved Vermont. Meg died a few years ago and is much missed.

We salute one of the giants of obstetric anesthesia, Philip Bromage.
the program committee and participants, and especially you, our members, enough – thanks for making it a special meeting.

Through our committee structure and efforts by the Board, SOAP is improving our understanding of obstetric anesthesia practices and reimbursements, fostering international outreach, building a more active membership, enhancing the transparency and visibility of our actions through our Web site and other media, providing a forum for research and researchers, focusing on patient safety, supporting ACGME accreditation of obstetric anesthesia fellowships, and ensuring the growth of new and legacy opportunities. These are all substantive efforts. So where’s the need for change?

SOAP’s Strategies for Change

In preparation for his latest album “Radiance,” the pianist Keith Jarrett intentionally “needed to get rid of stuff in my own brain that I was using as the raw material for my art. The fingers... and brain... develop habit patterns. And if the brain is making those decisions, you will not find the letter “o” in the alphabet; you may end up sticking around “b” and never get past it, because you did not want something peculiar to happen.” New approaches can therefore be gained by de-familiarizing ourselves from habits that have served so well. On an individual basis, perhaps this means grabbing the Miller instead of the Macintosh blade, or using a saline instead of air loss of resistance epidural technique. For SOAP, this means looking at the role of our Society critically.

Gary Vasdev, M.D. (SOAP President 2006-07) initiated our self-assessment by creating a Strategic Plan Task Force composed of Valerie Arkoosh, M.D., M.P.H., Robert D’Angelo, M.D., and myself. Over the past two years, with feedback from the Board, committee members and SOAP members, we’ve established specific goals for our short- and long-term development, which include improving our financial stability, increasing membership value (i.e., more members-only content on our Web site, lecture and article postings, ACOG guidance documents, etc.), facilitating research and providing more clinically relevant educational opportunities. We want both private practice and academic colleagues to directly experience greater benefits from their membership.

To this end, the new Web site is now available, with new content arriving daily; take a peek www.soap.org. You can (and should!) book your time off now for the clinically oriented Sol Shnider/SOAP Meeting in Obstetric Anesthesia (March 11-14, 2010); the Sol Shnider is the same great meeting it’s been for the past two decades, but now with direct SOAP involvement. In addition, stay tuned for more information on our new (and significant) Gertie Marx Research Grant. Finally, don’t forget to make your plans to come to the 2010 Annual Meeting – Dr. D’Angelo and Manny Vallejo, M.D., the 2010 SOAP Scientific Program Director and Meeting Host, respectively, are creating a fantastic meeting for San Antonio.

A Concluding Thought

The pianists mentioned above all required a disability to foster change. Fleisher experienced focal dystonia. Jarrett suffered from chronic fatigue syndrome. Despite our 40-plus years in existence, your SOAP Board is not waiting for something to occur that forces change; rather, we’re hunting (and working) to improve our Society for you now. However, this introspection and action can be difficult to navigate. We need your help! What are your thoughts? Are we headed in the right direction? How can SOAP better meet your needs? What can we do to enrich the status quo? Give some time and attention to these questions, and drop me a line at ltsen@zeus.bwh.harvard.edu. Together, I’m confident that we’ll be able to create something as heavenly as a Bach cantata.

Cheers,
Lawrence

Discography:
2009 Annual Meeting Report

*Continued from 9*

versity) was followed by the Fred Hehre Lecture, this year wonderfully presented by Joy L. Hawkins, M.D. (University of Colorado Denver). Her lecture on maternal morbidity and mortality, titled “Anesthesiology’s Contribution to Maternal Safety,” explored past trends and future directions toward everyone’s goal: the safety of every mother and infant.

Saturday afternoon showcased the five candidates in the “Best Paper” competition, followed by the Research Forum, in which presenters examined ways to “maximize success” in the difficult world of the research scientist.

Saturday Evening’s SOAP Awards Dinner was a rousing success with its Cinco de Mayo theme. Awards were presented, and attendees networked and danced well into the night.

Sunday featured a joint North American Society of Obstetric Medicine (NASOM)-SOAP symposium. It began with a discussion of the best case reports, expertly moderated by Robert S. McKay, M.D. (University of Kansas-Wichita) and Grace H. Shih, M.D. (University of Kansas Medical Center).

The Meeting wrapped up with the third in the “What’s New?” series: “What’s New in Obstetric Medicine?” This lecture traditionally emphasizes medical problems in pregnancy. This year, Alan Karovitch, M.D., F.R.C.P.C. (University of Ottawa) focused on the use of oral hypoglycemics in gestational diabetes and the future health implications for women with preeclampsia. The panel that followed discussed several cases involving parturients with systemic diseases, including thyrotoxicosis and pheochromocytoma.

With thanks to the incredible and no-doubt-exhausted meeting planners, SOAP 2009 adjourned, with hopes to see everyone again in San Antonio for SOAP 2010!

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Check out our new Web site: www.SOAP.org

How Would You Manage This Case? Informed Consent in the Parturient: A Case-Based Discussion

*Continued from 11*

al and legal bases. Active communication between the patient and the anesthesiologist is essential in order for truly informed consent to occur. The interaction between patient and physician that occurs during the informed consent procedure may lead to other positive outcomes, most importantly an increased level of trust in the doctor-patient relationship.

References:


2. O’Leary CE, McGraw RS. Informed consent requires active communication, standardized consent process may be useful. APSF NewsL. 2008; 23:4-5.


Barbara M. Scavone, M.D.  
Editor, SOAP Newsletter

Gertie Marx devoted her professional life to the care of mothers and their babies. It is not an exaggeration to say she helped set in motion the modern era of obstetric anesthesiology. She tirelessly advocated, sometimes against fierce opposition, to ensure the availability of neuraxial labor analgesia, and argued on behalf of the importance of regional anesthesia for cesarean deliveries. Her many honors and awards included the Distinguished Service Awards from SOAP, ASRA and the ASA.1 Dr. Marx has been called “the mother of obstetric anesthesia.” 2 Indeed, it would be difficult to overestimate her contributions to obstetric anesthesiology and to SOAP.

Dr. Marx was also generous to SOAP financially, and that benevolence is in part responsible for SOAP’s favorable financial position in these precarious economic times. Through the Obstetric Anesthesia and Perinatology Endowment Fund (OAPEF) and the Gertie Marx Education Fellowship Fund (GMEFF), her gifts fund educational and research efforts on behalf of SOAP. Recently, the SOAP Disbursement Committee had the pleasure of announcing to the membership the initiation (applications to be accepted January through September 2010; first monetary award to be distributed January 2011) of the SOAP/Gertie Marx Research Grant, which will provide seed money to support preliminary or pilot research that will eventually garner financial backing from other sources. Endeavors such as these offer the promise of advancing our specialty and perhaps will represent Dr. Marx’s most lasting legacy.

At a time when funding for education and research continues to decrease, gifts which foster the advancement of obstetric anesthesia gain greater importance. The value of an education and research trust such as OAPEF is that grants are made from the interest earned, thus allowing the principle and some amount of interest to be left untouched, allowing for continuous growth. Thus, giving may serve as a chance for one to leave his/her most lasting influence on the field of obstetric anesthesiology. Please contact SOAP if you’re interested in supporting OAPEF or would like to consider other opportunities.

References:

The Newsletter welcomes reader input. Please send letters to the editor to soapeditor@gmail.com. Note that space does not permit publication of all submissions. The Newsletter reserves the right to edit any contributions for grammar/length.
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