Table of Contents

- President's Message
- Research in Education Criteria
- 34th Annual Meeting Review with photos
- Photo Highlights
  - Breakfast with the Experts Photos
  - Industry Support Photos
  - Social Events Photos
  - Wine & Cheese Reception
- PRO/CON: Healthy Parturients Should be Classified as ASA I
  - Pro: Stephen D. Pratt, MD
  - Con: Manny Vallejo, MD
- SOAP Box
- Erratum to the SOAP review in ASA News
- Review article: Informed consent & language issues
- JCAHO Policies on emergency drug storage
- SOAP's Response to AWHONN Guidelines
- AWHONN Executive Director's reply

Fall 2002 Newsletter

A Publication of the Society for Obstetric Anesthesia & Perinatology

© Copyright 2002 The Society for Obstetric Anesthesia & Perinatology

Back to Newsletters
Back to Soap Home
President's Message

What a great annual meeting we had in Hilton Head! Our meeting host, Gary Vasdev has included a summary of events including pictures of many of the social and educational activities. A highlight of the meeting was our Distinguished Service Award presentation, given this year to our SOAP founders. It's quite amazing to look around and realize how far we've come from the initial six-person "interest group" meeting in an airport lounge at O'Hare.

Shortly after the Hilton Head meeting it appeared our subspecialty was in for some adverse publicity. In May 2001 the New York Academy of Medicine and the Maternity Center Association (MCA) sponsored a symposium titled "The Nature and Management of Labor Pain". A diverse group of obstetricians, nurse midwives, childbirth educators, epidemiologists and public health researchers gathered to discuss information about labor pain, methods to relieve it, ways to assure all women receive information on all methods of labor pain relief and to develop research priorities. A number of SOAP members participated including Don Caton, Val Arkoosh, Barbara Leighton, David Birnbach, Sheila Cohen, Susan Palmer, Mark Rosen and Bill Camann. Larry Saidman (former editor-in-chief of Anesthesiology) moderated. In early May 2002, a press release related to the meeting was circulated and a meeting supplement was published in the American Journal of Obstetrics and Gynecology. Most of the obstetric anesthesiologists who attended the meeting felt the statements in the press release did not accurately reflect the informative and collegial discussions that went on at the meeting, and indeed the portion of the press release concerning regional analgesia for labor was particularly negative. Unfortunately, none of the anesthesiologists attending had input into the press release.

The main concern raised by the MCA was patients receiving complete and accurate information about pain relief techniques and then having all possible options (especially non-pharmacologic ones) available. We certainly support that as well. SOAP's response to MCA's concerns was that non-pharmacologic methods of analgesia should be available to all women as they have few if any side effects and these methods may be effective for some. However, we also recognize that non-pharmacologic methods and the use of support personnel such as doulas are entirely compatible with a patient who ultimately decides to have a regional analgesic. Our main concern was that we would be unable to correct their misrepresentations and inaccuracies about regional analgesia, especially if the press release received wide attention. Fortunately, there seemed to be very little interest by the media when it was ultimately released. As one attendee noted, "it would seem to me that American women are voting with their `contractions' toward epidural analgesia…Will some women be influenced sufficiently [by this report] to elect a bath and a doula rather than an epidural I suppose so, but not many and not for long." The supplement to the "gray journal" is well worth reviewing and hopefully new areas of research and collaboration will come about as a result.
In addition to being an educational and social success, the Annual Meeting was financially successful as well, showing a profit of about $25,000. Our other assets are also doing well under the supervision of Independence Advisors in Philadelphia. The Obstetric Anesthesia and Perinatology Endowment Fund (OAPEF General Fund) has about $150,000, the Gertie Marx OAPEF fund has over $200,000, and we have an additional $140,000 in our Reserve Fund. The OAPEF General Fund supports the Gertie Marx Symposium at the annual meeting with monetary awards for our fellow and resident research competition. Contributions are welcome from everyone and you will receive a written acknowledgment for tax purposes. The Gertie Marx OAPEF Fund supports the Education Research Award given at our annual meeting. Dr. Marx gave a generous endowment to SOAP and the interest from her gift provides the financial portion of that award.

As you begin receiving your dues notices in the next few weeks, you will notice a place to make donations to OAPEF for support of research in obstetric anesthesia, including an award given jointly with ASA’s Foundation for Anesthesia Education and Research (FAER). Hopefully everyone will consider giving a donation at the time they renew their membership. We plan to begin mentioning the names of contributors in the newsletter and setting up a program so that members can make donations in honor of a SOAP member. And while you are renewing your membership, consider encouraging one or more of your colleagues to become a SOAP member as well. Our membership numbers are stable (as opposed to other subspecialty groups seeing a decline), but we would love to see more anesthesiologists become involved in our research and educational endeavors.

Our Web site is long overdue for an update, and David Wlody and his Publications Committee have agreed to this undertaking. If you have suggestions for content or ways in which the Web site could serve you better, please let David know. We would like to emphasize patient education as well as member information in separate locations. There is no shortage of patient information on the Internet about pain relief in childbirth, but little of it is accurate or well-balanced. We hope to make the SOAP website the place everyone laypersons and medical personnel goes to for the most up to date information on peripartum anesthetic care for the parturient.

Finally, the 2003 Annual Meeting will be held May 14-17 in Phoenix, AZ at the Pointe Hilton at Squaw Peak. Craig Palmer (Meeting Host) and Dick Wissler (President-elect) are hard at work finalizing an excellent program. Please reserve that time to attend. On-line submission of abstracts will be open November 1 with a deadline of January 31, 2003, so finish up that project and get that data ready to go! Our Distinguished Service Award recipient for 2003 is Dr. Brett Gutsche of the University of Pennsylvania, and he will be honored during the meeting and at the banquet. A good time will be had by all hope to see you there!

Joy L. Hawkins, MD
SOAP President

Joy L. Hawkins, MD
SOAP Award for Research in Education

Chosen from abstracts presented at

The Society for Obstetric Anesthesia & Perinatology 35th Annual Meeting

Award Criteria:

1) Abstracts may focus on the education of medical students, residents, patients, obstetric care providers, or the community.

2) All health care providers (anesthesiologists, fellows, residents, obstetricians, nurses, etc) are eligible as long as a member of SOAP or sponsored by a SOAP member.

3) $500 award is intended to recognize research in specific educational techniques and tools (including multimedia), development of instruments for evaluation of outcomes, or other innovative and creative investigations which impact the quality of obstetric anesthesia education.

4) For consideration please submit abstract online to www.soap.org beginning November 1, 2002.

ABSTRACT SUBMISSION DEADLINE: January 31, 2003
Review of the 34th Annual Society for Obstetric Anesthesia and Perinatology Meeting

Gary Vasdev, MD
Vice Chair, Program Committee
Meeting Host

The Society held its 34th Annual Meeting at the Marriott Resort, Hilton Head Island, May 1-5, 2002 in perfect spring weather. There were 429 registered attendees with 35 walk-ins.

This year's Program Committee introduced several new activities to an already successful SOAP meeting. Committee meetings were held prior to the main event, allowing time for all to participate and enjoy the scientific program. We included parallel sessions, refresher courses, and workshops.

The pre-meeting events included a Neonatal Resuscitation Course; 40 people were certified by Regional Instructors Lauri Cox and Debbie Gordon from Wake Forest and Drs. Gary Vasdev, Edwin Rho, Kristi Boldt, DeAnna Griebenow, and Mary Murry from Mayo Clinic. This venue was over subscribed, resulting in a few members unable to be certified this time around. As a result of the success and demand of this course, future meetings will continue the option of a Neonatal Resuscitation Course as a pre-meeting event.

Drs. Joy Hawkins and Gary Vasdev formally opened the meeting the morning of Thursday, May 2002.

The Gertie Marx competition was captivating with presentations from several outstanding young researchers in our field. The winner, Dr. Paul Bach from British Columbia Women's Hospital and Health Centre, Vancouver, Canada, presented, "The Importance of Methodological Variables in the study of Hypotension after Spinal Anesthesia for Cesarean Section: Pentastarch vs. Normal Saline." There was a tie for second place: Dr. Nisa Patel of the Royal Free Hospital, London, United Kingdom, "Early Labor is more Painful in Parturients who Eventually Deliver by Cesarean Section for Dystocia" and Dr. Panni from Brigham and Women's Hospital, Boston, MA, "Platelet Counts and Function: an in vitro Model of Producing Whole Blood with Low Platelet Counts." The extremely high quality of presentations made the job much harder for our judges.
One of the highlights which made this SOAP meeting so special was the Distinguished Service Award presented to the "founding fathers" of obstetric anesthesia by Dr. Valerie Arkoosh.

The first oral presentation session was moderated by Dr. Christopher James which led to the first of our two popular debates of the meeting; Gerald Burger and Ted Cheek duked out whether an anesthesiologist may leave the hospital when a patient has an indwelling catheter. Dr. Burger's slides provided the level of wit and cunning which made this debate so memorable.

Dr. Yaakov Beilin moderated Poster Review 1: Outstanding performance!

In our first afternoon we incorporated parallel sessions. The Refresher Courses were well received and Drs. Campbell and Dailey should be commended for their review of...
Coordinators for the Hands-on Airway Course, Drs. Barry Harrison, Gerard Kamath, and Gary Vasdev did an excellent job getting 53 participants certified in advanced airway management skills. Evaluations from meeting participants stated, "This is the best airway course I have ever attended." The afternoon was very much enjoyed by both participants and presenters.

The Lofgren award was presented to Dr. Sheila Cohen for her outstanding contributions to obstetric anesthesia. Drs. Birnbach, Abboud, and Hughes presented personal and insightful praise of her illustrious career. We are all indebted to her work and scientific foundation for OB anesthesia. Her contributions to SOAP have helped build our Society to its high standards of today.

Friday's Zuspan Awards had some great presentations making the judging extremely difficult. The winner was Dr. Goetzel from Baylor College of Medicine, "A Double-Blind Placebo-Controlled Trial of Prophylactic Acetaminophen to Prevent Epidural-Fever: Pilot Study Data."

Some registrants took the attire "resort casual" to heart

Poster Review 2 was delivered by Dr. Robert Gaiser, who provided wonderful summaries of the papers he reviewed. What's New in Neonatology was presented by Dr. Robert Chantigian. The issues he raised presented clinical dilemmas which are faced by us on a regular basis. His presentation was extremely well received by the Society as reflected by the outstanding scores he received from his evaluations.

Dr. Michael Greene, despite his difficult travel, made it on time for his presentation, What's New in Obstetrics. He delivered a truly outstanding lecture on the VBAC controversy which captivated the audience.

Saturday morning started early with two parallel sessions. Dr. Smiley presented Research Works in Progress and Drs. Sadler and Razzaque presented MOSES
(Multidisciplinary Obstetric Simulated Emergency Scenarios). This is a novel way to teach communication skills in simulated medical emergencies. The presenters (active clinicians) were excellent actors and encouraged audience participation. Due to time constraints, we only had a sample of the potential power of this phenomenal teaching aid.

Clinical Forum: Scripted Cases of Parturients with Cardiovascular Disease was presented by Drs. Warnes, Ramin, and Camann. The reviews of this session were outstanding. To coordinate and present a multidisciplinary Grand Rounds in a scientific meeting deserves special credit to the presenters.

Barry Glazer, MD gave the ASA presidential address and raised key issues which affect OB anesthesiology. This was a rather sobering presentation, reflecting the volatility of our current professional climate.

Everyone likes a good argument

The second debate delighted the audience. Dr. Andrew Malinow moderated the session of best friends, Drs. Joanne Douglas and David Gambling who presented excellent evidence to support their views on Failed Epidural for Urgent C/S: Spinal is Preferable to General Anesthesia. The audience was left much in favor of Dr. Douglas’ con view.

Our thanks to the immediate past-president, Dr. Alan Santos, for his contributions to our Society and support for the 34th Annual Meeting. The Gerard W. Ostheimer: What's New in Obstetric Anesthesia lecture was delivered by our Newsletter editor, David Wlody, MD. An excellent review of the recent literature was most precisely done by David. His personal touch to the presentation was delightful! The lecture received excellent reviews by the members of the Society and he should be commended for a "job well done!"

Poster Review 3 was delivered by Holly Muir, MD, who provided a superb summary of a number of excellent presentations.

The Business Meeting elected new members to the board. Drs. William R. Camann was elected to 2nd Vice President, Lawrence Tsen to Secretary, and Divina Santos as "Member at Large." The Society welcomes them and looks forward to their contributions for our growth. Our thanks to Edward Molina-Lamas and Donald Penning for their service as Member at Large and Secretary, respectfully.

The 2006 meeting site chosen was Miami Beach at the Fountainebleu Hotel and Resort. The meeting host will be Dr. Joy Steadman who will also join the Board in 2005 as Meeting Host.
Dr. Valerie Arkoosh presented Dr. Alex Pue the 2001 Meeting Host plaque for his coordination of the meeting in San Diego and thanked him for his contributions to the Society.

A summary of meeting expenditures revealed a healthy $25,000 surplus which will be used for the general support of SOAP. The Business Meeting concluded Saturday's scheduled sessions.

Sunday morning Breakfast With The Experts was very well attended. A wide variety of topics were chosen by the Program Committee and these were well received by those who attended.

Dr. David Dewan presented the Fred Hehre Lecture on the outstanding achievements of obstetric anesthesia and how it has evolved over the last 20 years. The impact of this was heart-felt by many society members. Cynthia Wong moderated the oral review sessions on Sunday, May 5.

SOAP started a new tradition of with the "Research in Education Award". The first recipients of this prestigious award were Drs. David Birnbach, "The Use of Video Tapes of Specific Errors as an Adjunct to Teach Epidural Technique," and Raymond Glassenberg, "The Virtual Larynx: Teaching Intubation Skills with Fewer Patients".

Four papers were nominated for "Best Paper of the Meeting". After excellent presentations, the judges conferred and made their decision during closing remarks. Dr. Hawkins presented the award to Dr. James Eisenach, "Morphine's Site of Action for Analgesia to Uterine Cervical Distension is Central and Antagonized by Estrogen".

Dr. Barbara Leighton was acknowledged as the recipient of a FAER grant to study "Mechanisms of Labor Slowing".

This event formally closed the 34th Annual Meeting.

The social highlights of the meeting made this one of the most adventurous SOAPs in recent history. The Dine-Around was low key with groups of friends and colleagues drifting off to some of the most outstanding restaurants in Hilton Head Island.

New members and friends from abroad joined the meeting host and other board members. This was a gracious welcome to our society.

The meetings athletic activities were, as always, well attended. The following participants prevailed over the competition:

Golf: Alison J. MacArthur, Michael James Paech and Susan Palmer
Fun Run: Men - Frank Stornolio (Again); Women - Ms. Erin Dewan

The banquet was held beachside in perfect weather. Dining and jokes were abundant and from the number of empty bottles of wine, so was the consumption.
society enjoyed socializing and participating in a variety of entertainment from crab racing to dancing with the live band.

Betting was heavy at the crab races

Windriders and sailboats were offered to Society members by Northern Breezes Sailing School (USCG Captain Tom Burns) and members were taken out for rides on these magnificent craft. Some were lucky enough to be captained by the meeting host!

Baxter Corporation generously sponsored sunset sailing on America's Cup sailboats, cruisers, and catamarans. Although the winds were light, the mood was jubilant and the voyage and sunset breathtaking.

Our meeting could not have been such a great success without the sponsorship of B. Braun Medical, Inc. (Fun Run), Baxter Pharmaceutical (Sunset Sailing), Becton
Dickinson Medical Systems, Rusch Inc, Sorenson Medical Inc, W. B. Saunders, Mosby and McGraw Hill, PNA Medical Systems, Protex, Inc., Purdue Pharma, Lippincott Williams and Wilkins, Glaxo SmithKlein, Imagine Medical Technologies, Arrow Industries, and AstraZeneca for their support of the 34th annual meeting of SOAP.

Industry Support Photos

As members departed for their outward bound planes, the Program Committee worked feverishly on the 2003 meeting in Phoenix, Arizona. I believe we continued with a high quality meeting in Hilton Head, and I am confident that our Society will grow in the future with participation from our strong membership.

Respectfully,

Gary Vasdev, MD

SOAP Meeting Host 2002
Healthy Parturients Should be Classified as ASA I

PRO

Stephen D. Pratt, MD
Clinical Director, Obstetric Anesthesia
Beth Israel Deaconess Medical Center
Harvard Medical School

At this year's SOAP meeting, Barbeito et al presented an abstract entitled "ASA physical status classification - A pregnant pause" (1). The authors surveyed 49 anesthesiologists, asking them to assign an ASA class to 6 hypothetical patients, 3 of whom were pregnant. Not surprisingly, there were significant inter-observer differences in ASA class assigned to each patient. Specifically only 39% stated that an otherwise healthy woman presenting for labor should be classified "ASA I." If that same woman presented for an urgent cesarean section 4% classified her as an ASA III and 2% stated she should be an ASA IV!! An impromptu vote by the SOAP members in attendance produced similar results, with a majority voting that a healthy parturient should be an ASA II. I was among the minority who voted that pregnancy should not increase the ASA class. I will defend my position below.

Drs. Saklad, Rovenstine and Taylor introduced the ASA classification in 1941 (2). They proposed a system with 6 classifications based on the degree of "systemic disturbance," graded none, definite, severe and extreme, with classes 5 and 6 used for emergency cases. The intent of this scheme was to improve communication between practitioners; it was never designed to be a risk index (1,7,11). The authors recognized that operative risk is altered by the surgical procedure and that the preoperative condition could not therefore be used as an independent predictor. The original system was modified to the current 5-class system and re-introduced to the ASA House of Delegates by Dripps in 1961 (3). Of note, the current classification uses the term systemic "disease" instead of "disturbance."

Anesthesiologists frequently disagree about how to classify patients (4,5,6). Of the 10 hypothetical patients in the study by Haynes and Lawlor, the anesthesiologists reached 80% agreement of opinion for only 3. By contrast, 9 were assigned 3 or more classes (2 patients were assigned 4 different ASA classes and 1 was assigned all 5!!) (5). Presumably, many of these inter-observer inconsistencies arise because of differences of opinion regarding the significance of a given disease process. For example, does chronic stable angina represent "mild systemic disease," "severe disease that is not incapacitating," or "systemic disease that is a constant threat to life?" I believe, however, that the variation seen in the classification of the parturient is due to a misunderstanding of the classification system itself.

The anatomic and physiologic changes of pregnancy affect nearly every organ system and do not need to be delineated to the readers of this column. They clearly define the parturients' pre-operative condition
and influence their anesthetic management. However, these changes should not alter the ASA classification because they do not represent a disease process. This distinction is more than simple semantics; it relates to the goal of the ASA classification: to communicate the pre-operative status of the patient (1,7). Many patients may present for surgery with significant physiologic alterations that are considered normal for their stage of life. For instance, I believe that all anesthesiologists would agree that an otherwise healthy 1-year-old who presents for myringotomy and tube placement is an ASA I. Just like the parturient, the physiology of this child is dramatically different from that of a healthy 22-year-old woman. In fact, the anatomic and physiologic changes of this 1-year-old are very similar to those of the parturient: increased cardiac output, blood volume, minute ventilation and metabolic rate, relative anemia, alterations in the response to inhalation anesthesia, high larynx leading potentially to difficult intubation. These changes certainly define the pre-operative condition and influence the anesthetic management of both the infant and the parturient. The communication of this important information, the primary goal of the ASA classification, can be made by the patient's age or pregnancy status alone and inflation of the ASA class is not necessary. It is assumed that the anesthesiologist will understand the special care needed to anesthetize either population.

An increased peri-operative risk is another reason that might be argued to assign the parturient to ASA II. The logic behind this argument is flawed on several fronts. First, as stated above, the ASA classification was never intended as a risk index. I will acknowledge that the ASA classification has been widely (and inappropriately) used as a risk index. Further, global perioperative mortality rates do trend with ASA class (8,9). Recent data from the Maryland QI project demonstrate a curvilinear relationship between ASA class and mortality rate, ranging from ~0.01% for ASA I to 15-20% for ASA V (10). However, it is specious logic to reverse these data and assign an ASA class based on mortality rates. The fact that ASA II patients have a 0.02% mortality rate does not mean that all patients with a 0.02% mortality rate are ASA II. Finally, were we to use this flawed logic, a close look at mortality rates actually indicates that the parturient presenting for labor should be an ASA I. The most recent data available for the United States demonstrate a Maternal Mortality Rate of ~7.5/100,000 live births (12). This is actually below that peri-operative mortality of ASA I patients!!

Similarly, an increase in anesthesia related mortality should not influence the parturients ASA class. While anesthesia has historically been a frequent cause of maternal death, and the parturient is at increased anesthesia risk, this should not influence the ASA class because it overemphasizes one aspect of the risk: the potential for a difficult intubation. The vast majority of anesthesia related maternal deaths are caused by failed intubation or loss of the airway (13,14). This risk is very real and demands the respect of every anesthesiologist who cares for the pregnant patient. However, the anesthesiologist should understand that this is based only on the fact that the patient is pregnant. It would be like changing the ASA class for all patients based on their Mallampati classification. In my practice, the potential for airway difficulty is communicated by the physical exam, not by the ASA classification. When airway difficulties are excluded, anesthesia related maternal mortality is one in several hundred thousand (14), consistent with modern anesthesia care of the "ASA I" patient.

In conclusion, I believe that healthy parturients should be classified as ASA I. This is consistent with the original intent of the ASA classification system: communication. Our training, not the ASA
classification, provides the knowledge needed to anesthetize this population. Inflating the ASA classification is redundant and confusing.

References:

10. www.qiproject.org/PublicData/acute/Indicator05 .
Healthy Parturients Should be Classified as ASA I

CON

Manny Vallejo, MD
Associate Director, Obstetric Anesthesia
Magee-Womens Hospital
University of Pittsburgh

The physical status classification system was first developed by Saklad in 1941 and updated by the American Society of Anesthesiologists (ASA) in 1963.1,2 This classification system provides a simple and concise summary of the patient's health status and has proven to be a practical and dependable predictor of perioperative and postoperative morbidity and mortality.3

ASA Class I is defined as a healthy patient with no systemic disease, and Class II, as mild systemic disease, with no functional limitations. Healthy parturients should not be classified as ASA I, because the physiological changes of pregnancy affect every system in the body and increase anesthetic risk. If these changes occurred in a non-pregnant woman, several specialists would be consulted resulting in a diagnostic medical work-up costing thousands of dollars.

Some of the maternal physiologic changes that increase anesthetic risk include:

1) Anatomic airway changes, such as edema of the of mucous membranes of the upper airway predispose
to bleeding during laryngeal instrumentation. Pilkington et al.\(^4\) has shown that Mallampati scores increase during pregnancy, and the risk of failed intubation in obstetrics is 8 times higher than in the general surgical operating suite.\(^5\) 2) Respiratory changes include increased oxygen consumption, increased minute ventilation, and decreased functional residual capacity (FRC). These changes lead to faster oxygen desaturation compared to the non-pregnant female. 3) The parturient is also at increased risk for aspiration of gastric contents due to relaxation of the lower esophageal sphincter, decreased GI motility, increased intra-abdominal pressure and increased gastric acid production. For these reasons, parturients beyond the 1st trimester are considered "full stomachs" and rapid sequence induction is indicated for general endotracheal anesthesia. Additionally, inherent to all rapid sequence inductions are unexpected airway difficulties, which further increases the risk of aspiration. 4) Neurologically, minimum alveolar concentration (MAC) is decreased due to altered neuronal sensitivity making the pregnant patient more susceptible to inhalation and intravenous agents.

Another factor contributing to morbidity and mortality is the presence of supine hypotension syndrome, which places the parturient at increased risk for hypotension and cardiovascular collapse. It is also well known that severe hypotension can result from neuraxial blockade secondary to sympathetic blockade.\(^6\)

Thus, the anesthesiologist is faced with the overwhelming task of caring for a patient with increased susceptibility to general and regional anesthetics, who is at increased risk for aspiration and whose airway may be more difficult to secure. Furthermore, it is often forgotten that emergent obstetrical interventions frequently occur to save the fetus regardless of the potential risks to the mother.

It is therefore not surprising The Centers for Disease Control and Prevention (CDC) has estimated the current overall maternal mortality rate (MMR) to be 7.5 per 100,000 live births.\(^7\) Anesthesia related complications are the sixth leading cause of pregnancy-related death which amounts to 1.7 per million births in the United States.\(^8\) Studies suggest the actual number of maternal deaths may be greater due to the problem of underreporting.\(^9\)

Most parturients who die of complications of general anesthesia die of airway management problems, including aspiration, failed intubation, inadequate ventilation and respiratory failure.\(^8\) However, regional anesthesia for vaginal delivery or cesarean section is not without problems, and about one fourth of all anesthesia related deaths were associated with the administration of regional anesthesia.\(^8\) Approximately 70% of regional anesthesia deaths occurred among women who had epidural anesthesia and the remaining 30% with spinal anesthesia.\(^8\)

Because of the physiologic changes of pregnancy which increase risk, as well as the increased risk with cesarean and vaginal delivery, healthy parturients should not be classified as ASA I, but should be classified as ASA II. Just because pregnancy is considered natural, one should not overlook nor underestimate the potential and inherent risks associated with pregnancy. Assigning the Class II status acknowledges these risks.

(The author would like to thank Sivam Ramanathan, M.D., and Gordon Mandell, M.D., for their help in
reviewing this manuscript)

References

Dear Dr. Arkoosh:

I recently joined SOAP. I oversee obstetric anesthesia for our group and recently had to address the AWHONN recommendations with our obstetric nursing staff. The Texas Board of Nurse Examiners (Board Action 02/1991) determined that it is within the scope of a registered professional nurse to administer analgesia and anesthetic agents via the epidural route for purposes of pain relief.

At present we have reached a compromise situation with the obstetric nurse educator. Specifically, nurses who meet the following criteria may bolus and adjust epidural catheter rates:

1. Two years L & D experience
2. Attendance at inservice classes conducted by an anesthesiologist.
3. ACLS
4. Demonstrated experience with infusion pumps
The anesthesiologists at our hospital have performed greater than 10,000 labor epidurals during the past 10 years with monitoring of the epidural, bolusing of the epidural, and rate adjustment of the epidural performed by the obstetric nurse.

I know of no complication due to the policies we have employed. Our department is willing to be involved in a prospective study, that will offer evidence that obstetric nurse management of epidurals is a sound policy and provides quality care.

Sincerely,

Thomas D. Easley, M.D.
1901 Medipark, Suite 1059
Amarillo, Texas 79106
Erratum to SOAP 2002 Review in ASA Newsletter

In the September ASA Newsletter in the section regarding the founders of SOAP it should be corrected to state that Robert Hustead was at the University of Kansas in 1968--not at Johns Hopkins. He was at Hopkins from 1958-61 and then at University of Kansas from 1961 to 1973. Dr Henry Lim was at Hopkins in charge of OB anesthesia in 1968 and attended the first SOAP meeting.
INFORMED CONSENT AND LANGUAGE ISSUES

Donald Wallace, M.D.
University of Texas Southwestern Medical Center

A patient who gives informed consent has voluntarily agreed to a plan of medical treatment or clinical investigation after considering the advantages or benefits and the personal costs or risks, and has compared these to available alternatives. To obtain informed consent the physician or study investigator shares key elements in the consent form, answers the patient’s questions, and responds to any comments. The verbal exchange and discussion is a continuing process until it is evident the patient fully understands the treatment plan, or the purpose and requirements of the study, and the consequences thereof. Informed consent has been considered by some to be synonymous with the ideal of shared decision making between physician and patient. The sense of informed consent as "shared decision making" was promoted by the President’s Committee for the Study of Ethical Problems in Medicine. Another sense is of a norm-governed social practice incorporated into law and medicine. Contemporary informed consent allows patients to have autonomy and protect their well-being as they see it. Autonomy is derived from the Greek words "auto" and "nomos", meaning 'self-rule.' Informed consent has the primary goals of protection of the patient (or the subject of a study) and the promotion of autonomy, and is an important part of the physician-patient relationship.

There is increasing use of translator and interpreter services in obtaining informed consent, whether for medical treatment or approved studies. The ready availability of translator and interpreter services are keys to the successful sharing of information essential to decision making by the patient, and to physicians in fulfillment of ethical and potentially legal obligations. Typically there is need for translation of English language consent forms into other languages, and the availability of an interpreter at the bedside. In the era of managed care patients sometimes have to make difficult choices about their health care, further complicated by limited English proficiency. Also managed care - in the forms of modified fee for service, risk sharing, and capitation - has resulted in changes in economic management intended to hold down costs. It has evolved into a series of techniques to limit the discretion of physicians and patients in the availability of alternatives to authorized treatment. Consequently the question has been raised as to what extent these changes of managed care require changes in the doctrine of informed consent. One issue is that physicians, medical organizations, ethicists, and legal experts have begun to suggest that exclusion of economic factors from informed consent is not justifiable. It is thought that the failure to require HMO’s and other insurers (rather than physicians) to disclose financial incentives or pressures is fundamentally unfair to patients.

Physicians are considered to have a tradition of being truthful with their patients, and reported benefits of supplying information to patients include reduction of anxiety, relief of depression about health states, improved compliance, greater patient satisfaction, and success in monitoring symptoms. It is important when obtaining informed consent to avoid several errors (BOX 1). Unfortunately even with the assistance of translator services, and the availability of an interpreter at the bedside, the provision of information by the written consent form together with physician disclosures has been reported in numerous studies to be associated with poor patient understanding and poor retention of information.
BOX 1

Errors to avoid in obtaining informed consent.

* Delaying the approach to the patient to obtain informed consent until the last minute.
* Rushing through the discussion.
* Failing to appreciate possible consequences of the patient's symptoms on informed consent.
* Appearing to be too busy to answer the patient's questions.
* Making frequent use of technical jargon when talking with the patient.
* Failing to simplify the English language of the consent form or language of the translation.
* Using an unnecessarily long consent form.

It is important to be aware of cultural differences between patient and physician, as well as the impact of the patient's educational level. Further, it is recommended that the discussion of risks and benefits should avoid language that increases anxiety. Also, special consideration should be given to the readability of a translated version of the English language consent form. Other possible causes for a lack of understanding of the information in the consent forms are the findings in earlier reports that these forms are typically written at a college level. At the time 20% of Americans were reported to have reading skills at the 5th grade level or below. Unfortunately, more recent reports indicate that this problem persists. For example, in one study 96% of 76 consent forms evaluated had readability levels higher than the target level of the 8th grade; and in another less than 10% of 284 forms examined were written at 10th grade level or below. Taken together with the problem of limited English proficiency and the increased technical complexity of clinical care and medical research, significant challenges exist to the promotion of improved understanding of the consent form, or its translation. Although the informed consent document is often considered the foundation of the consent process, it does not represent the entire process. The following steps are suggested to improve understanding of the consent form (BOX 2).

BOX 2

STEPS DESIGNED TO IMPROVE PATIENT/SUBJECT COMPREHENSION

* Keep information simple and concise.

* Summarize the contents of the consent form verbally.
*Allow the patient/subject time to read the consent form.

*Answer all questions.

*Include the subject’s significant other or advocate in the consent process.

*When feasible, introduce a waiting period between reading and signing the consent form.

*Evaluate subject comprehension through follow-up questions.

*Answer the questions again.

*Respect the limits of the subject’s capabilities.

*If possible supplement the information or description with audiovisual materials.

Societal interest is evident in achieving increased availability of translator and interpreter services, for example the educational activities of the multi-professional American Translators Association (ATA) which organizes continuing education meetings across the nation, and publishes news and reports of its activities monthly in the ATA Chronicle36. The ATA also tests and certifies translators and interpreters. The ATA has many Language Divisions - the Spanish Language Division has more than 2000 members: also the ATA Interpreters Division has evolved into the second largest Division in the ATA with 854 members. At present institutional managers have responsibilities for testing the proficiency of interpreters and translators, and monitoring the availability and efficiency of their services. It is customary for interpreters at the bedside to introduce themselves to the patient or subject, and in medical centers to wear identifying credentials, and white coat or other uniform. In addition there is institutional testing of the proficiency and monitoring of the availability and efficiency of interpreter and translator services. If the language spoken by the patient is not immediately available, another resource is to use the language line of AT&T37.

Certain limits to informed consent38 must be kept in mind- informed consent by itself does not cure illness. Also, special situations justify additional safeguards to avoid potential for compromise if informed consent is to be obtained; for example, from a traumatized pregnant woman who is emotionally vulnerable and highly dependent on medical professionals. Again, special care must be taken to prevent any coercion if informed consent is required from a patient from a socio-economically disadvantaged
population, or should different ethnicity and cultural issues conflict with obtaining informed consent? Other populations at risk of compromise are those with a medical history of psychiatric illness, if there is use of non-medically prescribed drugs, or if patient treatment may impair mental processing. Although informed consent may help in management, in obtaining it the physician must remain aware of a significant risk of compromise in any patient who is unable to adequately process or analyze the information presented.

In this brief communication no attempt has been made to discuss the information on "Informed Consent" available in a recent SOAP Newsletter, or the responsibilities of the Institutional Review Board, except to say that Federal regulations were cited defining the criteria to be met before an IRB may approve waiver or modification of a written informed consent. For the clinician there is also an exception to the requirements of informed consent known as "waiver" - the Supreme Court has determined that patients may waive their right to give informed consent to treatment. "Waiver" must be voluntary and an intentional surrender of a known right. Waiver is considered to promote the same value as the doctrine of informed consent itself - autonomy. In emergency care, at least fifteen States have language in their informed consent statute to allow treatment without first obtaining informed consent - accepting that in an emergency, disclosure and obtaining informed consent could add to risk and be detrimental to the patient. Other exceptions to the legal requirements are therapeutic privilege, and compulsory treatment. The basis for therapeutic privilege (that patients can be harmed by disclosure of information, or that they will refuse beneficial treatment because of risk disclosure) has not been validated. The exception of "compulsory treatment" has parameters stated to require judicial intervention; also the complex and controversial major exception of incompetence cannot be briefly described. Our societal traditions of respect for the integrity of the individual are linked to the primary goals of informed consent - autonomy and the protection of the patient. In conclusion, a process of obtaining informed consent may be optimal if the sense of "shared decision making" promoted by the President's Commission is facilitated as needed by translator and interpreter services for the patient (or subject of an approved study). Further, the belief that the patient has a right to authorize their own medical treatment was supported by most subjects of a large study sponsored by the President's Commission. Awareness of cultural differences and sensitivity to this situation and to educational limitations are keys to use of simple language to make available information essential to the process of obtaining informed consent. Discussion of informed consent issues in medical ethics and law should continue to be active, as should the use and further development of model curricula. Advantageously there is potential to benefit physician-patient communications and interactions since the increasing use of the electronic communication media, including Email. Our societal traditions of respect for the integrity of the individual are linked to the primary goals of informed consent - autonomy and the protection of the patient.
JCHO Policies on Emergency Drug Storage

By the pricking of my thumbs,
Something wicked this way comes,
Open, locks, Whoever knocks!

Shakespeare, MacBeth Act IV, Scene I

The safe provision of obstetric anesthesia through the use of secured, yet readily accessible, emergency medications is wonderfully introduced by Shakespeare. During the playwright's time, to have a "pricking of the thumbs" was to have a sense that something was about to happen. Indeed, in a very close analogy, patient complaints of hand and finger paresthesias often correctly prophesy the sequelae of a high spinal or epidural anesthetic. To counteract these events, anesthesiologists often break into their locked boxes of medications, spells and incantations.

How do we keep these medications? What guidelines exist regarding their storage and availability? To get a sense of the guidelines and practices which exist, the SOAP Committee on Governmental Affairs reviewed information from a number of regulatory organizations and solicited responses from obstetric anesthesiologists in different locations and practice settings. This article will briefly summarize our findings regarding the storage of emergency medications in the practice of obstetric anesthesia.

Guidelines

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issues the most readily accessible and cited guidelines for the storage of emergency medications. In their Comprehensive Accreditation Manual for Hospitals (website below), JCAHO defines professional standards of practice which mandate that all medications need be secured, however, how secure depends on the classification of the medication as a controlled substance or not. Currently, only Schedule II controlled substances (e.g. narcotics; see DEA website below for a complete listing) need to be secured under lock and key based on DEA laws and regulations (standard TX.3.4). Although most states no longer require a "double-lock" system, these products must be stored in a "substantially constructed locked cabinet". In addition, these drugs must be tightly controlled and accounted for, under law and regulation.

For other drugs and products, including anesthetic medications, JCAHO expects "reasonably secure", but not necessarily "locked", storage to prevent diversion or tampering. These include thiopental, a schedule III drug, as well as succinylcholine and vasopressor agents. To be "reasonably secure", these medications should not be kept in areas readily accessible to or easily removed by the public. For example, medications and products left in an unlocked drawer in a patient waiting area, hallway, or room would...
not be considered secure. However, if these agents are kept in an area where patients and visitors are not allowed without supervision or the presence of a healthcare professional (e.g. an operating room) they are considered secure, even if not locked. Of note, all areas restricted to authorized personnel only are considered "secure".

Of interest, the requirement for locking medications is not a JCAHO standard per se, but rather a federal regulation. Federal law requires that all hospitals receiving Medicare funding must adhere to the Medicare Conditions of Participation (COP) developed and published by the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA). Under this agency, the requirement for locking medications can be found within "Conditions of Participation 482.24 (b)(2), which state that "Drugs and biologicals must be kept in a locked storage area at all times". "Locked" has been interpreted as either physically locked or under constant surveillance by responsible healthcare staff (RN, MD, etc.) (personal communication, JCAHO to Dr. Airola, Chair, California Society of Anesthesiologist's Division of Legislative Advocacy and Practice Management).

Various states can have additional requirements which must be met. Michigan considers thiopental a controlled substance and requires it to be "locked". Utah requires a metal lock and key on all "crash" carts, although whether this extends to anesthesia carts remains unclear. California has among the most restrictive regulations specifically regarding anesthesia carts and the storage of anesthesia medications. Citing the California Code of Regulations Title 22, Section 70263(q)(8) and 70269(b) on drug accessibility and storage, Brenda Klutz, the Deputy Director of the California Department of Health Services, issued a statement on the security of anesthesia carts (letter to general acute care hospitals, 4/24/02). In this letter, she stated that "anesthesia carts and machines may remain unlocked during and in between consecutive cases in a given operating room, as long as there are surgical service personnel in the immediate vicinity. Some surveyors consider in the immediate vicinity as 'line of sight' although this is not specified in the regulation, nor is it necessary. Nevertheless, the area needs to be maintained secure at all times. When an individual anesthesiologist finishes cases for the day, the cart should be locked". The relevance of the last sentence may be called in question, as most obstetric operating rooms are open for cases at all time periods. Finally, local, municipal and hospital jurisdictional bodies may have requirements which must be considered as well. In keeping with all of the intent of these regulations, we have surveyed a geographically and practice-style diverse population of obstetric anesthetists regarding their operating room and labor and delivery floor storage of medications.

Operating Room Anesthesia Medications and Carts In keeping with the cited rulings above, the degree of security for emergency medications depends primarily on the accessibility of the operating rooms. Where entry into the operating room suite requires an electronic access card or is under the direct visualization of authorized healthcare personnel, less security is required. This degree of security allows the medications and the carts to be unlocked, with the exception of schedule II drugs (i.e. narcotics). While most practices use Pyxis machines to obtain controlled substances, which are then carried on the anesthetist, one novel idea in use at a large Midwestern academic practice is the storage of such medications in locked handgun safes, which are attached permanently to the anesthesia machine.

Below is a summary of different practices.
Practice Type and Location OR Access Induction, Controlled Substances Vasopressors Carts
Community, Northern Plains Restricted access to OR’s Drugs locked in personal carts Pyxis-narcotics Ephedrine available in cart, but not drawn up Unlocked
Community, West Electronic key card to get to L/D; nursing station in front of OR’s STP in plastic tab lock box, by pharmacy, replaced q24 Pyxis-midaz, narcotics Ephedrine, sux in syringes. Other meds in cart drawers. Unlocked

Academic, New England Electronic key card to get to L/D; authorized personnel signs by two sets of doors to OR’s STP taper evident cap and plastic tab locked box by pharmacy, replaced q24 Pyxis-midaz, narcotics Ephedrine, sux, neosynephrine in syringes on top of cart. Other meds in tab locked tackle box. Unlocked

Academic, Northern Great Lakes Authorized personnel signs by doors to OR’s STP-tamper-evident caps Pyxis-midaz, narcotics Ephedrine, sux drawn up, on top of cart. Other meds in cart drawers. Unlocked

Academic, Midwest Restricted access to OR's STP-in powdered form in cart. May be mixed prior to case. Pharmacy-midaz, narcotics, ephed Ephedrine, sux may be drawn up. Other meds, including ketamine, in trays in cart. Keypad locked carts

Academic, Middle Atlantic Electronic key card to OR's STP-Pyxis-midaz, narcotics, Ephedrine in syringes with tamper-evident caps Unlocked

Community, Southeast Restricted access to OR's STP-tamper-evident caps, Pyxis-midaz, narcotics Ephedrine, sux in syringes in anesthesia cart. Other meds in a plastic bag in cart. Unlocked

Labor and Delivery Suite Anesthesia Medications and Carts

Practice Type and Location Cart Location Induction, Controlled Substances Vasopressors Carts
Community, Northern Plains Personal portable carts Pyxis-narcotics Ephedrine in cart, drawn up as needed. Keyed locks

Community, West 3 portable carts for 16 rooms Pyxis-narcotics Ephedrine in syringes. Other meds in cart drawers. Keyed locks

Academic, New England Portable cart in each of 24 rooms Pyxis-narcotics, including pharmacy premixed infusion bags, CSE doses Ephedrine, drawn up for each patient; all
emergency meds in plastic tab locked tackle box. Keyed locks

Academic, Northern Great Lakes 4 portable carts Keyed, double locked narcotic cabinet Ephedrine. Other meds in cart drawers. Unlocked, but kept in combination locked work rooms.

Academic, Midwest 3 portable carts for 17 rooms Pharmacy-narcotics Ephedrine carried by anesthetist.

Other meds in trays in cart. Keyed locks

Academic, Middle Atlantic Portable carts Pyxis-narcotics, Pharmacy prepared infusion bags Ephedrine in syringes with tamper-evident caps Electronic combination locks

Community, Southeast 15 rolled carts for 50 rooms. Pyxis-narcotics Ephedrine. Other meds in a plastic bag in cart. Keypad combination locks. Drawers have motion sensors which automatically locks in 15 min if not moved.

Summary

In the provision of anesthetic care to the obstetric population, emergency medications must be readily available. Balanced against this practice is the need to prevent possible diversion of these agents. While the rulings above are necessarily stringent on schedule II medications, the agencies with jurisdictional ability have allowed a dichotomous system of unlocked carts in the operating room versus locked carts in labor and delivery rooms to exist. The practices cited above have various locking solutions, however, the most easy and effective mechanism remains unclear. Keys and electronic swipe cards can be misplaced or become nonfunctional. Are keypad or combination locks more reliable? We’re interested in how your practice accomplishes these goals; please email me: ltsen@zeus.bwh.harvard.edu.

With your assistance, perhaps we'll be able to suggest a novel or functional solution that will allow us all to keep Shakespearean curses to a minimum when emergent situations arise!

What you can do

The purpose of this article is to raise awareness of the guidelines and issues surrounding the storage of emergency medications in your labor and delivery unit. How do your practices compare? What are the regulations that surround your particular setting? Educate yourself:

1). Ask your own hospital administrators (pharmacy, nursing, and anesthesia) and state anesthesia associations if there are any hospital, community or state guidelines regarding the preparation and storage of emergency (and other) medications.
2). Review national guidelines. The JCAHO website is a wonderful resource (http://www.jcaho.org/accredited+organizations/hospitals/standards/hospital+faqs/faq+index.htm). In addition, Federal Regulations can be found under various governmental agencies, including the DEA (http://www.deadiversion.usdoj.gov/schedules/schedules.htm) and the CMS (http://cms.hhs.gov).

3). Finally, are these types of articles helpful? How can the SOAP Committee on Governmental Affairs help you? What rulings or regulations are of interest to you and your practice? Let us know.

Lawrence Tsen, MD
Committee on Governmental Affairs
Response to AWHONN Guidelines

April 1, 2002

Martha G. Lavender, RNC, MSN, DSN
President
Association of Women's Health, Obstetric and Neonatal Nurses
2000 L Street, N.W.
Suite 740
Washington, D.C. 20036

Dear Dr. Lavender:

The American Society of Anesthesiologists (ASA) together with the Society for Obstetric Anesthesia and Perinatology (SOAP), have reviewed the recent AWHONN position statement titled: Role of the Registered Nurse (RN) in the Care of the Pregnant Woman Receiving Analgesia/Anesthesia by Catheter Techniques (Epidural, Intrathecal, Spinal, PCEA Catheters). This position statement will have a negative impact on the care of laboring women in the United States. Additionally, our societies have serious concerns about the accuracy of certain statements contained within this document. Together, we wish to formally register these concerns and request that this position statement be withdrawn.

That being said, we are very aware of the increased workload burden being placed on Labor & Delivery room nurses across the country. Absences, difficult recruitment and the increased use of agency nurses (travelers) contribute to burnout and low moral. We point out that nursing shortages are occurring at the same time as severe reductions in anesthesia care providers, both physician anesthesiologists and Certified Registered Nurse Anesthetists. In order to care for our pregnant patients it is essential that we work together to support each other. We present the following concerns in the spirit of initiating a dialogue to better understand how we can be mutually supportive.

Neuraxial analgesia includes epidural, spinal and combined spinal-epidural techniques. It is the most commonly used modality for the treatment of labor pain. Current estimates hold that half of all laboring women in the US receive a neuraxial analgesic on demand. The majority are placed on continuous infusions to maintain their level of pain relief throughout their labor.

While only anesthesiologists, other physicians with appropriate training, nurse anesthetists, and anesthesiologist's assistants are given hospital privileges to initiate neuraxial analgesia for labor and delivery, once a catheter is placed for continuous pain management labor nurses can and should assist in the management of the patient's pain relief. The following points support this position.

*Infusion adjustment of a properly placed epidural catheter can be performed safely within defined parameters.*
Ample precedence exists for labor nurses to adjust or manage potentially dangerous intravenous agents such as oxytocin and magnesium sulfate once adequate training occurs. There is no evidence to suggest that this practice is unsafe.

Continuous epidural analgesia is routinely used to manage pain after thoracic, abdominal and orthopedic surgery. Post anesthesia care unit (PACU) nurses, ICU nurses and post-surgical nurses nationwide regularly assist in the pain management of their patients by adjusting epidural infusions within defined parameters. This practice has not compromised patient safety. There is no evidence suggesting that with proper training, labor nurses are not capable of the same level of patient care as their colleagues. To the contrary, many institutions already train labor nurses to adjust continuous epidural infusions under a physician's written order. There is no published data to suggest that this places laboring patients at risk. On the contrary, in the UK, where midwives routinely administer epidural top-off doses there have been no reports of epidural-related morbidity or mortality related to this practice\(^1\), despite a very thorough system for evaluating these complications (Reports on Confidential Enquiries into Maternal Deaths in the UK, UK Health Department).

*The current practice of using dilute solutions for labor epidural infusions makes overdosing nearly impossible.*

It is the responsibility of the anesthesia provider to perform the initial administration of medication and monitor for any signs of catheter misplacement or adverse drug responses as well as to achieve the goal of adequate labor analgesia. This may not be delegated to a labor nurse. Once an infusion is started, it is possible for the catheter to migrate from the epidural space into the subarachnoid space or a blood vessel. Should this occur, the risks to the patient are minimal because of the dilution of medications used.

If the catheter should enter the subarachnoid space it would take a lengthy period of time for enough of a drug dose to cause a motor block indicative of such a migration. The unusual intensity of motor block would alert the trained labor nurse to contact the anesthesia department to evaluate the patient. Likewise, an intravenous catheter will not result in high enough systemic concentrations of medication to cause a toxic reaction. On the contrary, the patient would complain of inadequate pain relief long before systemic complications could occur. Again, complaints of pain would trigger a call to those providing anesthesia coverage. Defined parameters would prevent a labor nurse from increasing an infusion to high levels. Instead, proper parameters would require a call to the anesthesia provider to assess the patient and take the proper actions.

To underutilize all reasonable resources in the delivery of care will mean that ultimately it will be laboring women who lose the most.

It is common practice in medicine to utilize non-physicians to assist in the delivery of care once training is provided and parameters defined. The fact that this practice is growing speaks to its safety and benefits to the patient. The specialty of Anesthesiology is no exception to the utilization of non-physician
providers to assist in the safe delivery of anesthesia and analgesia.

Anesthetic services in general are in greater demand than ever before in the history of the specialty. It is also true that requests for labor analgesia and on-demand anesthesia services are rising. Statistics support the statement that anesthesia manpower, be it a physician Anesthesiologist, Certified Registered Nurse Anesthetist or Anesthesiologist's Assistant, is insufficient to provide all laboring women the analgesia they request. Therefore it is reasonable and necessary to provide training and define parameters within which labor nurses may become a useful resource in the maintenance of analgesic management. Without this, many women will suffer pain needlessly.

It is the position of our Societies that labor nurses should be active participants in all aspects of their patients' obstetric management, including pain relief. Education programs must be developed, as have been reported for post-operative nurses\(^2\) and competence should be assessed regularly. We support the published position statement produced by the Nursing Organization Liaison Forum and endorsed by over 20 nursing organizations which states that "RNs with advanced education in obstetric analgesia may administer subsequent bolus doses or adjust the drug infusion rates in compliance with the anesthesia provider's or physician's patient-specific written orders."\(^3\) We urge the continued training and appropriate supervision of dedicated labor nurses. Without their assistance, the realities of inadequate resource utilization will only serve to deny those who request our help.

Sincerely yours,

Barry M. Glazer, MD
President
American Society of Anesthesiologists

Valerie A. Arkoosh, MD
President
Society for Obstetric Anesthesia and Perinatology

(Footnotes)


\(^2\) Richardson J., J of Clinical Nursing 2001;10: 238-45

\(^3\) AORN 1992;55: 209-210
May 14th, 2002

Barry M. Glazer, MD
President
American Society of Anesthesiologists
1433 Brewster Road
Indianapolis, Indiana 46260

Dear Dr. Glazer:

We received the joint letter from you and Dr. Arkoosh highlighting your societies' concerns regarding AWHONN's position statement titled: Role of the Registered Nurse (RN) in the Care of the Pregnant Woman Receiving Analgesia/Anesthesia by Catheter Techniques (Epidural, Intrathecal, Spinal, PCEA Catheters). Thank you for taking the time to continue the important dialogue and exchange of information so necessary to health care professionals whose work is as intricately related as the anesthesia care provider and the registered nurse.

AWHONN's position statement was approved less than a year ago by the full AWHONN Board of Directors. The statement reflects AWHONN's position on optimal conditions for promoting the health of women and newborns and was developed in conjunction with AWHONN's Evidence-based Clinical Practice Guideline: Nursing Care of the Woman Receiving Analgesia/Anesthesia in Labor (2001). Although the position statement is not scheduled for review in the near future, we value and appreciate the considered opinions of ASA and the Society for Obstetric Anesthesia and Perinatology, and we plan to share your letter with AWHONN's Board of Directors.

Again, thank you for bringing your concerns to our attention. We will keep you appraised of any further developments regarding this position statement.

Sincerely yours,

Gail G. Kincaide
Executive Director
AWHONN

cc: Valerie Arkoosh