



Society for Obstetric Anesthesia and Perinatology

Newsletter  
Newsletter

www.soap.org

Spring 2009



Linda S. Polley, M.D.  
SOAP President

## A Message From the President

We are pleased to continue our collaboration with other societies who share our interest in the peripartum care of the pregnant woman and her fetus. The Joint OASAO/SOAP Symposium will include lectures from both SOAP and OASAO speakers and provide an opportunity for attendees to compare respective obstetric anesthesia practices and exchange ideas. On Sunday, we will have joint sessions with the North American Society of Obstetric Medicine

John Sullivan, M.D., M.B.A., is the invited speaker for the 2009 SOAP Annual Meeting's Gerard W. Ostheimer Lecture, "What's New in Obstetric Anesthesiology?" His lecture will be a comprehensive review of the literature from the preceding year, highlighting advances relevant to obstetric anesthesia. SOAP Past President Joy L. Hawkins, M.D., will share her wisdom and insights in the honorary Fred Hehre Lecture, "Anesthesiology's Contribution to Maternal Safety." We will also celebrate the professional accomplishments of the 2009 SOAP Distinguished Service Awardee, Sanjay Datta, M.D.

**P**lans are in motion for our next annual meeting, which will be held in Washington, D.C., at the Renaissance Washington Hotel from April 29 to May 3, 2009. Current President-Elect Lawrence Tsen, M.D., Meeting Host Robert Gaiser, M.D., and SOAP Executive Director Jill Mlodoch are organizing an outstanding meeting with the theme "Creating a Safer Practice Environment." The program focuses on new information to help us provide the highest quality and safest care to parturients across a variety of practice settings. Issues that will be explored include crisis management, the effects of sleep deprivation on the anesthesiologist, how to minimize the risks of neuraxial anesthetic techniques, and how to proceed when neurologic injury does occur.

Please consider arriving in time to take advantage of three special offerings on Wednesday, April 29: 1) The Obstetric Anesthesia Crisis Simulation Course (offered as either a morning or afternoon session); 2) the morning Research/Grantmanship/Study Design Seminar; and 3) the afternoon joint symposium between the Obstetric Anaesthesia Society of Asia and Oceania (OASAO) and SOAP.

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**"SOAP members have volunteered to share their expertise in neuraxial anesthesia techniques and neonatal resuscitation with local physicians and midwives in (developing) countries. Members who have participated in these trips describe the experience as deeply rewarding..."**

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(NASOM), a group of internal medicine physicians with expertise in the care of pregnant women with concomitant medical disease. Past lectures from NASOM have been uniformly excellent and well received and have illuminated issues important to the multidisciplinary care of pregnant women. NASOM President Alan Karovitch, M.D., F.R.C.P.C., will be the 2009 speaker for the "What's New in Obstetric Medicine" lecture.

We extend a particularly warm welcome to all anesthesiology residents and invite you to participate in the Resident Forum on Friday afternoon. The session provides the opportunity to present your research and

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case reports in a collegial and relaxed atmosphere. You will have the opportunity to meet SOAP leaders, obstetric anesthesia fellowship program directors and your resident colleagues from around the country.

The social program for this year's meeting is particularly exciting and truly offers something for everyone. Dr. Gaiser has planned an amazingly full program, which includes a welcome reception at Madame Tussauds Wax Museum, a lively SOAP Awards Dinner with a Cinco de Mayo theme, and the first annual Family Movie Night! Visit [www.soap.org](http://www.soap.org) for further details and meeting updates.

Please congratulate Ashraf Habib, M.D., who has been appointed to chair the SOAP International Outreach Committee; and many thanks to Vernon Ross, M.D., for his service as previous chair. The original committee chair, Medge Owen, M.D., founded the nonprofit humanitarian organization Kybele, which is dedicated to the improvement of childbirth conditions worldwide. SOAP has provided partial financial support to Kybele medical missions in developing countries, including Ghana, Georgia, Armenia and Brazil. Additionally, SOAP members have volunteered to share their expertise in neuraxial anesthesia techniques and neonatal resuscitation with local physicians and midwives in these countries. Members who have participated in these trips describe the experience as deeply rewarding because they see the immediate impact on the women served as well as the long-term gains realized by "teaching the teacher."

On a sad note, we mourn the recent passing of Robert F. Husted, M.D., one of

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**“John Sullivan M.D., M.B.A. is the invited speaker for the 2009 SOAP Annual Meeting’s Gerard W. Ostheimer Lecture “What’s New in Obstetric Anesthesiology?”... a comprehensive review of the literature from the preceding year, highlighting advances relevant to obstetric anesthesia... We will also celebrate the professional accomplishments of the 2009 SOAP Distinguished Service Awardee, Sanjay Datta, M.D.”**

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the six founders of our Society. Dr. Husted died on December 6, 2008, from complications of pneumonia. We are grateful that he was in attendance at the celebration of SOAP’s 40th anniversary at the most recent Annual Meeting in Chicago. Please see the article in this newsletter detailing Dr. Husted’s many accomplishments, written by his good friend and SOAP co-founder, Bradley Smith, M.D.

I am looking forward to seeing everyone in Washington, D.C.!

Best regards,



Linda S. Polley, M.D., President

## OAPEF Contributors – 2008

Rishi Mani S. Adsumelli, M.D.  
Glenn W. Alper, M.D.  
Valerie A. Arkoosh M.D., M.P.H.  
Douglas R. Bacon, M.D., M.A.  
Michael W. Barts, C.R.N.A.  
Yaakov Beilin, M.D.  
Terrence D. Bogard, M.D.  
Terrance W. Breen, M.D.  
Walter U. Brown, Jr., M.D.  
Jodie L. Buxbaum, M.D.  
William R. Camann, M.D.  
James W. Carlin, M.D.  
Richard B. Clark, M.D.  
Theodore G. Cheek, M.D.  
Jason C. Cheung, M.D.  
Harry Cohen, M.D.  
Olga C. Correa, M.D.  
Margaret G. Craig, M.D.  
David S. Currier, M.D.  
Patricia A. Dailey, M.D.  
Joanne Douglas, M.D.  
Susan D. Dumas, M.D.  
Paul T. Elder, M.D.  
Thomas R. Farrell, M.D.  
David R. Gambling, M.D.  
Charles P. Gibbs, M.D.  
Lesley I. Gilbertson, M.D.  
Gilles R. Girouard, M.D.  
Jeffrey Goldsmith, M.D.  
Joy L. Hawkins, M.D.  
Charles D. Hershey, Jr., M.D.  
Philip E. Hess, M.D.  
James S. Hicks, M.D.  
Barbel Holtmann, M.D.  
Rehana Kausar, M.D.  
Nancy B. Kenepp, M.D.  
U.H. S. Khatun, M.D.  
Vijay K. Krishnan, M.D.  
Jeffrey S. Lee, M.D.  
Yunping Li, M.D.  
Jonathan G. Lord, D.O.  
Simon J. Lucy, M.D.  
Gary L. Messick, M.S., C.R.N.A.  
Kenneth M. Mims, M.D.  
Edward R. Molina-Lamas, M.D.  
Patricia F. Norman, M.D.  
Craig M. Palmer, M.D.  
Susan K. Palmer, M.D.  
Sumedha Panchal, M.D.  
Donald H. Penning, M.D., M.S.  
Lee S. Perrin, M.D.  
Roanne L. Preston, M.D.  
Alan C. Santos, M.D.  
Barry Shaw, M.D.  
Michael Shaw, M.D.  
Richard M. Smiley, M.D., Ph.D.  
Vitaly D., Soskin, M.D., Ph.D.  
Paul S. Steinberg, M.D.  
Alan F. Strobel, M.D.  
Paloma Toledo, M.D.  
Lawrence C. Tsen, M.D.  
Edward A. Yaghmour, M.D.

SOAP is now accepting nominations for the following elected positions (to be voted into office at the 2009 meeting): **Second Vice President** and **Treasurer**. You can learn more about these positions in the SOAP bylaws on the Web site at [www.soap.org/bylaws.htm](http://www.soap.org/bylaws.htm). If you would like to nominate yourself or someone else, contact Jill Mlodoch at [j.mlodoch@asahq.org](mailto:j.mlodoch@asahq.org).

# SOAP 41st Annual Meeting – Washington, D.C.



*Robert R. Gaiser, M.D.,  
2009 Meeting Host*

## **Be sure to attend the 41st Annual Meeting “Creating a Safer Practice Environment”**

***Renaissance  
Washington, D.C. Hotel  
Washington, D.C.***

***April 29-May 3, 2009***

**D**rs. Lawrence Tsen and Bob Gaiser would like to take this opportunity to invite you to the 41st Annual Meeting in Washington, D.C., so you can make your plans to attend! Washington, D.C. is a great place to hold a meeting. It's easy to get to, with three airports in close proximity. The closest airport is Reagan International [www.mwaa.com/national](http://www.mwaa.com/national), which is seven miles away and a focus airport for US Airways [www.usairways.com/awa](http://www.usairways.com/awa). It is possible to get to the hotel from this airport by cab, bus or metro. Dulles [www.metwashairports.com/Dulles](http://www.metwashairports.com/Dulles) and Baltimore/Washington [www.bwiairport.com](http://www.bwiairport.com) are further away (approximately 30 miles) and require a cab or shuttle. Dulles is a hub for United Airlines [www.united.com](http://www.united.com); Baltimore/Washington is a hub for Southwest Airlines [www.southwest.com](http://www.southwest.com).

The hotel [www.marriott.com/hotels/travel/wasrb-renaissance-washington-dc-hotel](http://www.marriott.com/hotels/travel/wasrb-renaissance-washington-dc-hotel) is located within walking distance of great sights. The National Portrait Gallery [www.npg.si.edu](http://www.npg.si.edu) is one block away from the hotel, while the Spy Museum [www.spymuseum.org](http://www.spymuseum.org) is just two blocks away. The Spy Museum explores espionage and its role in history. It takes about two hours to visit, but allow four hours if you bring the kids. Washington, D.C. is definitely kid-friendly and a perfect place to bring the family (just don't let the kids know that they are learning, because they will be having a great time seeing the sights). Madame Tussauds Wax Museum [www.madametussaudsdc.com/spiritofdc.html](http://www.madametussaudsdc.com/spiritofdc.html) is three blocks away, and the Smithsonian Museum of Natural History is just four blocks away.

One of the best aspects of Washington, D.C. is visiting the monuments. It provides the opportunity to reflect upon our history and future. The feeling that one has when standing in front of the Vietnam War Memorial [www.nps.gov/vive](http://www.nps.gov/vive) can't be described.

Within walking distance of the hotel are numerous ethnic and traditional restaurants. With great food, great sights and a superb meeting discussing “Creating a Safer Practice Environment,” the 41st SOAP Annual Meeting promises to be an outstanding experience in all regards. Looking forward to seeing you in Washington, D.C. April 29-May 3!

## SOAP Future Meetings

**SOAP 42nd Annual Meeting  
May 12-16, 2010**

**Grand Hyatt San Antonio**

**SOAP 43rd Annual Meeting  
Loews Las Vegas Resort  
April 13-16, 2011**

# 41st Annual Meeting “Creating a Safer Practice Environment”

DATE	TIME	SESSION TITLE
<b>Wednesday, April 29</b>	6:30 a.m.-2 p.m.	<b>Registration</b>
	<b>NEW</b> 8 a.m.-noon and 1-5 p.m.	<b>Obstetric Anesthesia Crisis Simulation Course</b> <i>Separate registration required.</i>
	<b>NEW</b> 8 a.m.-noon	<b>Research/Grantmanship/Study Design Seminar</b> <i>Separate registration required.</i>
	8 a.m.	Overview of the NIH and the Funding Process
	8:30 a.m.	The Nuts and Bolts of Creating and Submitting a Funding Request
	9 a.m.	FAER: Another Source for Funding
	9:30 a.m.	Panel Discussion and Questions and Answers
	10 a.m.	Break
	10:20 a.m.	Writing the Manuscript, Where Do I Start?
	11 a.m.	Maximizing Success: The Right Paper and the Right Journal
	11:30 a.m.	Manuscript in Review: Why Accepted, Revise, Rejected
	<b>NEW</b> 1-5:30 p.m.	<b>OASAO-SOAP Joint Symposium</b> <i>Separate registration required.</i>
	1 p.m.	<b>Welcome</b>
		<b>Session 1</b>
	1:05 p.m.	Are There Two Subdural Spaces? The Evidence and Relevance to Obstetric Anesthesia
	1:25 p.m.	Epidural Test Doses Re-Visited
	1:45 p.m.	The Epidural Test Doses: Who Needs Them?
	2:05 p.m.	Best Labour Epidural Practices
	2:25 p.m.	Problems and Pitfalls of Setting Up an Obstetric Anaesthesia Service in a Closed Community in a Developing Country
	2:40 p.m.	Question Period
	2:55 p.m.	<b>Break</b>
		<b>Session 2</b>
	3:20 p.m.	Can Genetics and Ethnicity Affect Post Caesarean Analgesia in the Asian Population?
	3:45 p.m.	The Single Shot Spinal as a Method of Pain Relief in Labour - An Indonesian Success Story Which Bears Looking Into
	4:20 p.m.	Safety Profile of Spinal Analgesia Adjuvants
	4:45 p.m.	A New Paradigm in the Management of Peripartum Haemorrhage
5:10 p.m.	Delayed Respiratory Depression from Intrathecal Morphine and Sensitivity to Opioid	
5:30-5:50 p.m.	Question Period	
<b>Wednesday, April 29</b>	7-9 p.m.	<b>Welcome Reception at Madame Tussauds Wax Museum</b>
<b>Thursday, April 30</b>	6:30 a.m.-5 p.m.	<b>Registration</b>
	6:45-7:45 a.m.	<b>Breakfast with Exhibitors and Poster Viewing</b>
	7:45-8 a.m.	<b>Welcome to the 41st Annual Meeting: “Creating a Safer Practice Environment”</b>
	8-9:30 a.m.	<b>Gertie Marx Research Competition</b>
	9:30-9:45 a.m.	<b>Distinguished Serve Award</b>
	9:45-10 a.m.	<b>Coffee Break with Exhibitors and Poster Viewing</b>
	10-11 a.m.	<b>Special Lecture: “Work, Sleep Hours, and Patient Safety”</b>
	11 a.m.-noon	<b>Pro/Con Debate: Attending Obstetric Anesthesia Call Should Be Limited to No More Than 15 Consecutive Hours</b>
	Noon-1 p.m.	<b>Lunch with Exhibitors</b>
	1-2 p.m.	<b>Panel #1: Developing Clinical Protocols: Evolving Practices to Reduce Practitioner and Patient Risk</b> A. Obstetric Hemorrhage B. “All Hands On Deck-BWH” C. “Condition O” D. Patient/Family Activation of Obstetric Rapid Response Teams
	2-3:30 p.m.	<b>Oral Presentations - Session #1</b>
	3:30-4 p.m.	<b>Coffee Break with Exhibitors and Poster Viewing</b>
	4-6 p.m.	<b>SOAP Business Meeting and Election</b>

Register on line at [www.soap.org](http://www.soap.org)



## April 29-May 3, 2009 • Renaissance Washington D.C. Hotel • Washington, D.C.

DATE	TIME	SESSION TITLE
<b>Friday, May 1</b>	7 a.m.-5 p.m.	<b>Registration</b>
	7-8 a.m.	<b>Breakfast with Exhibitors and Poster Viewing</b>
	8-9:15 a.m.	<b>Oral Presentations - Session #2</b>
	9:15-10:15 a.m.	<b>Neuraxial Techniques: Risk Management Informed Consent: If Only I'd Known ... What Risks Should Be Shared?</b>
		<b>Injury Following Neuraxial Techniques: Practical Next Steps</b>
	10:15-10:45 a.m.	<b>Coffee Break with Exhibitors and Poster Viewing</b>
	10:45-11:45 a.m.	<b>Poster Review #1</b>
	11:45 a.m.-12:45 p.m.	<b>What's New in Obstetrics?</b>
	1-4 p.m. 1-2 p.m. 2-4 p.m.	<b>SOAP Resident Forum</b> Welcome and Lunch Oral Presentations
	<b>NEW</b> 1-4 p.m.	<b>ASA Practice Advisory Committee on Infectious Complications of Neuraxial Techniques</b>
<b>Friday Social Activity</b>	8:30-10 p.m.	<b>Family Movie Night</b>
<b>Saturday, May 2</b>	6-7 a.m.	<b>Wellness Run/Walk</b>
	6:30 a.m.-5 p.m.	<b>Registration</b>
	7-8 a.m.	<b>Continental Breakfast</b>
	7-8 a.m.	<b>Breakfast with the Experts</b>
	8-9 a.m.	<b>Panel #2: Minimizing Risks with Neuraxial Techniques</b>
		Anticoagulation and Neuraxial Techniques
		Opioid Respiratory Depression
	9-10 a.m.	<b>Gerard W. Ostheimer Lecture: What's New in Obstetric Anesthesia?</b>
	10-10:15 a.m.	<b>Coffee Break and Poster Viewing</b>
	10:15-11:15 a.m.	<b>Poster Review #2</b>
	11:15 a.m.-12:15 p.m.	<b>Fred Hehre Lecture: Anesthesiology's Contribution to Maternal Safety</b>
	12:15-1:45 p.m.	<b>Lunch on own</b>
	11:45-3 p.m.	<b>Best Paper Presentations</b>
	3-3:15 p.m.	<b>Coffee Break</b>
	3:15-4:45 p.m.	<b>Research Forum: From Idea to Publication</b> What Research Should Be Done in Obstetric Anesthesia Maximizing Success: The Right Paper and the Right Journal How to Write a Manuscript/What an Editor Wants
	6-10 p.m.	<b>SOAP Awards Dinner</b>
<b>Sunday, May 3</b>		<b>NASOM/SOAP Joint Symposium</b>
	7-11 a.m.	<b>Registration</b>
	7:30-8 a.m.	<b>Breakfast</b>
	8-9 a.m.	<b>Best Case Reports</b>
	9-10 a.m.	<b>What's New in Obstetric Medicine</b>
	10-10:15 a.m.	<b>Coffee Break</b>
	10:15-11:15 a.m.	<b>Panel: Interesting Cases in Obstetric Medicine and Anesthesia</b>



### Hotel Information

The Renaissance Washington, D.C. Hotel is the official headquarters hotel for the **SOAP 41st Annual Meeting**.

Renaissance Washington DC Hotel  
999 Ninth Street NW  
Washington, D.C.

Phone: (202) 898-9000 Fax: (202) 289-0947

[www.marriott.com/hotels/travel/wasrb-renaissance-washington-dc-hotel/](http://www.marriott.com/hotels/travel/wasrb-renaissance-washington-dc-hotel/)

The daily room rate is \$249 for single occupancy; \$280 for double occupancy plus applicable taxes.

### Hotel Reservations

Reservations must be made by April 10, 2009.

For online reservations, go to:

<http://www.marriott.com/hotels/travel/wasrb?groupCode=saoasaa&app=resvlink&fromDate=4/28/09&toDate=5/4/09>

For phone reservations, please call 1-(888) 236-2427 (U.S. and Canada).

For international phone reservations, please visit

<https://www.marriott.com/reservation/worldnum.mi>

to obtain a list of telephone numbers for international reservations by country.

# Committee Reports

## Education Committee: Three for One



*John T. Sullivan, M.D.  
Chair, Education Committee*

One of the consequences of working in an organization full of individuals committed to teaching is that the education “committee” more closely resembles a senate in size. In order to more fully utilize the energy and talent of this group, last year we decided to split into three functional subcommittees that report back to the committee as a whole. Deborah Qualey, a private practitioner in

Delaware, now leads the Programs Subcommittee, Mark Zakowski, from Cedars-Sinai in Los Angeles, heads the Awards Subcommittee, and Cathleen Peterson-Layne, from Duke, chairs the Information Subcommittee. Although each subcommittee works on many endeavors, I will summarize some of their most significant work from the last year.

Mark Zakowski’s Awards Subcommittee is responsible for deciding the SOAP Research in Education and Teacher of the Year awards as well as reviewing educational grant applications. The Teacher of the Year Award was rolled out for the first time last year. The purpose of the award is to recognize and promote SOAP members who distinguish themselves in the often undervalued service of teaching. SOAP is beginning to advertise the availability of funding for clinical and educational research this year, and those with hypotheses related to education will be directed toward Mark

and his group to evaluate for merit and potential funding.

Deborah Qualey’s Programs Subcommittee will be involved in many of the new strategic initiatives of SOAP. As an organization, we have been involved in running educational conferences alone and in conjunction with other societies such as the OAA and SMFM. The SOAP leadership would like to more aggressively market our strength in providing high-quality educational programs in a variety of new venues and will be looking to this subcommittee for some of that organization and planning. The Programs Subcommittee will also be engaged in judging the case reports for the annual meeting this year. As this submission format has grown over the last few years, Rich Smiley, the chair of the Research Committee, requested our participation in evaluating these case reports.

Cathleen Layne-Peterson agreed to lead our Information Subcommittee, which is

## ‘Publications’ Committee Gets New Name



*Barbara M. Scavone, M.D.  
Chair, Media Committee*

Last May at the annual meeting, the Board of Directors recommended, and the membership agreed, to rename the SOAP Publications Committee the “Media Committee” to more accurately reflect its involvement with diverse means of communication with the membership. The committee assumed responsibility for the newsletter and periodic e-blasts and will assume

responsibility for the Web site after it is overhauled by the Web site task force. In addition, the committee will award the SOAP Media Award annually.

You may have noticed some changes in the newsletter. We hope you are enjoying the new features: the “Patient Safety” column, the “Pioneers’ Corner,” which features pieces relating to SOAP history, and the “Coda,” which is an editor’s column. Also, we changed the schedule of newsletters so they are more evenly distributed throughout the year; expect a newsletter in March, July and November. As part of an effort to control costs, the Board of Directors has decided that all but the March newsletter (our important pre-annual meeting newsletter) will be available in an electronic-only format. So look for your newsletters to arrive in PDF format via e-mail in July and November. Check the Web site [www.SOAP.org](http://www.SOAP.org) to

make sure we have your current e-mail address. The newsletter is happy to accept comments from its readers. Send letters to the editor to [SOAPeditor@gmail.com](mailto:SOAPeditor@gmail.com).

In October, the Board of Directors asked the committee to send blast e-mails periodically to keep members updated on the Society’s activities. You received your first one in December. Again, I urge you to update your e-mail address with SOAP via our Web site. If you need to communicate with the membership via one of these e-blasts, send the relevant information to me at [SOAPeditor@gmail.com](mailto:SOAPeditor@gmail.com).

The committee is soliciting nominations for the SOAP Media Award. The award acknowledges the contribution of a member of the media in furthering public awareness of the important role obstetric anesthesiology plays in the care of the parturient. Journalists, photographers, producers, directors and

responsible for disseminating educational products in a variety of formats such as the SOAP newsletter. There has been interest in expanding our printed educational product line to include other CME formats in the near future, and Cathleen's subcommittee will likely spearhead that effort.

As always, the Education Committee greatly values the feedback of all SOAP members – don't hesitate to send an e-mail. I look forward to your input and support. Contact me at [sullivan@northwestern.edu](mailto:sullivan@northwestern.edu).

The Education Committee is seeking nominations for the 2009 Teacher of the Year Award. Send nominations to Mark Zakowski at [mark.zakowski@cshs.org](mailto:mark.zakowski@cshs.org).

other media professionals involved in the development and advancement of the above content will be considered. All relevant media genres, including print, radio, television and the Internet, are eligible. Any SOAP member may submit a candidate for consideration. Send relevant information to Mark Zakowski of the SOAP Media Committee at [mark.zakowski@cshs.org](mailto:mark.zakowski@cshs.org).

I look forward to seeing you all at the annual meeting in D.C.!

The SOAP International Outreach Committee has a new chair! Please welcome Ashraf Habib, M.D., to the position, which presents SOAP's face to the world.

## Bylaws Change: For vote by the membership at the annual business meeting in D.C.



David Woldy, M.D.  
Chair, Bylaws Committee

In 2008-09, in response to the request of the Board of Directors, the members of the Bylaws Committee formulated a number of changes to the Bylaws, including the establishment of Patient Safety and Resident Affairs Committees, renaming the Publications Committee the Media Committee, and providing a non-voting Board of Directors position to the Chair of the ASA Scientific Content Subcommittee for Obstetric Anesthesia. We urge all members of SOAP to familiarize themselves with the Bylaws and to feel free to bring any proposed changes to the attention of the committee chair.

Consistent with SOAP Bylaws 12.1-12.4, the following proposed changes have been presented by the Bylaws Committee to the SOAP Board of Directors, which by majority vote has approved their distribution to the members. These will be voted on at our Annual Business Meeting in Washington, and, if approved by majority vote of the members present, will become effective at the end of that meeting.

### Proposed Bylaws Changes, 2009

To be voted on by the membership at the 2009 business meeting in Washington DC

#### DELETE:

**1.2** This SOCIETY provides a forum for the discussion of medical problems unique to the peripartum period. It promotes excellence in medical care, education and research in obstetric anesthesia.

**6.13** Chair of the Scientific Content Subcommittee for Obstetric Anesthesia of the American Society of Anesthesiologists (Appointed by the President of ASA, expected to be a member of this SOCIETY).

#### INSERT:

**1.2** 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 anesthetic clinical care.

**6.13** Chair of the Educational Track Subcommittee on Obstetric Anesthesia of the American Society of Anesthesiologists (Appointed by the President of ASA, expected to be a member of this SOCIETY).

**9.4.5** The Meeting Host cannot simultaneously serve as President-elect, i.e. Chair of the Scientific Program. In the event that a Meeting Host is subsequently elected to an officer position that would cause their term as President-elect to coincide with their term as Meeting Host, the Board of Directors will designate a new Meeting Host.

**10.13** No member may serve as Chair of more than one of the aforementioned Standing Committees

# Committee Reports

## Disbursement Committee: Funding Our Future



McCallum Hoyt, M.D., M.B.A.  
Chair, Disbursement Committee

The charge of the Disbursement Committee is to oversee the use of funds within the Obstetric Anesthesia and Perinatology Endowment Fund, also known as OAPEF. Based upon applications for use of those funds, the committee suggests to the SOAP Executive Committee of the Board of Directors how best to disburse the funds available. The Executive Committee makes the final determination on what to fund and with how much.

OAPEF was created by the SOAP leadership 20 years ago for the purpose of making distributions to select tax-exempt organizations and “to provide and develop information regarding problems unique to the peripartum period of child-birth including the clinical practice of medicine, basic research, and practical business and public health aspects thereof.” It was incorporated in May 1987. After several iterations, the SOAP Executive Committee became the OAPEF Board in the late 1990s. Through members’ donations and Dr Marx’s generous bequeaths, OAPEF has grown so that it now makes donations to foundations such as the Foundation for Anesthesia Education and Research, funds portions of the annual meeting, and has funds available for research and other requests. The committee evolved because the growth of OAPEF has redefined SOAP’s ability to offer funding for research in basic science, clinical science and education.

Historically, SOAP members have sought funding for projects by approaching the SOAP President and making requests. Although this may have worked well in the

past, it is no longer a viable mode of operation as it is neither an efficient way for the membership to ask for funding nor for the OAPEF Board to exert its due diligence.

The most pressing work of the committee at this time has been to develop a formalized grant application process that SOAP members can use to request funding. Thus at the Annual Meeting in Washington, D.C., the committee will formally announce the grant and open the application process. Applications will be reviewed, and these reviews may be performed by the appropriate members of the Research or Education committees. They will report to the Disbursement Committee, which will make the final determination and present their suggestions to the OAPEF Board (i.e., the SOAP Executive Board). From this process, the board will assign the awards as appropriate. The goal will be to award several thousand dollars per year; exactly how much will be announced in the spring. Concurrently, the committee will continue to review requests for donations from foundations and make those recommendations as well.

The committee is small and consists of four members who have contributed significantly to the welfare of SOAP and support its mission as well as three others who are members by virtue of their office. These are the chair of the Research Committee, chair of the Education Committee, and Treasurer. The two chair positions are in place as SOAP members often think to approach these committees with research ideas that might warrant

funding. Additionally, members of these committees could reasonably be asked to review applications. The role of the treasurer is to review OAPEF finances and work with the committee to determine a reasonable budgetary amount for distribution based on knowledge of current and upcoming requests.

If you are developing a research or educational project that needs funding, please be sure to attend the Annual Business Meeting to learn about the application process or follow up on the Web site after the meeting. Of course, committee members are always available for advice and consultation.

### Disbursement Committee Members:

McCallum Hoyt, M.D., M.B.A., Chair  
SOAP Treasurer

John Sullivan, M.D.  
Chair, Education Committee

Richard Smiley, M.D., Ph.D.  
Chair, Research Committee

Valerie Arkoosh, M.D., M.P.H.

Gerard Bassell, M.D.

Joy Hawkins, M.D.

Alan Santos, M.D.

The SOAP Media Committee is soliciting nominations for the SOAP Media Award. The award acknowledges the contribution of a member of the media in furthering public awareness of the important role obstetric anesthesiology plays in the care of the parturient. Journalists, photographers, producers, directors and any other media professionals involved in the development and advancement of the above content will be considered. All relevant media genres, including print, radio, television and the Internet are eligible. Any SOAP member may submit a candidate for consideration. Send relevant information to Mark Zakowski of the SOAP Media Committee at [mark.zakowski@cshs.org](mailto:mark.zakowski@cshs.org).

## Announcing New SOAP Resident Affairs Committee



*Paloma Toledo, M.D.  
Chair, Resident Affairs Committee*

**W**e are happy to announce that since last May, SOAP officially has a resident component, under the auspices of the Resident Affairs Committee. The purposes of this committee are to promote resident, fellow and medical student participation in SOAP; to address issues of importance to residents and medical students; and to encourage residents to gain experience in organized medicine, therefore promoting their development as future leaders within the Society.

The SOAP resident component has been involved in several activities since last May. One of the most exciting was the completion of the obstetric anesthesia

fellowship directory. The purpose of the fellowship directory is to provide a central location with information for all U.S. obstetric anesthesia fellowships. Several people contributed to this product, but Drs. Anne Baetzel and Emily Park deserve special recognition for overseeing this project. The fellowship directory should be available soon on the SOAP Web site.

Another significant happening was the recognition of the SOAP Resident Component by the ASA Resident Component House of Delegates. The delegate from SOAP to the ASA Resident Component House of Delegates is a full voting member of the house and therefore participates in the creation of policy and selection of the ASA resident leadership.

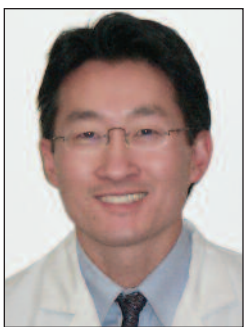
Lastly, in order to better communicate with the resident membership, the SOAP Resident Affairs Committee established a Facebook group page for important updates and discussions.

There are many benefits to resident membership in SOAP. In addition to all of the other annual meeting events, there is a resident/fellow/medical student forum at which trainees can meet and interact with program directors and other members of the SOAP community. During the resident forum, residents present their research in

resident-only sessions moderated by leaders in obstetric anesthesiology. The research presentations follow the same format used in the rest of the SOAP program, thereby allowing residents to gain experience and confidence in their oral presentation skills.

Joining as a resident is easy. All you need to do is fill out the membership form on the SOAP Web site found at [www.soap.org/membership\\_form.php](http://www.soap.org/membership_form.php). We no longer require a letter from your fellowship or program director to become a member. In addition to general membership, there are several opportunities for leadership within the SOAP resident committee. There are three elected positions in the committee: president, president-elect and secretary. Elections occur at the annual meeting. If you are interested in running for an office, please e-mail your CV and a statement of interest to [p-toledo@md.northwestern.edu](mailto:p-toledo@md.northwestern.edu).

To find out more about the SOAP Resident Affairs Committee, visit the SOAP Web site at [www.soap.org](http://www.soap.org). We hope you discover how valuable resident membership in SOAP can be, and we look forward to many active and productive years ahead.



*Lawrence C. Tsen, M.D.  
SOAP President-Elect*

## SOAP Members: Your Input Is Needed!

**H**ave you always wanted to release your inner “creative” side? Do you want to make a lasting and visible impact on SOAP? We have a terrific opportunity... help us design a timeless and memorable new logo! It’s been more than 40 years since our first logo was conceived. A growing number of members have suggested that it’s time to create a new look, especially as we develop more of a Web presence; moreover, many members think the current logo is reminiscent of a tadpole and a guppy.

General requirements: Appropriate (reflects the mission and membership of our Society), aesthetically pleasing and memorable. Also, it shouldn’t be so complex as to not be clearly visible or understandable at various sizes. Feel free to move completely away from the current design. Of note, the designs don’t have to be of professional quality; if the basic concept is liked, we’ll work with a professional designer to come up with the final image.

Due date: March 30! Yes, it’s a quick turnaround time, but we sent out a previous notice late last year, and we’d like to give you a final chance before our annual meeting, where we’ll reveal some designs (and hopefully vote for one!).

Please send all designs to: Lawrence Tsen, M.D., Brigham and Women’s Hospital, Department of Anesthesiology, Perioperative and Pain Medicine, 75 Francis Street, Boston, MA 02115 or by e-mail: [ltsen@zeus.bwh.harvard.edu](mailto:ltsen@zeus.bwh.harvard.edu). Thanks!

# How Would You Manage This Case?



*Audrey S. Alleyne, M.D.  
Assistant Professor  
Director of Obstetric Anesthesia Services  
Medical College of Georgia  
Augusta, Georgia*

## An Unusual Cause of Postpartum Hemorrhage

**W**e encountered a case of abdominal pregnancy diagnosed intraoperatively during cesarean delivery. The parturient presented complaining of abdominal pain not associated with labor, preeclampsia or chorioamnionitis. The case represents an unusual but potentially fatal cause of maternal hemorrhage

### Introduction:

Abdominal pregnancy is a rare yet serious type of extrauterine gestation. It accounts for approximately 1.4 percent of all ectopic pregnancies.<sup>1</sup> The clinical presentations described in the literature are variable. A maternal mortality rate greater than seven times that of non-abdominal pregnancies has been reported.<sup>1</sup> Abdominal pregnancies are classified as primary when fertilization takes place outside the uterus, while the more common secondary classification occurs from undetected rupture of a tubal pregnancy.<sup>2</sup> Abdominal pregnancy has been reported after hysterectomy with placental tissue implanting on the broad ligament and ovary.<sup>3</sup> These cases are rare and tend to occur because of preexisting fertilization.<sup>4</sup>

### Case Presentation:

The obstetrical anesthesia service was consulted to assist in the care of a 34-year-old, 85 kg, gravida 5 para 2 patient at 35-weeks gestation with a pregnancy complicated by placenta previa and large uterine fibroids. She had previously received a course of bethamethasone as corticosteroid therapy for fetal lung maturity because of preterm labor. Her past medical history was significant for non-insulin-dependent diabetes, polysubstance abuse (tobacco, alcohol and cocaine) and anemia. She was referred to our hospital for a fetal echocardiogram because of her large intake of nonsteroidal anti-inflammatory drugs throughout the pregnancy. She complained of abdominal pain.

On physical exam, she was afebrile with a temperature of 36.1 degrees Celsius. Her heart rate was 81 beats per minute, respiratory rate was 22 beats per minute, and blood pressure was 118/66 mmHg. The fetal heart rate was reassuring. Uterine tocography showed no contractions, but the patient appeared uncomfortable in bed. Her airway was clear, patent with a Mallampati 2 score, good mouth opening, normal thyromental distance and good dentition. Her cardiovascular exam revealed a regular rate and rhythm with 2/6 systolic ejection murmur. Her lungs were clear to auscultation bilaterally, and her abdomen was soft, gravid with a moderate degree of tenderness to palpation but no rebound or guarding noted. A sterile vaginal exam by the obstetrician showed the cervix closed, thick and high. There was no blood in the vaginal vault. The extremities revealed no cyanosis, clubbing or edema. The neurologic exam was significant for no sensory or motor deficits.

Her laboratory findings were significant for O positive blood type with antibody negative screen. Her white blood count was 15,000 cells/mm<sup>3</sup>. Her hemoglobin was 10.8 g/dL, her hematocrit 33 percent, and her platelet count was 252,000/mm<sup>3</sup>. Her electrolytes, liver function, urinalysis and coagulation panel were within normal limits. Her urinary drug screen was positive for cocaine.

A previous ultrasound showed evidence of placenta previa with suspected abnormal implantation, probable accreta and multiple leiomyomata. She had previously received weekly biophysical profiles that were reassuring with no score below 8 out of 10, losing points for decreased amniotic fluid. The patient was admitted to the antepartum service for external fetal monitoring. Fetal echocardiography revealed a restricted ductus arteriosus and pericardial effusion. The patient continued to complain of significant abdominal pain with no evidence of contractions.

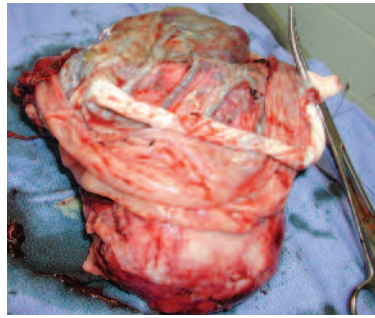
Do you have old SOAP T-shirts or other memorabilia cluttering up the house? Give it a new home: Send it to Brad Smith, Chair, SOAP History Task Force. You can contact him at [bradley.smith@Vanderbilt.Edu](mailto:bradley.smith@Vanderbilt.Edu).

Magnetic resonance imaging (MRI) of the pelvis, interpreted by a radiologist, revealed complete placenta previa with abnormal implantation not extending into the urinary bladder. The fetus was in transverse position, and large fibroids were evident. The obstetricians diagnosed her with degenerating fibroids causing infractory abdominal pain, placenta previa with abnormal implantation, oligohydramnios and restricted ductus arteriosus in the fetus. Because of the patient's desire for surgical sterilization and the suspected placenta accreta, the surgical plan was cesarean delivery with hysterectomy. The patient declined regional anesthesia.

After an eight-hour preoperative fast and premedication with 30 ml of sodium citrate by mouth, rapid sequence induction of anesthesia with cricoid pressure was performed. Propofol 2 mg/kg, succinylcholine 1.5 mg/kg and standard monitors were given, followed by uneventful oral intubation using a Macintosh 3 blade and 6.5 mm endotracheal tube. The anesthetic was maintained with a mixture of oxygen, isoflurane and vecuronium. A diagnosis of abdominal pregnancy was made during surgery when the surgeons noted the amniotic sac intraperitoneal, above the uterine fundus, extending to the stomach covered in infracolic omentum. The surgeons entered the amniotic sac and delivered the infant. The umbilical cord was clamped and cut. The viable female infant was handed to the pediatric team. The newborn received blow-by oxygen for two minutes and was transported to the neonatal intensive care unit for cardiac evaluation. The APGAR scores were 7 at 1 minute (one point off for tone, two points off for color) and 8 at five minutes (one point off for tone, one point off for color). The infant weighed 2445 grams.

During abdominal exploration, the surgical team found the placenta attached to the uterine fundus [Figure 1], extending into the right adnexa with small adhesions to the left colon and sigmoid colon. They removed the uterus supracervically with the right adnexa after creation of a bladder flap and take down of adhesions. Fluid resuscitation with one liter of crystalloid,

**Figure 1. Intraoperative gross specimen of placenta attached to fundus of uterus.**



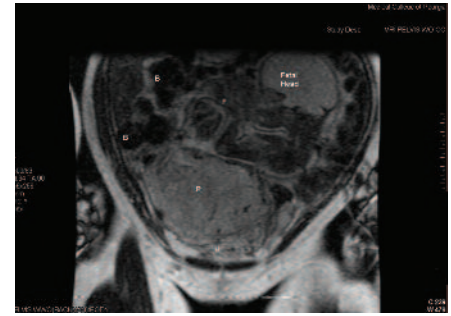
500 ml of hetastarch and four units of packed red blood cells were administered for an estimated blood loss of 2200 ml. Urine output was 4300 ml. At the end of surgery, the patient emerged from anesthesia without event, was extubated and transported to the postanesthesia care unit. The post-transfusion hemoglobin was 7.7 g/dL, hematocrit 23 percent, and platelet count 123,000/ mm<sup>3</sup>. The vital signs remained stable throughout the perioperative period.

The patient recovered appropriately from surgery, achieving satisfactory postoperative analgesia using intravenous morphine patient-controlled analgesia. After a slow return of bowel function, the patient tolerated a regular diet, her pain controlled with oral analgesics, and she remained afebrile throughout her hospital stay. The patient and her infant were discharged to home on post-operative day five.

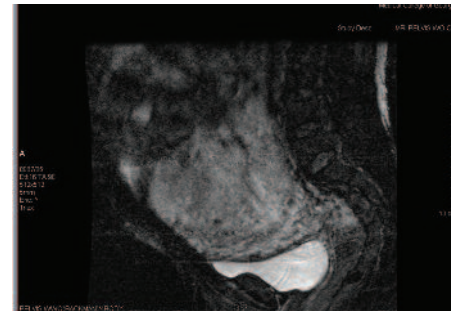
#### **Discussion:**

Extrauterine abdominal pregnancy is uncommon. The diagnosis requires a high degree of suspicion. During the later stages of pregnancy, ultrasound imaging of the fetus, placenta and uterus in the same views can be difficult to see clearly.<sup>5</sup> Teng and colleagues report a 50-90 percent diagnostic error with ultrasound in diagnosing abdominal pregnancy.<sup>6</sup> With a high index of suspicion, an MRI scan can diagnose abdominal pregnancy because of its good soft tissue contrast and non-ionizing property.<sup>6,7</sup> Postoperative review of the MRI with a senior radiologist reveals the presence of the infant in the abdomen [Figure 2]. Motion artifact obscured many of the MRI views [Figure 3], prompting the radiologist to focus his reading on the

**Figure 2. Coronal MRI T2 view of abdomen and pelvis showing fetus on top of uterus.**



**Figure 3. Sagittal MRI of abdomen and pelvis with motion artifact obscuring view.**



pelvis to determine the extent of the abnormal placenta implantation. The team presumed the etiology of the abdominal pain was her degenerating fibroids.

In our patient, placenta abruption was also high on our differential because of her complaint of pain out of proportion to the clinical setting and her history of cocaine abuse. The physical exam finding of uterine tenderness gave support to this diagnosis. Our patient did not complain of vaginal bleeding, but the uterus can hide significant blood loss before physical signs such as vaginal bleeding, hypotension or anemia manifest. Ultrasonography does not always reveal placenta clot, however, significant placenta bleeding is usually associated with fetal heart rate abnormalities. Our patient had normal, reassuring fetal heart rates throughout her prenatal hospital course.

The laboratory data and vital signs of our patient did not support preeclampsia. The blood pressure remained within normal range as did the bilirubin and liver enzymes. Spontaneous subcapsular hepatic hemorrhage is possible in severe

vasoactive states, but the patient showed no signs of cardiovascular instability, making this diagnosis unlikely as well.

Chorioamnionitis is a common diagnosis for the parturient with uterine tenderness. This diagnosis however, is usually associated with fever, tachycardia, leukocytosis greater than 15,000 cells/mm<sup>3</sup> and fetal tachycardia. Although our patient had a white blood count of 15,000 cells/mm<sup>3</sup>, she exhibited no fever, no maternal tachycardia and no fetal tachycardia. Surgical causes of abdominal pain such as appendicitis and cholecystitis are not uncommon in pregnancy. Classic localizing symptoms can be distorted because of the gravid uterus masking physical exam signs such as guarding and rebound tenderness. Food intolerance, nausea and vomiting are usually associated with these surgical causes of abdominal pain. Our patient did not experience these symptoms.

Abdominal pregnancy poses significant clinical challenges. Near exsanguination has been reported.<sup>2</sup> The partial or total separation of the placenta can produce massive hemorrhage. Because of abnormal attachment to sites such as the uterine wall, bowel, mesentery, liver, spleen and bladder, the placenta can detach at any time. After delivery, removal of the placenta is desired to avoid the risks of secondary hemorrhage. When placental implantation occurs on vascular immobile surfaces or unremovable surfaces, methotrexate can effect rapid placental degeneration.<sup>8</sup> However, the cumulative necrotic tissue from the degeneration increases the risk of infection.<sup>9</sup> Although the diagnosis of abdominal pregnancy was unexpected in our patient, the diagnosis of placenta previa and suspected accreta had the team prepared for hysterectomy to minimize blood loss. Blood products for transfusion were obtained preoperatively. Large-bore intravenous lines were already in place.

Maternal hemorrhage can result in disastrous outcomes. It is important to have adequate resources for fluid resuscitation, blood transfusion and surgical expertise. Packing the abdomen, direct pressure to bleeding surfaces,

uterine and hypogastric artery occlusion with ligation or radiologic embolization are techniques to consider besides hysterectomy. While many obstetrical patients are young with excellent physiological reserve, a multidisciplinary team approach facilitates care when faced with unanticipated crisis.

I graciously thank my colleagues Dr. Lawrence Devoe for the surgical images, Dr. Chadburn Ray for his surgical comments, Dr. Jim Rawson for his postoperative radiologic interpretation, and Dr. Ranita Donald for her assistance with the case.

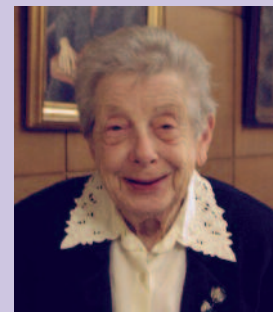
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## Announcement of SOAP/Gertie Marx Research Grant

Thanks to the forward-thinking nature of our founding members and the generosity of Dr Gertie Marx, SOAP is proud to announce the initiation of the SOAP/Gertie Marx Research Grant. This grant is intended for initiating research at the early part of an investigator's career. The intent is to provide "seed money" for preliminary or pilot investigations leading to continued work supported by other sources such as FAER, IARS or the federal government. This award is not intended to supplement ongoing projects or to provide additional funding to partially funded projects.

The SOAP/Gertie Marx Research Grant will provide up to \$50,000 over two years to support research in any area specifically concerning or related to obstetric anesthesia, including basic physiology,



clinical practice or teaching/training methods. The specifics of this program will be detailed at the Annual Meeting business session at the Washington, D.C. meeting and can be accessed on the Web site thereafter. The application deadline will be September 1, 2009, with expected funding of the grant in early 2010. It is anticipated that this grant will be awarded on an annual basis starting in 2010.

# Patient Safety Update



Paula A. Craig, M.D.

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**“Two recent publications indicate that the timing of anesthesia-related maternal mortality is changing, with profound implications for patient safety...the critical incidents occurred after the procedure was completed.”**

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UPDATE

## Is Airway, Airway, Airway Enough?

**A**ny junior trainee can tell you the three keys to safety in obstetrics: Airway, Airway, Airway: examine it, avoid it, secure it awake.

Residency training in obstetric anesthesiology traditionally emphasizes regional anesthesia to avoid intubation. In fact, we have done such a good job of establishing regional anesthesia as our first line of defense against airway catastrophes that graduating residents may administer only one or two general anesthetics for cesarean delivery during all three years of clinical training. Traditional teaching includes endotracheal intubation to avoid pulmonary aspiration and advanced airway techniques that allow us to secure the difficult airway while the patient is awake or, in the event of failed airway establishment, create a pathway for oxygenation and ventilation.

Two recent publications indicate that the timing of anesthesia-related maternal mortality is changing, with profound implications for patient safety. The most recent Confidential Enquiry into Maternal and Child Health found that of six anesthesia-related maternal deaths, in three of the cases the critical incidents occurred after the procedure was completed.<sup>1</sup> In addition, in a recent study of obstetric mortality in Michigan over three decades, five of eight anesthesia-related deaths were due primarily to airway or respiratory events that occurred post procedure. None occurred at induction or intubation.<sup>2</sup>

What about “airway-airway-airway”? It’s not that our efforts are misguided, but it’s time to shift our focus: Let’s not drop the ball we have kept in the air — let’s get the others up and flying.

What do we do next? Both of the above-referenced publications emphasize the need for “anesthetic involvement” in the immediate postoperative period. Many obstetric patients are not recovered in the areas used by other surgical patients, but are recovered on the labor and delivery ward or in an obstetric post-anesthesia care unit (PACU) staffed by perinatal nurses. We can requisition the appropriate

monitors and equipment and hand the peripartum nurses the same orders and protocols used in the general PACU and say we have done our bit — we have been “involved.” However, ensuring that obstetric patients receive the same quality of post-anesthetic care as do other surgical patients is not straightforward. Often, postoperative care of obstetric patients is provided by labor and delivery/perinatal nurses who are very skilled in newborn care, institution of breast-feeding, assessment of the postpartum uterus and supportive care of the new mother and family, areas in which PACU nurses are far less comfortable. At the same time, the obstetric nurses may not have seen a cardiac arrest in years, and never in an obstetric patient. Airway skills are understandably minimal. Though advanced cardiac life support certification can be required of obstetric nurses, how much understanding and retention can occur when the skills are rarely used?

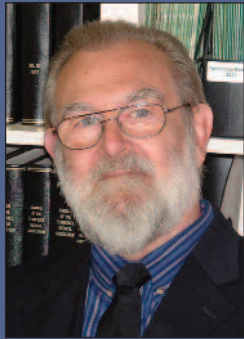
The shift of anesthesia-related maternal mortality to the post-anesthetic period means we must improve the systems within which we work. It’s not enough to be an excellent anesthesiologist — you can be no better than the system in which you work.

What challenges have you encountered in ensuring safe post-partum care in your hospital? What solutions have you found? We would be interested in hearing from you! E-mail correspondence to [pc6104@gmail.com](mailto:pc6104@gmail.com).

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# Pioneers' Corner



Bradley Smith, M.D., Chair  
SOAP Repository Task Force

**“In 1952, David M. Little (then at Yale) appointed Bob to independently cover obstetric anesthesia night call – believe it or not, this was a common practice in medical schools at that time – thus starting Bob’s love of OB anesthesia.”**

## IN MEMORIUM: SOAP’S 1st President, Robert F. Hustead, M.D.

**B**ob Hustead died in Johns Hopkins Bayview Hospital on December 6, 2008, of pneumonia. He was born in Pueblo, Colorado, in 1928 and graduated from Yale in 1950 and Yale Medical School in 1954. In 1952, David M. Little (then at Yale) appointed Bob to independently cover obstetric anesthesia night call — believe it or not, this was a common practice in medical schools at that time — thus starting Bob’s love of OB anesthesia. It was at this very early stage that Bob began to hand fashion his legendary “Hustead epidural needle.”

After anesthesiology residency at Yale and Hartford, Bob was assigned by the Army to the prestigious Edgewood Chemical and Biological Center near Baltimore and promptly began attending obstetrics and gynecology rounds at nearby Johns Hopkins. There he met and collaborated with numerous legendary figures in obstetrics and neonatology and was invited to teach and provide obstetric anesthesia on weekends. After discharge, Bob joined the Hopkins faculty. His first involvement with the American Society of Anesthesiologists came at this time as one of the earliest members of the Maternal Welfare Committee, under its founder (also of Baltimore) Otto C. Philips (SOAP charter member).

The next move was to Kansas University in Kansas City where Bob headed the division of obstetric anesthesia. There he made a convert of a junior OB-Gyn house officer, Jim Evans (third SOAP President), whom he influenced to follow a career in OB anesthesia. During these years, he met and collaborated with both Elwyn S. Brown (SOAP charter member) and James O. Elam (SOAP founder).

In 1968 and 1969, this group of friends, along with Elam’s associate, Bob Bauer (SOAP founder), my friend Dick Clark (SOAP founder) and me, began to make solid plans for the foundation of SOAP. Bob volunteered to organize the first national meeting of the new group at Kansas City, Kansas, on September 19,



Robert F. Hustead, M.D.

1969, and he was elected our first president.

In 1973, Bob and his wife, Joy (a CRNA), moved to Wichita to start a private OB anesthesia practice. However, after four years of great professional success, he and Joy reluctantly left OB anesthesia because the remuneration at that time would not support educating their nine children. They together moved into ophthalmic anesthesia. As in his previous endeavors, Bob invented new techniques, wrote, published and taught. His 1993 book, *Ophthalmic Anesthesia*, with James Gills has been called a “classic.” In 1986, Bob was instrumental in helping to found the Ophthalmic Anesthesia Society, to which he was still a major contributor. Among his other accomplishments, he was a consultant anesthesiologist to the Office of the Surgeon General of the United States for nearly two decades.

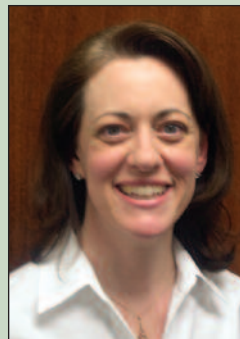
In 1978, Bob and Joy (they ultimately were married 36 years) survived a terrible private airplane crash that required prolonged intensive care and rehabilitation for them both. Characteristically, they vigorously returned to ophthalmic anesthesia until retirement. All nine of their children earned advanced degrees and certifications, and Bob and Joy had 16 grandchildren.

Bob was a person of integrity, inventiveness and compassion. I am proud to have been called his friend for 45 years. The good will and prayers of hundreds of SOAP members go out to Joy and their wonderful extended family!





Those of us in academic practices and many in private practice settings are charged by the Accreditation Council for Graduate Medical Education and the American Board of Anesthesiology with assessments of resident competency.<sup>1</sup> In addition, many of us evaluate medical students and/or student nurse anesthetists. What are our responsibilities regarding these appraisals of competency? Clearly our primary duties are to the resident/student: “Formative assessment” is a type of assessment that provides meaningful feedback designed to improve performance and includes judgments based on written examinations, direct supervision or other observations of clinical activity, video and/or clinical simulation review, and self-reflection.<sup>2,3</sup> Regarding supervision of clinical activities, feedback must be specific and accompanied by expectations in order to change behaviors. Rather than a list of inadequate behaviors (e.g., “You are messy and disorganized...” or “You do not pay attention to details...”), meaningful performance assessments include specific examples (e.g., “The top of your cart has disarranged syringes and trash such as syringe and needle wrappers on it...” or “You were unaware your patient was taking a certain medication...”). Such criticisms are best accompanied by expectations (e.g., “Arrange your syringes on top of your cart the same way every case, and dispose of trash immediately...” or “You should know every medication your patient takes, and you should look up information regarding mechanisms of action, side-effect profiles and potential interactions, etc., for medications with which you are unfamiliar...”). Also, feedback must be timely in order to maximize learning, and judgments of clinical performance lose reliability and validity after as little as seven to 14 days.<sup>3</sup> In addition to improving performance, accurate determinations of capabilities protect residents/students from acting in clinical situations for which they may not possess adequate knowledge or skills. We have a commitment to document



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

performance inadequacies so that our charges are not unfairly placed in settings they are not prepared for, where they may do harm to patients.

Evaluations of competency are known to serve the interests of the universities and health care facilities we work in and the public at large, our potential patients, and when used in this way, they are referred to as “summative assessments.”<sup>2,3</sup> I would argue that our duties to our institutions and to the public are fulfilled insofar as our duties to our residents are. When we provide our residents with meaningful feedback that improves performance and protects against their placement in circumstances beyond their capacities, then we have by default achieved many of our obligations to our parent institutions and our communities.

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## Letter to the Editor:



Dear Editor:

Virginia Apgar is known to all anesthesiologists, and most physicians, for her development of the APGAR Score for measuring neonatal well-being. For a long time, I wondered as to the nationality of the name. Is it Hungarian? Romanian? I have learned that it is a German name spelled “Apgard.” Also, for a long time, I had looked for another person or place with that name, as it seemed to be a very unusual name. In 2006, my wife and I were visiting Glacier National Park in Montana and came upon Apgar Village in the southwest corner of the park. This was the first instance in which I encountered the name, besides in association with the well-known Dr. Apgar. The village was named for Milo Apgar, a 19th century guide and outdoorsman. No doubt he was distantly related to Virginia. One can access the Apgar Web site and find quite a few Apgars. I have enclosed a picture of my wife and me at the Apgar Village Visitors’ Center.

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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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