SPRING 2026

SOAP NEWSLETTER

Official Newsletter of the Society for Obstetric Anesthesia and Perinatology

PRESIDENT'S MESSAGE

A Society in Motion

Dr. Ron George
President, Society for Obstetric Anesthesia and Perinatology

Since the start of the year, SOAP has continued to advance with a clear and deliberate sense of direction grounded in alignment, impact, and a deep commitment to improving care for pregnant patients and their families. What is increasingly evident is not simply the volume of activity across the society, but the coherence between our strategy, our programming, and our community.

Our focused strategic plan is now translating into action. Across committees and initiatives, there has been a deliberate shift toward ensuring that what we produce is not only academically rigorous, but clinically meaningful and accessible. Purposeful content, delivered in ways that reflect how clinicians actually learn and practice continues to define our trajectory.

Bridging Knowledge and Care

A defining theme of this year has been the continued emphasis on translating evidence into practice. Advancing obstetric anesthesia

(cont'd. - President's Message)

WHAT'S NEW AT SOAP:

requires more than generating knowledge; it requires coordination, communication, and thoughtful implementation within complex clinical environments.

This perspective is shaping how we think about education, research, and quality improvement. Excellence in our field is not static, it is continuously refined by how effectively we integrate evolving evidence into everyday clinical care. Bridging that gap between knowledge and practice remains central to SOAP's mission.

This perspective is reflected in recent collaborative work with the Obstetric Anesthetists Association (OAA) and the World Federation of Societies of Anaesthesiologists (WFSA) highlighting the convergence of global priorities across obstetric anesthesia societies, including a focus on safety, equity, and access to labor analgesia as a fundamental component of care.

The Power of Community

At the core of this progress is our community. Committee engagement has strengthened, with clearer alignment around deliverables and a shared commitment to execution.

There is a noticeable shift from discussion to action, with initiatives increasingly focused on producing tangible outputs that directly support clinicians and patients.

Programs such as the PEAK series, ongoing webinars, and continued development of the Research Network reflect a society that is both academically vibrant and operationally focused. At the same time, our State Representative program and Special Interest Groups continue to expand our reach, ensuring that SOAP remains connected to diverse practice environments and responsive to the needs of its members.

Meeting Members Where They Are

Our approach to engagement continues to evolve. Platforms such as the SOAP Community and Learning Center are becoming central to how members interact, learn, and collaborate. These are no longer simply repositories of content, but dynamic environments that support continuous learning and professional connection.

This shift reflects a broader recognition that education must align with the realities of modern clinical practice.

(cont'd. - President's Message)

EDITOR'S NOTE

Kristen L. Fardelmann, MD
Editor, Society for Obstetric Anesthesia and Perinatology Newsletter

Spring is here!

With renewed energy, we welcome this season of growth and possibility. Dr. Ron George opens the Spring 2026 publication of the SOAP Newsletter with momentum and inspiration – moving our society forward with action and supporting all to bloom where they are rooted.

Highlighting the network of global obstetric care provided in United States Military Hospitals, Drs. Janik and Hood discuss the subspecialty training opportunities in obstetric anesthesia and maternal fetal medicine and the application of obstetric anesthesia knowledge in clinical practice for the Defense Health Agency.

Dr. Anne-Sophie Janvier shares a short story from her personal experience caring for a Black patient with inadequate neuraxial anesthesia as an obstetric anesthesiologist in New York. This account is accompanied by the SOAP Newsletter Pro-Con debate, authored by Drs. Hofkamp and Sharpe, that compares management strategies for patients undergoing intrapartum cesarean delivery in the setting of labor epidural analgesia.

It was a pleasure connecting with everyone in Montreal!

Sincerely,

Kristen L. Fardelmann

Flexibility, accessibility, and relevance are essential. Our goal is to ensure that SOAP is present not only at major events, but in the everyday professional lives of our members.

Investing in the Future

SOAP's financial position remains strong, providing a stable foundation for both current initiatives and future growth. This strength allows us to think more deliberately about how we invest in programming, research, and member value.

Importantly, this is not just about sustaining what we currently do, it is about enabling what comes next. We are positioning SOAP to deliver sustained and measurable impact through thoughtful investment in education, innovation, and collaboration.

Recognizing Impact, Building What Lasts

An important evolution for our society has been a renewed focus on recognizing meaningful contributions and creating opportunities for members to shape the future of SOAP in lasting ways.

We are formalizing how we acknowledge individuals whose work has had enduring influence, while also developing pathways that allow members to contribute to the long-term strength and sustainability of the society.

These efforts reflect a broader shift from participation alone to stewardship.

The future of SOAP will be defined not only by what we achieve today, but by what we choose to build and support for the next generation.

The Road Ahead

As we reflect on the Annual Meeting in Montreal, there is a strong sense of momentum. The program was designed to reflect the full spectrum of our specialty from foundational clinical practice to emerging science and systems-level innovation.

More importantly, it provided an opportunity for our community to come together to share perspectives, challenge assumptions, and collectively define what excellence in obstetric anesthesia should look like moving forward.

Our Collective Responsibility

SOAP's strength has always been its people. The progress of the past several months reflects what is possible when that collective expertise is aligned around a shared purpose.

As we move forward, our focus remains clear, to translate knowledge into practice, to elevate patient-centered care, and to ensure that the impact of our work extends well beyond our immediate community.

Increasingly, this work does not occur in isolation. It is part of a broader, coordinated effort across organizations and health systems to advance safety, equity, and access to high-quality obstetric anesthesia care worldwide.

This shared vision, *improving maternal and peripartum anesthesia care together,* reflects both the responsibility and the opportunity in front of us. It challenges us to move beyond individual excellence toward collective progress, where alignment across education, research, quality, and advocacy translates into meaningful improvements in care at the bedside.

What comes next will not be defined by direction alone, but by how effectively we act on it, together.

Ron George, MD, FRCPC
President, Society for Obstetric Anesthesia and Perinatology

MEMBER CONTENT

AN OVERLOOKED AND VITAL AREA FOR DELIVERY OF OBSTETRIC ANESTHESIA: MILITARY HOSPITALS

Zachary Janik, MD and Courtney Hood, MD

Disclaimer: The views expressed in this article are those of the authors and do not necessarily reflect the official policy of the Department of Defense or U.S. Government

Zachary Janik, MD

Courtney Hood, MD

Distinct from hospitals run by the Department of Veterans Affairs for eligible veterans, the Defense Health Agency (DHA) oversees the Military Health System (MHS): an entirely separate health system servicing approximately 9.4 million beneficiaries composed of active-duty service members, National Guard and Reserve members, retired service members, dependent family members, eligible members of the U.S. government, and select foreign force members. The MHS manages over 50 hospitals across 601 military treatment facilities (MTFs), the Uniformed Services University of the Health Sciences, and Graduate Medical Education in nearly all available specialties, including Anesthesiology, Pediatrics, and Gynecologic Surgery & Obstetrics.

Of the hospitals within the system, 41 provide inpatient labor and delivery services and five additional MTFs provide outpatient obstetric care. An average of 30,000 deliveries per year occur at MTFs worldwide. Some MTFs provide critical access to patients stationed at remote bases where care would otherwise be difficult to obtain or local standards differ from care delivered in American hospitals. Examples include U.S. Naval Hospital Okinawa in Japan; Landstuhl Regional Medical Center in Germany; and U.S. Naval Hospital in Guam. Hundreds of thousands of U.S. military and civilian personnel are stationed outside the continental United States. Patients who do not deliver at a MTF may be sent to local hospitals, where labor analgesia options may vary, with many not offering epidural analgesia.

Obstetric capabilities vary by MTF. At present, there are three fellowship-trained Obstetric Anesthesiologists (OBAs) and 16 Maternal Fetal Medicine specialists within the MHS. These active-duty providers serve at the few Level III subspecialty maternal and newborn care centers, receive referrals from around the world, and provide expert consultations via telehealth to remote locations. Care provided to complex obstetric patients that would otherwise be transferred out of the health system saves substantial healthcare costs to the taxpayer. These subspecialty physicians also serve in DHA leadership roles, helping shape DHA policy related to women's and neonatal health.

Military OBAs help meet the GME mission at three Anesthesiology Residency Programs located in San Diego, CA, San Antonio, TX, and Bethesda, MD. These programs produce 37 active-duty anesthesiologists per year, joining a small cohort of additional military- and civilian-trained anesthesiologists who serve on active-duty following residency graduation.

(cont'd. An Overlooked and Vital Area for Delivery)

AN OVERLOOKED AND VITAL AREA FOR DELIVERY - CONTINUED

Military OBAs play a key role in educating military residents who will provide care at often, small and remote MTFs, sometimes as an independent practitioner or with a small number of anesthesiologists. Opportunities for OBA fellowship vary yearly by military need but, are generally open to one applicant per year per branch of service (Air Force, Army, Navy only). Subspecialty training requires approval from the branch of service and incurs an additional service obligation.

Unique to military medicine, Certified Registered Nurse Anesthetists (CRNAs) contribute a significant amount of obstetric care at MTFs as independent providers with physicians available for consultation. MTFs employ both active-duty and civilian contractor CRNAs who train Student Registered Nurse Anesthetists through the U.S. Army Graduate Program in Anesthesia Nursing, a 36-month DNP program.

There are currently no SOAP Centers of Excellence within the MHS, but the current Military OBAs use these guidelines to influence local practice and guide DHA standards for excellence. Obstetric Anesthesiology is and should remain a key strategic pillar as the MHS strives to create both a *medically ready force* and a *ready medical force*. Thank you, SOAP, for highlighting this important work! ✦

MEMBER CONTENT

IN THE SPACE BETWEEN HEARTBEATS

Anne-Sophie Janvier, MD

On labor and delivery, we often measure time in heartbeats.

Sometimes those heartbeats belong to the fetus on the monitor, tracing fragile peaks and valleys across the screen. Sometimes they belong to the patient in front of us, breathing through contractions. And sometimes, unexpectedly, they belong to us.

—

It was one of those busy days on the labor floor when every patient carried a story larger than the chart in front of me. I had just taken over the anesthesia board from a colleague when I met her: a young Black woman being induced for preeclampsia and gestational diabetes. Her pregnancy had already been medically complicated, and her body bore the strain of it—blood pressures climbing, swelling in her limbs, fatigue written across her face.

My colleague gave me a quick sign-out. The epidural had been technically difficult to place - challenging anatomy, multiple attempts. It was finally threaded, but the block was imperfect — more numb on one side than the other. Not ideal, but sometimes that is the reality in obstetric anesthesia. We do the best we can with the time and circumstances we are given.

I introduced myself and adjusted the epidural as best I could, hoping to improve the coverage as her induction continued. She answered my questions quietly between contractions, clearly exhausted and gracious.

In the corner of the room stood her father.

He was impossible to miss—at least 6'2", easily 300 pounds, with shoulders broad enough to fill the doorway. At first glance he looked intimidating, standing silently with his arms folded across his chest.

Every time his daughter grimaced through a contraction, his expression shifted. The tension in his eyes gave him away.

Then the fetal heart rate dropped.

(cont'd. In the Space Between Heartbeats)

The atmosphere in the room changed instantly, the way it always does. Voices sharpened. The obstetrician studied the monitor only briefly before looking up.

“We need to go to the OR.”

Within moments we were moving—disconnecting monitors, pushing the bed down the hallway under fluorescent lights that suddenly seemed too bright.

In the OR, the familiar choreography of urgency began. The plan was to extend the epidural for cesarean delivery. If the neuraxial anesthesia proved adequate, her father would be able to come into the room and sit beside her.

And when we tested the block, it became clear the epidural was not sufficient.

She could still feel far more than she should.

And the fetal heart tracing gave us very little time.

I looked at her and said the words no obstetric anesthesiologist wants to say in that moment.

“Your anesthesia isn’t working well enough. We need to put you to sleep so we can deliver the baby quickly.”

Her eyes filled with tears almost immediately.

“I want to see my dad,” she said. There was no hesitation.

“Bring him in quick,” I told the nurse.

He entered the OR cautiously, his large frame suddenly seeming unsure in the sterile space. The monitors beeped steadily around us as his daughter reached for him with both hands.

The transformation was immediate. The imposing figure in the doorway softened into something else entirely —a father who was afraid.

He leaned over the bed and held her hand tightly.

“Are you sure about this?” he asked quietly.

His voice trembled.

She nodded through tears.

“Yes.”

I stood beside them, witnessing a moment that felt both deeply personal and profoundly fragile. In obstetric anesthesia, we stand at the intersection of life and risk every day. But rarely do we witness this kind of interaction.

Then he looked at me.

In his eyes was a question far larger than medicine. It was a question shaped by history, by stories shared within families, by statistics that many of us know too well. The quiet fear that hospitals have not always been safe places for Black mothers and their children.

Without thinking, I placed my small hand on his broad arm.

“I understand what you are feeling,” I told him.

I paused, choosing my words carefully.

“I am a Black woman too. And I will do everything I can to help your daughter.”

For a moment, the room felt still.

His shoulders softened slightly. The fear did not disappear, but something else replaced it—trust, fragile and real.

(cont’d. In the Space Between Heartbeats)

He squeezed his daughter's hand one last time before stepping out of the OR.

The doors closed.

The urgency returned immediately.

With the help of the nurse beside me, we moved quickly through the familiar sequence: oxygen, medications, induction. Within seconds she was asleep, her airway secured, and the obstetric team began.

Minutes later, a cry filled the room.

A small but powerful sound that cut through the tension like light through a window.

The baby was out.

Both mother and child did well.

Long after the monitors stabilized and the OR quieted, that brief moment between father and daughter stayed with me. The weight of his arm beneath my hand. The vulnerability in his voice. The responsibility behind the words I had spoken.

In obstetric anesthesia, we are trained to manage physiology—blood pressure, airways, medications, pain. Yet some of the most meaningful parts of our work happen in the spaces between those tasks.

A hand placed on an arm.

A promise made in a moment of fear.

And the quiet privilege of being present when a family entrusts us with what matters most, in the space between heartbeats.

✦

SOAP NEWSLETTER PRO-CON DEBATE

INTRAOPERATIVE MANAGEMENT OF INDWELLING LABOR EPIDURAL CATHETERS FOR INTRAPARTUM CESAREAN DELIVERY: WHAT ARE MY OPTIONS?

Michael P. Hofkamp, MD and
Emily E. Sharpe, MD

From left to right: Michael P. Hofkamp, MD and Emily E. Sharpe, MD

Patients' personal stories of experiencing pain during cesarean delivery (PDCD) are unsettling and these accounts have helped raise awareness of this issue among anesthesiologists.[1-4] The incidence of intraoperative pain varies dramatically based on method utilized to define inadequate anesthesia. Although PDCD can happen with any anesthetic modality, labor epidural analgesia (LEA) top up for cesarean delivery (CD) has a higher incidence of pain.[5] **What is the optimal management strategy for a patient with an indwelling labor epidural who is now about to undergo an intrapartum CD?**

A common management practice for indwelling LEA catheters is to administer concentrated local anesthetic to achieve surgical anesthesia.

(cont'd. Intraoperative management of indwelling labor epidural catheters for intrapartum cesarean delivery: what are my options?)

Lidocaine 2% with epinephrine is frequently used along with chloroprocaine 3%. Sodium bicarbonate may be added for alkalinization to enhance onset of action. The addition of fentanyl to the epidural solution can also improve anesthesia quality. Advantages of this technique include the ability to carefully titrate neuraxial anesthesia, the option to give additional epidural boluses during the CD, and the limitation of additional neuraxial procedures and their associated risks.

However, topping up an indwelling LEA catheter has potential drawbacks. A systematic review encompassing 13 trials and approximately 8600 patients reported that increasing occurrences of physician-administered rescue LEA boluses, urgency of CD, and care provided by a non-obstetric anesthesiologist were associated with failed LEA catheter top up for CD.[6] With hopes to minimize this risk, it is imperative to actively manage LEA and replace non-functioning epidurals during labor. Another recent systematic review reported patients who had epidural top up for CD experienced the highest pooled incidence of pain and patients who had spinal anesthesia experienced the lowest pooled incidence of pain.[7] This begs the question: **are there other options for CD anesthesia for patients with indwelling LEA catheters?**

A randomized controlled trial of patients who underwent intrapartum CD after receiving LEA found that patients who had removal of their LEA catheters followed by spinal anesthesia had a 2.5% incidence of failure of pain free CD compared to 15.3% of patients who had epidural catheter top up with 17 mL 2% lidocaine with 1:200,000 epinephrine, 100 mcg fentanyl, and 2 mEq bicarbonate ($p<0.001$).[8] In the same study, patients who had conversion to general anesthesia, a sensory block below T5 prior to surgical incision, a "poor quality" block, a "patchy" block, or who had a visual analogue scale pain score of 30 mm or more which triggered intravenous administration of fentanyl 100 µg were deemed to not have met the criteria for "pain free" anesthesia.

A propensity-matched retrospective observational study of patients who had intrapartum CD with indwelling LEA catheters reported the adjusted odds ratio for "regional only" anesthesia was 4.3 for patients who have removal of their epidural catheters when compared to patients who had epidural top-up.[9]

So, how does one go about deciding whether to use or remove an indwelling labor epidural catheter for CD? First, the quality of LEA should be assessed. A functional LEA catheter that has provided satisfactory analgesia is more likely to be successful than a catheter that has required one or more physician administered rescue analgesia boluses. Second, a multidisciplinary discussion with obstetrical colleagues can help determine if there is enough time to remove an indwelling LEA catheter and attempt a new neuraxial technique. And the most important consideration is the preference of the patient; the patient must be agreeable to an attempt at a new neuraxial procedure.

Now that you have decided to remove the indwelling LEA catheter, what new neuraxial anesthetic technique do you attempt? Each technique has its advantages and disadvantages. For example, a single-injection spinal anesthetic avoids the potential morbidity of an unintentional dural puncture with an epidural needle but does not allow the flexibility of additional administration of local anesthetic through an epidural catheter that a traditional epidural or combined spinal-epidural technique would provide. Other

(cont'd. Intraoperative management of indwelling labor epidural catheters for intrapartum cesarean delivery: what are my options?)

techniques include a combined spinal epidural and simply replacing the indwelling labor epidural catheter with a new epidural catheter at the same or different level.

Another consideration is the dose of local anesthetic that should be used in single-injection spinal or combined spinal-epidural anesthesia. Epidural volume extension has been described as a technique where saline injected into the epidural space can augment the level of a spinal anesthetic.[10] It is difficult to determine the effect of a previously administered epidural infusion on augmenting a new spinal anesthetic and the possibility of a high spinal block must be considered. For most patients, author MH prefers to use 9 mg hyperbaric bupivacaine, 15 µcg fentanyl, and 150 µg preservative free morphine with a reduction of 1.5 mg hyperbaric bupivacaine for shorter patients and an increase of 1.5 mg bupivacaine for taller patients.[11] If the epidural catheter has already been bolused, then deemed inadequate, a lower intrathecal dose of bupivacaine is recommended. Determining the correct dose of local anesthetic in the setting of a single-injection spinal technique is difficult to predict.[12] If a dose is too small, then the patient is likely to experience PDCD and conversion to general anesthesia. Even if the spinal appears to be adequate initially, it may not be adequate for the entire duration. Of greater concern is if the intrathecal dose is too large, the patient can experience a high or total spinal block, which can have profound maternal adverse effects including nausea, hypotension, and cardiac arrest.[13] Any adverse psychologic effects of high neuraxial blocks are not well described.

Yet another option is to replace an indwelling labor epidural catheter with another epidural catheter. The same principles of using concentrated local anesthetic, epinephrine, sodium bicarbonate, and fentanyl in the epidural top up solution for an indwelling labor epidural catheter apply to a newly placed epidural catheter. To our knowledge, there are no observational studies or clinical trials that have addressed this practice. We believe that placement of a new epidural catheter at a different spinal interspace may improve the chances for successful neuraxial anesthesia, especially in patients with poorly functioning LEA catheters. This technique is likely the most conservative with the lowest risk of a high neuraxial block and is also likely the slowest technique which can be problematic for urgent indications of delivery.

In conclusion, patients presenting for intrapartum CD who have indwelling LEA catheters are at increased risk of PDCD. While top up of indwelling LEA catheters for surgical anesthesia has been the predominant practice, some patients may benefit from an alternative anesthetic technique. Future patient-reported outcome studies are needed to evaluate management of indwelling labor epidural catheters for CD.

References

1. Burton S. *The Retrievals, Season 2*. Episode 1: The Case. July 10, 2025. Accessed April 1, 2026. https://www.nytimes.com/2025/07/10/podcasts/the-retrievals-c-section-women-health.html
2. Davis AE. Anesthesiologists and the Greatest Moment. *Anesthesiology*. Published online February 13, 2026
3. Somerstein R. I feel pain, not pressure: a personal and methodological reflection on pain during cesarean delivery. *Am J Obstet Gynecol*. 2026;233(6S):S129-S134
4. Stanford SE, Bogod DG. Failure of communication: a patient's story. *Int J Obstet Anesth*. 2016;28:70-75

(cont'd. Intraoperative management of indwelling labor epidural catheters for intrapartum cesarean delivery: what are my options?)

INTRAOPERATIVE MANAGEMENT OF INDWELLING LABOR EPIDURAL CATHETERS FOR INTRAPARTUM CESAREAN DELIVERY: WHAT ARE MY OPTIONS?- CONTINUED

5. Litman J, Bates R, Lindheim SR, Sharpe EE, Ehrig JC, Hofkamp MP. Patient and clinical characteristics associated with pain during cesarean delivery: a prospective single-center patient-reported outcome study. *Int J Obstet Anesth*. 2025;61:104324
6. Bauer ME, Kountanis JA, Tsen LC, Greenfield ML, Mhyre JM. Risk factors for failed conversion of labor epidural analgesia to cesarean delivery anesthesia: a systematic review and meta-analysis of observational trials. *Int J Obstet Anesth* 2012;21:294-309
7. Charles EA, Carter H, Stanford S, et al. Intraoperative Pain during Cesarean Delivery under Neuraxial Anesthesia: A Systematic Review and Meta-analysis. *Anesthesiology*. 2025;143:156-167
8. Yoon HJ, Do SH, Yun YJ. Comparing epidural surgical anesthesia and spinal anesthesia following epidural labor analgesia for intrapartum cesarean section: a prospective randomized controlled trial. *Korean J Anesthesiol* 2017;70:412-419
9. Shepherd B, Sharpe EE, Hammonds K, Hofkamp MP. A comparison of anesthetic outcomes between activation and removal of epidural catheters for patients who underwent unscheduled intrapartum cesarean delivery. *Proc (Bayl Univ Med Cent)* 2023;36:473-477
10. Tyagi A, Sharma CS, Kumar S, Sharma DK, Jain AK, Sethi AK. Epidural volume extension: a review. *Anaesth Intensive Care* 2012;40:604-613
11. Sanchorawala A, Sharpe EE, Ehrig JC, Hofkamp MP. Spinal anesthetic dose following removal of an indwelling labor epidural catheter for patients who underwent unscheduled intrapartum cesarean delivery stratified by height and weight: a single-center retrospective study. *Proc (Bayl Univ Med Cent)* 2025;39:64-67
12. Carvalho B. Failed epidural top-up for cesarean delivery for failure to progress in labor: the case against single-shot spinal anesthesia. *Int J Obstet Anesth* 2012;21:357-359
13. Lucas DN, Bamber JH, Stocks G, Sharpe P, Knight M. Incidence, risk factors, management and outcomes of high neuraxial block in obstetric anaesthetic practice: a prospective national observational study using the UK Obstetric Surveillance System. *Anaesthesia* 2026;81:24-30 ✦

WELCOME TO THE 2026-2027 SOAP BOARD OF DIRECTORS!

Daniel Katz, MD
Vice President

Brandon Togioka, MD
Secretary

Alex Butwick, MD
Director-at-Large
Academic Practice

Aria Shafai, MD
Director-at-Large
Community Practice

Ioannis (Yanni) Angelidis, MD, MSPH
Director-at-Large
Less Than 15 Years in Practice

Phil Rubin, MD
Chair
Annual Meeting & Live Events Committee

Congratulations to all 2026 SOAP Annual Meeting Award Recipients!

Distinguished Service Award
Mark Zakowski, MD, FASA
Cedars-Sinai Medical Center
Los Angeles, CA, USA

Diversity & Inclusivity Award
Kokila Thenuwara, MD
University of Iowa
Iowa City, IA, USA

Mentoring Excellence Award
Daniel Katz, MD
Mount Sinai Hospital/Icahn School of Medicine
New York, NY, USA

Research in Education
Lei Man Kuan, MD
University of California San Francisco
San Francisco, CA, USA

Teacher of the Year Award (More than 10 Years)
Pervez Sultan, MD, FRCA, MbChB
Stanford University
Palo Alto, CA, USA

Frederick P. Zuspan Award
Braydon Bak, MB BCh, BAO
Duke University
Durham, NC, USA

Teacher of the Year Award (Less than 10 Years)
Sharon Reale, MD
Brigham & Women's Hospital
Boston, MA, USA

SOAP & Anesthesia Patient Safety Foundation (APSF) Patient Safety Award
Daniel F. Berenson, MD, PhD
Brigham & Women's Hospital
Boston, MA, USA

WE WANT YOUR FEEDBACK!

The SOAP Member Value Committee has created a **Member Needs Assessment** to help us learn more about the type of programs and content you would like to see from SOAP.

Fill out the assessment by Tuesday, June 16 for a chance to win a **$50 Amazon gift card!**

Take the survey