

FALL 2022

# SOAP NEWSLETTER

Official Newsletter of the Society for Obstetric Anesthesia and Perinatology

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## PRESIDENT'S MESSAGE

Klaus Kjaer, MD, MBA



For the 2022-23 academic year, SOAP plans to continue its work towards a vision of safe and equitable care for women and newborns everywhere, and will do so via its mission to advance and advocate for the health of pregnant women and their babies through research, education, and best practices in obstetric anesthesia care. Along the way, the society will aim to stay true to its core values of care, excellence, professionalism, respect, diversity, and inclusivity.

To work effectively towards these goals, SOAP is organized into seven committees which provide oversight of our Annual Meeting and Live Events planning, Intersociety activities, Research programs, Education efforts, Governance effectiveness, Member Value creation, and Finance sustainability. Each of these committees reports directly to the Board of Directors, allowing us to stay focused on our priorities. Key areas of focus for SOAP over the coming year will be maintaining the society's position of thoughtful leadership, reaching out to future members of the society, and growing the SOAP Endowment. As of the end of August 2022, SOAP's net assets exceeded \$5 million.

*(cont'd. - President's Message)*

## PRESIDENT'S MESSAGE - CONTINUED

SOAP has experienced significant growth over the past year, both in membership numbers and financial assets, and has done so while nurturing its historical core of highly engaged members. More than 238 volunteers from the membership serve on committees and subcommittees, and more than 389 members participate in SOAP's eight special interest groups around Fetal Surgery, Maternal Health Inequities, Maternal Mental Health and Birth Trauma, Obstetric Anesthesia Physician Wellness, Placenta Accreta, Point of Care Ultrasound, Private Practice, and Simulation. At the end of August 2022, SOAP had 1,121 active members and 1,863 total members.

On August 2, 2022, SOAP held a Town Hall on Reproductive Access and Health following the Dobbs Ruling by the U.S. Supreme Court. Members of the SOAP Board of Directors and the SOAP Reproductive Access and Health (REACH) Taskforce kicked off a conversation where all SOAP members were able to share ideas, in a safe space, on how to navigate the rapidly changing health care landscape. The REACH Taskforce is working with various SOAP committees to explore educational and research opportunities to support both our members and our patients.

SOAP is starting to offer year-round content. The Annual Meeting and Live Events committee is currently deep into planning the Virtual Fall Forum on Pathways to Success in Obstetric Anesthesia, which is a professional development event co-sponsored by the SOAP Mentoring Academy. It will focus on four domains — Research, Education, Leadership, and Quality Improvement — and is scheduled for November 4-5, 2022. Mark your calendars!

SOAP's Education Committee put out a statement over the summer on the ongoing supply chain disruptions affecting the availability of epidural kits. Titled "It's a 'Kit'astrophe! Tips on Epidural Kit Shortage," it shares some approaches to navigating these disruptions. While these approaches are not to be interpreted as guidelines or standards of care, many members have shared that they have found them very helpful.

The first SOAP Research Network Symposium will be held at the ASA Annual Meeting in New Orleans on October 23, 2022. Planned and hosted by the SOAP's Research Committee, the symposium will provide the opportunity to present research proposals to SOAP's network of research experts, who will provide constructive feedback on rigor, relevance, methodology, ethics, feasibility, and fundability of research ideas and help identify project collaborators. Please join us for this in-person event!

*(continued - President's Message)*

## EDITOR'S NOTE

Kristen L. Fardelmann, MD



Dear SOAP Members,

For the past 7 years, Dr. Kathleen Smith has led the publication of the SOAP Newsletter as Editor. I would like to thank Dr. Kathleen Smith for her excellent leadership and service to SOAP and the Newsletter.

It is an exciting time to be a SOAP member. Not only is SOAP dedicated to promoting the safe and equitable care for women and newborns everywhere, it is also committed to the personal and professional development of its members. Please find information for the inspiring upcoming inaugural professional development events including the Virtual Fall Forum: Pathways to Success in Anesthesia and the SOAP Research Network Symposium within the Newsletter.

It is our pleasure to share member driven content as we transition the Newsletter into its next phase with new vision and purpose. We look forward to highlighting your experiences, expertise, educational insights, and achievements through future publications. Please submit short stories, editorials, educational pieces, new insights, and recent achievements to ([kristen.fardelmann@yale.edu](mailto:kristen.fardelmann@yale.edu)) for consideration.

Please check out the many upcoming opportunities to engage with SOAP and its membership in this fall newsletter. We are thankful for all our members and their continued contributions to the SOAP community and mission. We look forward to engaging with new members through the Newsletter in the coming year.

## PRESIDENT'S MESSAGE - CONTINUED

SOAP's Center of Excellence (COE) designation continues to be highly sought after, with 86 centers currently having earned that certificate. The 2022 COE cycle opened in July with a large number of applications received. This is an opportunity for groups to adopt and hardwire the highest standards of obstetric anesthesia in a number of different practice dimensions.

Anesthesia for the majority of deliveries in the United States is not provided by SOAP members. Help us broaden our reach! I encourage you to think about friends and colleagues who might benefit from joining the SOAP community. Membership in SOAP is an opportunity to influence, educate, connect, and volunteer at the local, national, and international levels. We are present on Twitter, Instagram, LinkedIn, and Facebook. This year, if you refer a new member, you will have the opportunity to be entered in a drawing to receive a complimentary registration for the 2023 SOAP Annual Meeting in New Orleans. Don't miss out! Simply ask the prospective member you referred to check the referral field in the membership form and enter your name.

Looking forward to a great year. Please continue to share your ideas, expertise, time, and energy with SOAP!

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## MEMBERSHIP CONTENT

### "DO I REALLY NEED THOSE STRAPS?"

Tracey M. Vogel, MD and Andrea Traynor, MD

Another busy night on labor and delivery. It's 2am and your patient is undergoing cesarean delivery for failure to progress. She's very nervous that the epidural won't work for surgery. You test it several times and know it is working. T4 sensory level bilaterally with excellent motor block. You secure her arms with the straps on the arm boards "just as a reminder not to touch the surgical field". She has not had any sedation and is wide awake asking questions. The blue drape goes up. You work on charting and hope you can sleep at some point during the night.

*When you got pregnant, all you could think of was a beautiful vaginal delivery. You and your partner together, in a private place, filled with love and hope. You tried changing positions and pushed your hardest. The baby wouldn't come out and your doctor said the safest thing was cesarean delivery. You've been at the hospital for 36 hours and it's 2am. You are exhausted and scared. The lights are blinding. You can't move your legs and are told it's normal. Your arms are on boards out to the side. Then they are strapped down. The next step is to have an operation while you are wide awake, can't move, and are strapped to the table. There is a blue drape. You can't see what's happening. You try to get the attention of the anesthesia provider and she has her back to you working on the computer.*

**Do you really need those straps?**



Tracey M. Vogel, MD



Andrea Traynor, MD

# MEMBERSHIP CONTENT

## "DO I REALLY NEED THOSE STRAPS?" - CONTINUED

The use of arm restraints is standard practice in the operating room (OR). This stems largely from recommendations by the ASA Task Force for Prevention of Perioperative Nerve Injuries, which include positioning of arms on an armboard or at the patient's side with padding to prevent pressure on the ulnar groove and upper extremity peripheral nerves.<sup>1</sup> Arms typically are secured in these positions. Pressure points are padded and any other sources of injury (e.g., IV ports) are padded or removed. The task force document specifically states, "this advisory is intended to apply to patients who have been sedated or anesthetized". They do not apply to patients who are not sedated.

Although well-intentioned, the use of restraints to "protect" a patient may be causing harm. Restraining a fully conscious individual who is in a vulnerable position can have significant long term psychological consequences. There is no known literature on restraint use in awake patients undergoing cesarean delivery. Studying this prospectively would be impossible due to ethical considerations. However, use of physical restraints has been studied in other populations. A recent meta-analysis of ICU patients showed that those who are physically restrained have an 11-fold higher incidence of delirium.<sup>2</sup> In this same population, the prevalence of post-traumatic stress disorder (PTSD) was 10%, with restraint use without sedation being a major risk factor.<sup>3</sup> Psychiatric patients subject to physical restraints report higher perceived coercion, increased levels of depression and powerlessness, and 25% higher scores on PTSD assessment.<sup>4</sup>

Multiple reports are emerging in obstetric patients, who state that their autonomy and decision-making capacity were neither considered nor respected during their childbirth experience.<sup>5,6</sup> A recent review of over 2000 patient experience reports showed that lack of control and powerlessness were primary contributors to a traumatic birth experience in 54% of patients.<sup>5</sup> Additionally, according to a Dutch social media campaign #genoegezewegen (#breakthesilence) of over 450 reports of birth experiences, being "left powerless" was the overarching theme in all reports.<sup>6</sup> Imagine you're on your back, arms restrained, legs paralyzed, surrounded by strangers; you're naked and terrified that you will be in a great deal of pain. It is hard to overstate the vulnerability this position could evoke for anyone, but it is especially relevant for a pregnant woman who is trying to reconcile feelings of overwhelming fear and helplessness in the unfamiliar OR environment with the physiological need for her and her child's safety. This psychological distress can cause long-lasting feelings of helplessness, distrust, terror and guilt.<sup>7</sup> When these birth experience reports are correlated with data from other patient populations where physical restraints have been studied, it is reasonable to infer that physical restraint of an unsedated patient's arms in the OR for cesarean delivery can result in an experience of powerlessness, and consequently increase the risk for a traumatic birth and postpartum PTSD.

Information regarding psychological effects of physical restraint use has prompted data driven hospital guidelines for non-obstetric patients. At Stanford University, indications for use of restraint are to prevent the patient from pulling out medically necessary tubes/lines, prevent interference with treatment in a way that will cause harm, or in cases where immobilization is necessary to promote healing. The restraint policy at the Allegheny Health Network states that restraint or seclusion may only be imposed to ensure immediate physical safety of the patient, a staff member, or others and should be discontinued at the earliest possible time; and further, all patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Integral to all these protocols is the requirement that restraint be used as a last resort after other interventions have failed. These interventions include reorientation, increased monitoring, relaxation techniques, assisting the patient with problem solving, encouraging the patient to verbalize fears, reassuring safety, and offering the patient alternative ways to have needs met.<sup>8</sup> Additionally, the reason for restraint must be clearly documented and reassessed hourly.

# MEMBERSHIP CONTENT

## "DO I REALLY NEED THOSE STRAPS?" - CONTINUED

An often-cited reason by OR personnel to restrain a woman's arms during cesarean delivery is the fear that she will reach out and disrupt the surgeon and/or contaminate the surgical field. Fear of resulting complications could be interpreted by some as an indication for restraint, but per widely accepted hospital guidelines, restraints should not be utilized without attempting other interventions.

A higher level of vigilance is required when arms are not strapped down because verbal reminders, redirection, and relaxation techniques might be necessary. Since women have intact decision-making capacity during labor and childbirth, anesthesia providers must presume competence with verbal instructions. In other words, providers must assume that when instructed, patients will not reach up and cause harm. If they are unable to follow these instructions, it is the responsibility of providers to determine why. Is it an inadequate block and severe pain? Is it a high block with hypoxemia? Is it severe anxiety and panic? Is it a language barrier? All of these reasons have a remedy. General anesthesia. Intubation and airway control for high spinal. Reassurance and low dose anxiolysis. Presence of an interpreter. Restraints are not a solution to problems that are solved with vigilance, medical decision making, and presumed patient competence.

Psychological trauma can be thought of as any event that overwhelms an individual's sense of control over themselves or their environment, their ability to maintain connections to others, and to make meaning out of an experience. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM V) states that trauma may result from actual or threatened, death, serious injury or sexual violence. Recently, perinatal mental health specialists included negative events surrounding childbirth as fulfilling the definition of a traumatic event.<sup>9</sup> With this new development in the early 2000's, the symptoms that postpartum patients were experiencing in the areas of intrusive thoughts, hyperarousal, negative cognitions and mood, and avoidance could now be identified and properly diagnosed and treated. What was not always easily identified, however, was what contributed to the traumatic experience or increased the risk for a woman to develop posttraumatic stress symptoms, or in some cases PTSD.

### **A note from the authors...**

*This article was inspired by a debate within the Physician Anesthesiologist Moms Facebook Group. A member posted a photo of her sister with her arms strapped down during her cesarean delivery and asked if others do this. The response was shocking. Many female anesthesiologists, mothers themselves, said they often did so "just as a reminder".*

*We hope this article serves to educate about the psychological harm that is done to patients when they are aware of being strapped to an operating table during childbirth. Our goal is to prompt changes in personal, unit, hospital, and system protocols and practices, and to encourage obstetric anesthesiologists, as the "guardians of psychological safety" to spread the word among our non-obstetric anesthesia colleagues to affect change.*

*Sincerely,  
Dr. Tracey M. Vogel and Dr.  
Andrea Traynor*



# MEMBERSHIP CONTENT

## "DO I REALLY NEED THOSE STRAPS?" - CONTINUED

Although researchers have associated significant intrapartum events such as perinatal loss, neonatal ICU admission, and emergency procedures with an increased risk of postpartum PTSD, in many recent studies, the patient's negative subjective experience of childbirth, loss of control and fear of childbirth, and minimal support during labor and delivery have consistently emerged as significant predictors of PTSD.<sup>10</sup> This can include feelings of powerlessness as a result of being awake, rendered immobile (with neuraxial anesthesia), and strapped to an OR table.

### **Do you really need those straps?**

You tell the patient "Here is a place to put your arms. You can hold your partner's hand. You can place your hands on your chest, feel yourself breathing, and calm yourself. You will be able to hold your baby. That blue drape is there to show you where it is safe and not safe to reach. You are not restrained."

### **No, you don't need those straps.**

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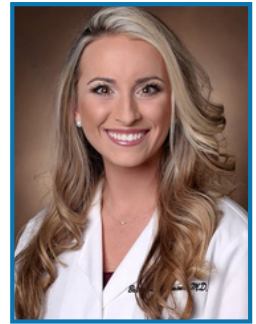
# MEMBERSHIP CONTENT

## BARRIERS TO POINT-OF-CARE ULTRASOUND USE IN OBSTETRIC ANESTHESIA: RESULTS OF A 2020 SOAP PATIENT SAFETY COMMITTEE SURVEY

Holly B. Ende MD, Britany L. Raymond MD, and Rachel Kacmar MD



Holly B. Ende, MD



Britany L. Raymond, MD



Rachel Kacmar, MD

Point-of-care ultrasound (POCUS) is expanding perioperatively<sup>1</sup> and is an important skill set for obstetric anesthesiologists, with many applications on labor and delivery. Because of its noninvasive nature and widespread applicability, POCUS is projected to be a standard extension of the physical exam for all medical graduates within the next decade. Cardiac and lung ultrasound can assist diagnosis and guide therapy during acute peripartum events. Neuraxial ultrasound can help identify spine anatomy and facilitate difficult epidural placement.

In 2022, the Accreditation Council for Graduate Medical Education (ACGME) updated the evaluation milestones for obstetric anesthesiology fellows to include an assessment of their POCUS skills.<sup>2</sup> Faculty must be proficient in this skill set to provide both needed teaching and the highest level of patient care. Despite this, in a 2020 survey of SOAP Patient Safety Committee members (n=28) who primarily work in academic settings, only 18% report using POCUS often or extremely often. This highlights one of the barriers to utilizing this technique for clinical care on labor and delivery.

Specifically, barriers to the use of POCUS may include:

**Lack of trained personnel:** In our survey, 32% of survey respondents reported two POCUS-proficient obstetric anesthesia faculty. Many currently practicing obstetric anesthesiologists completed training before robust POCUS curricula in either residency or fellowship. Thus, motivated clinicians must seek out formal training courses, such as those described below, to practice POCUS confidently on the labor and delivery floor. In general, an average learning curve for proficiency requires performance of 25-50 exams reviewed for quality by trained providers.<sup>3</sup>

Until recently, one of the largest barriers to POCUS training has been lack of formal educational programs. However, the American Society of Anesthesiologists has recently filled this gap with the Diagnostic POCUS Certificate Program. This program includes image interpretation training, image acquisition training, and a final written exam.<sup>4</sup> The program emphasizes cardiac, lung, and abdominal exams, as these exams have been deemed most relevant to the specialty of anesthesiology by the American Board of Anesthesiology and the ACGME. Importantly, this external certification does not establish privileges or credentials, which are ultimately granted at the discretion of individual departments.<sup>5</sup>

# MEMBERSHIP CONTENT

## BARRIERS TO POINT-OF-CARE ULTRASOUND USE IN OBSTETRIC ANESTHESIA: RESULTS OF A 2020 SOAP PATIENT SAFETY COMMITTEE SURVEY - CONTINUED

Holly B. Ende MD, Britany L. Raymond MD, and Rachel Kacmar MD

**Lack of equipment:** In our survey, 79% of respondents reported a dedicated ultrasound machine for labor and delivery; however, only half of those were equipped with a phased array probe necessary to perform transthoracic echocardiography. Without proper equipment readily available in the obstetric care environment, both training and clinical use of POCUS are unlikely to occur.

**Lack of standardized documentation requirements:** In our survey, 40% of respondents did not document their ultrasound exam in any way. Only 1 of 28 placed a full ultrasound report, and only 4 of 28 saved images in the patient's chart. While these issues may seem minor in comparison to clinical skill and appropriate equipment, communication of POCUS findings to other care teams by formal written communication (as well as informal verbal communication) is an essential component to building a sustainable POCUS practice on any clinical unit.

**Lack of reimbursement for additional skill and time:** In our survey, 0% of respondents reported billing for POCUS on labor and delivery. Again, while patient care is paramount, reimbursement for services provided helps to finance both provider time and appropriate equipment, as noted above. On busy labor and delivery units, the time and expertise of anesthesia providers are a limited resource, and appropriate reimbursement will be necessary to create sustainable models for POCUS.

In conclusion, POCUS has rapidly become an essential diagnostic tool for patient assessment. Compulsory education among medical trainees has led to an exponential adoption of ultrasound technology into their routine practice. Therefore, medical educators must also expand their own POCUS skill sets to adapt to this new emerging standard of care. Departments can encourage the incorporation of POCUS through intentional actions aimed at addressing known barriers, such as providing appropriate equipment and developing easy documentation templates to optimize reimbursement. While this survey was small and likely only generalizable to academic institutions, its findings nonetheless suggest areas for improvement in incorporating POCUS on obstetric anesthesia units.

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# MEMBERSHIP CONTENT

## "THE SIGN"

Davida Grossman, MD



Davida Grossman, MD

"You worked really hard to get here, maybe you shouldn't give it all up," was what my well-meaning friend said when I told her about my plan to radically change my life. I really respect and admire her, but what she doesn't know is that I really want to change the course of my life. I want to do it, and I'm scared.

So when she said this to me, I had to think about it all over again. How many times could I rethink it before fear and practicality would win out and my chance to do something that I have dreamed about for years would be lost? My nature is to be careful and safe. My nature is to go out of my way to avoid catastrophe. I mean really out of my way, to think of every possibility and do all the small things that decrease the likelihood of badness occurring. It's who I am. It's my career. I am an anesthesiologist. Perhaps you can relate?

Perhaps you too feel a draw to do something else, to move out of your comfort zone, to make a radical life change. Perhaps fear is holding you back. Fear has become infamous. Fear, our protector, the emotion that prevents us from making bad choices, and in my case entices me to do all the small things that keep my patients safe, has become infamous as the emotion holding us back from living our best lives. Many tout the wisdom of this acronym, Fear - False Evidence Appearing Real and this common saying, "Everything you want is on the other side of fear." My guru Elizabeth Gilbert emphasizes, "Fear...you are...forbidden to drive." Despite these wise teachings, fear was starting to get the best of me, until I saw the sign.

I'm not the kind of person who believes in signs, but truth be told, I want to be. In my fantasy where I am the woman behind the counter in the store that sells incense, and clothes and jewelry from exotic places, the fantasy where I am tan and wear beaded anklets and flowy clothes, in that fantasy, I also believe in signs. But that isn't me. I'm the person who was in the chemistry lab trying to get the mass spec to spit out the answer I needed because anything less than an A grade wasn't acceptable.

I'm trying to change, so when I see something that is so clearly a sign I try to embrace it. I try to be the kind of person who makes life moves based on a sign, especially if that sign shows up when I really need it.

Tomorrow, I plan to tell my partners of 20 years about my cockamamie plan to work half a year and travel half a year. Tomorrow, I tell my suburban private practice partners that I am drawn to Latin America and that I want to leave our lucrative practice to go learn Spanish. Tomorrow, I will ask my partners to let me do this and still employ me. I had been feeling really confident and prepared for this meeting. I had put together three scenarios to present to them and decided I would be satisfied if they accepted any of them. In this way, I had insulated myself against failure. I backed up the gold medal with a silver one and a bronze one. Give me any of those, and I'll be happy. Sure, I want the gold, but here is a silver option in case you don't want to give me the gold, you can give me the silver, or the bronze. On second thought, don't even worry about the gold and the silver, just give me the bronze. Do it quickly please and put me out of my misery. I can't take the stress.

# MEMBERSHIP CONTENT

## "THE SIGN" - CONTINUED

Davida Grossman, MD

But wait, now it occurs to me that they may not award me any medal. They may see my routine and they may decide I don't deserve any medal at all. What will I do if that happens? Maybe I shouldn't even ask? Maybe I'm making a mistake? Perhaps I need more preparation? I'm beside myself. I'm terrified of tomorrow and don't know what to do to secure my outcome. I'm afraid to proceed without a known outcome. I'm not ready. I don't know which way to turn. All I feel is FEAR.

And then I see it, the sign. While I am standing in line to buy coffee, while I am standing in line worrying about how I can possibly go through with this meeting, I see the sign. I see, quite literally, the sign on the wall in the coffee shop, and the sign says,

### Coffee of the Day COLOMBIA

*Davida Grossman, MD transitioned from full time practice to part time practice at West Jersey Anesthesia Associates in January 2020. She now works half a year and travels half a year splitting time between Latin American countries and VanLife. To make this happen, she gave up her partnership and her position as Director of Obstetric Anesthesia. She continues to be active in Obstetric Anesthesia and SOAP. She is currently contemplating her next move.*

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# *In Memoriam:*

## **Mieczyslaw (Mike) Finster, M.D. 1924-2022**



*Mike was a giant in our specialty - to many of us he was an incredibly generous mentor and dear friend.*

*Ruthi Landau, MD - SOAP Past President*

Mike was born in Lwow, Poland almost a century ago. I only heard these past days how incredibly difficult his early life had been. He managed to escape the Nazis and ultimately made his way to Israel where he met Lily, whom he married a few years later.

Mike and Lily moved to Geneva, Switzerland, where Mike obtained his medical degree in 1957 before emigrating to New York. Mike completed an anesthesia residency at Columbia University (1958 to 1960), followed by a research fellowship (1960-1961). Succeeding Virginia Apgar and Frank Moya, Mike was appointed Director of Obstetric Anesthesia, a position he held for 32 years (1962-1994), before serving as acting Department Chair (1994-1995). Mike was on Faculty at Columbia for 47 years and became Professor Emeritus in 2007.

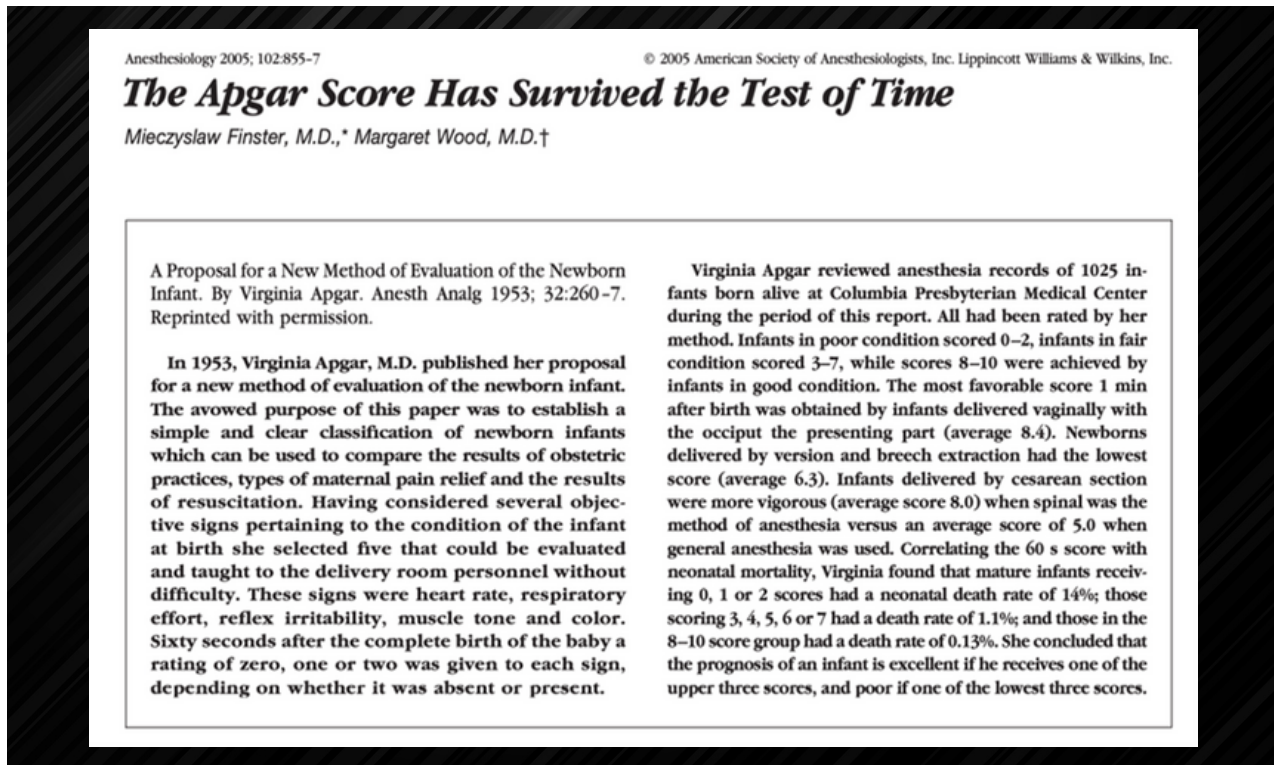
In his earliest publication, Mike reported on four cases of caudal labor analgesia resulting in the accidental injection of mepivacaine into the fetus' scalp (Am J Obstet Gynecol, 1965). This report became a major factor in caudals being replaced by lumbar epidurals for labor analgesia. Mike started to study the pharmacokinetics and pharmacodynamics of local anesthetics in pregnancy. Mike's research, working in his Columbia lab for three decades with Hisayo Morishima, Hilda Petersen, Paul Poppers, Alan Santos, and many others, was groundbreaking. His studies, comparing local anesthesia systemic toxicity in pregnant and nonpregnant ewes, the transplacental transfer of local anesthetics, and the maternal and fetal toxicity of anesthetics resulted in 30 publications between 1966 and 1996.

Anesthesia-related complications and ways to avoid them were certainly on Mike's agenda. Mike published a Letter to the Editor with Gertie Marx on the "alarmingly high incidence of difficult intubations, with consequent maternal and fetal complications, in women undergoing general anesthesia for emergency cesarean section because of fetal distress" (Anesthesiology, 1979). This alerted the world to the growing concern of failed intubations in pregnant women causing maternal deaths, and though brief, the paper proposes a stepwise approach to avoid a "CICO" situation.

Another publication reporting on the possible neurotoxic effect after epidural or inadvertent injection of subarachnoid 2-chloroprocaine (Anesth Analg, 1980) resulted in a change of drug formulation, and publication of another Letter "Chloroprocaine: safe after all!" (Anaesthesia, 1982).

Mike wrote two narrative reviews on the effects of epidural analgesia on the progress of labor and the mode of delivery (Eur J Obstet Gynecol Reprod Biol, 1995; Baillieres Clin Obstet Gynaecol, 1998). In the absence of well conducted randomized controlled trials, Mike concluded "Studies showing that introduction of an 'on demand' epidural service did not increase the primary cesarean section rate are particularly instructive -- Premature rupture of membranes and the choice of obstetrical service may be the most important factors affecting the course of labor and delivery." We now have the data, and Mike was right.

Finally, in his last published paper “The Apgar score has survived the test of time” (Anesthesiology, 2005), Mike described how Virginia Apgar developed at Columbia the famous scoring system that would “ensure observation and documentation of the true condition of each newborn during the first minute of life,” with five signs easily observed in the newborn (heart rate, respirations, muscle tone, reflex irritability, and color). It was only two years later that the acronym was created by two pediatricians to facilitate teaching of the Apgar score (appearance, pulse, grimace, activity, and respiration). The value of the score was examined in several large studies (1952-1956; 1959-1966; 1988-1998) and while it was not intended to be a measure of perinatal asphyxia, a strong correlation between the Apgar score at 5 minutes and neonatal mortality was confirmed.



It comes as no surprise that Mike served as a Consultant to the NIH Perinatal Research Branch and an Expert for the FDA Center for Drug Evaluation. He also received the ACOG Associate Fellowship Award and the Niels Lofgren Award.

Mike published 69 papers, authored 83 Textbook Chapters, and was invited around the world for Visiting Professorships. He served on the Editorial Board of many prestigious journals. He served as Chair of the Committee on Obstetric Anesthesia at ASA, as the Scientific Chair of NYSSA/PGA (1984-1987), and the NYSSA/PGA Chair (1987-1990). Mike presented the Emory A. Rovenstine Memorial Lecture at PGA in 1993 and received the NYSSA Distinguished Award in 2003.

Mike was a giant, a memorable teacher, a legendary leader, and an outstanding storyteller. His contributions to SOAP are listed in the [SOAP Pioneers Booklet](#) (celebrating SOAP's first 40 years) including:

- -One of 64 Charter Members (person enrolled at the first national SOAP meeting held in Kansas City) in 1969
- -The President of SOAP in 1995-1996
- -The Fred Hehre Lecturer in 1997 (“Abandoned Techniques and Drugs in Obstetrics and Obstetric Anesthesia”)
- -The recipient of the Distinguished Service Award in 2001

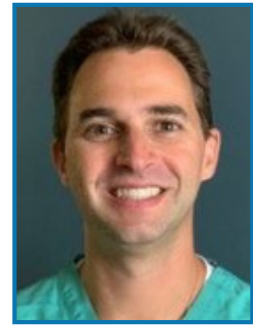
To innumerable SOAP members, Mike was a great source of advice and support. He was the perfect European gentleman with a witty sense of humor. One of a kind. Mike will be missed around the world, not only as an anesthesiologist who shaped ‘safe obstetric anesthesia’, but as the brilliant, kind, and generous friend he was to so many of us.

Mike died on 9/11, surrounded by his loving family. We will keep Lily, his children Evelyn and Victor, and his five grandchildren in our thoughts. Mike’s memory is forever with us and may he now rest in peace.

# EDUCATION COMMITTEE REPORT

Daniel Katz, MD

Chair, SOAP Education Committee



The education committee has been hard at work ensuring that regular high-quality content is available for SOAP members, patients, and others. Please head to our website section on simulation to check out the latest simulation of the month (SIMOM) which continues to be developed regularly. For the fellows, please consider attending our fellowship lecture series, the next one coming up in October! The patient education subcommittee has also been hard at work designing new materials, infographics, and pamphlets that you can distribute to your patients for the purposes of patient education. For those of you who have been impacted by the epidural kit shortage, check out our recent post on tips and potential alternatives, with a more robust piece in the works. Our latest tip sheet titled, "Monkeypox – What to Know!" provides information regarding anesthesia care for the obstetric patient with monkeypox.

We are excited to announce the development of a POCUS based case series. These clinical case discussions will include a patient stem supplemented with ultrasound clips that will aid in the diagnosis and management of a challenging obstetrical case. This is a new project that is under development that we hope to release in the coming months. Stay tuned for more content!

We are still looking for members to help us with our projects. If you would like to volunteer, feel free to reach out to me at [Daniel.Katz@mountsinai.org](mailto:Daniel.Katz@mountsinai.org)!

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# ANNUAL MEETING & LIVE EVENTS COMMITTEE REPORT

Heather Nixon, MD

Chair, SOAP AMLE Committee

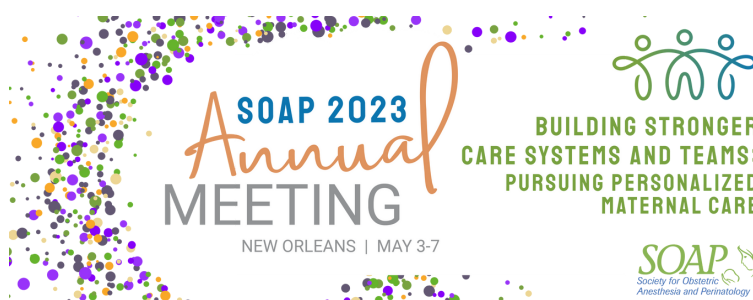


## SAVE THE DATE!

The AMLE committee is diligently working on the upcoming 55th annual meeting and is excited to announce the theme "Building Stronger Care Systems and Teams: Pursuing Personalized Maternal Care".

## SUBMIT YOUR IDEA FOR A PRE-CONFERENCE WORKSHOP

The Annual Meeting and Live Events Committee is interested in your ideas for pre-conference workshops at the 2023 Annual Meeting. [Submit your proposal online](#) no later than November 1.





# 2022 ANNUAL MEETING HONOREES



Congratulations to our 2022 Annual Meeting honorees, including research competition winners, award recipients, grant recipients, and Centers of Excellence designees! Below is a summary in case you missed the awards ceremony. We encourage you to share congratulations on social media using #SOAPAM2022.

## Gertie Marx Research Competition

- First Place: Dr. James O'Carroll, Stanford University, Stanford, California, USA
- Second Place: Dr. Natalia Portela, Mount Sinai Hospital, Toronto, Ontario, Canada
- Third Place: Dr. Katelyn Scharf, University of Maryland Medical Center, Maryland, USA

## Best Research Paper Competition

- First Place: Dr. Jose Carvalho, Mount Sinai Hospital, University of Toronto, Ontario, Canada

## Best Case Reports Competition (Top 10)

- Dr. Mohammed Idris, Beth Israel Deaconess Medical Center, Boston, Massachusetts, USA
- Dr. Hilary Gallin, Massachusetts General Hospital, Boston, Massachusetts, USA
- Dr. Caroline Thomas, Northwestern University, Chicago, Illinois, USA
- Dr. Mohammed Hussain, University of Texas Medical Branch at Galveston, Houston, Texas, USA
- Dr. Shradha Khadge, Cedars-Sinai Medical Center, West Hollywood, California, USA
- Dr. Michael Kim, New York Presbyterian-Columbia University Campus, New York, New York, USA
- Dr. Monique Osigbeme, Vanderbilt University Medical Center, Nashville, Tennessee, USA
- Dr. Samantha Rubright, Duke University Medical Center, Durham, North Carolina, USA
- Dr. Sapna Ravindranath, Indiana University Hospital, Indianapolis, Indiana, USA

## Award Recipients

- Distinguished Service Award: Dr. Craig Palmer, University of Arizona, Tucson, Arizona, USA
- Teacher of the Year Award (More than 10 Years): Dr. Heather Nixon, University of Illinois, Chicago, Illinois, USA
- Teacher of the Year Award (Less than 10 Years): Dr. David Berman, Johns Hopkins, Baltimore, Maryland, USA
- Diversity & Inclusivity Award: Dr. Allison Lee, Columbia University, New York, New York, USA
- Patient Safety Award: Dr. Jean Guglielminotti, Columbia University, New York, New York, USA
- Research in Education Award: Dr. Maria Sheikh, Columbia University, New York, New York, USA
- Frederick P. Zuspan Award: Dr. Grace Lim, UPMC Magee, Pittsburgh, Pennsylvania, USA
- SOAP/Kybele International Outreach Grant: Dr. Moris Baluku, Kabale University, Uganda

## Center of Excellence Designees

- Al Wakra Hospital, Hamad Medical Corporation – Doha, Qatar
- Baptist Medical Center Jacksonville – Jacksonville, Florida, USA
- Baptist Medical Center South – Jacksonville, Florida, USA
- Baylor College of Medicine – Houston, Texas, USA
- Clements University Hospital at UT Southwestern Medical Center – Dallas, Texas, USA
- NYC Health and Hospitals/Elmhurst – Elmhurst, New York, USA
- Kitasato University Hospital – Sagami-hara City, Japan
- Memorial Hermann Hospital, Texas Medical Center – Houston, Texas, USA
- Parkland Health – Dallas, Texas, USA
- Pro Matre Paulista-Grupo, Santa Joana – Sao Paulo, Brazil
- The University of Texas Medical Center, Galveston – Galveston, Texas, USA
- Westchester Medical Center – Valhalla, New York, USA
- University of Colorado Hospital – Aurora, Colorado, USA



# AN UPDATE FROM THE ASA COMMITTEE ON OBSTETRIC ANESTHESIA



Mark Zakowski, MD, FASA

Chair, ASA Committee on Obstetric Anesthesia

ASA and SOAP are better together! We work closely on education, practice guidelines and other aspects of obstetric anesthesia. As a Past-President of SOAP, I am keenly aware of the nuances and goals for each organization. First, I'd like to welcome you to ASA 2022 in New Orleans, which again has a terrific Obstetric Anesthesia educational track program. Special thanks to Brenda Bucklin as chair, Brendan Carvalho as vice-chair and the entire ASA Educational Track Subcommittee on Obstetric Anesthesia, speakers and presenters for what will be an outstanding program. Both in-person and a more limited virtual experience are being offered. Don't miss sessions like Top Papers in Obstetric Anesthesia That WILL Change Your Practice, Postpartum Hemorrhage, Maternal Mental Health Consequences of Traumatic Labor Events, Debunking Myths and Dogmas on L&D and more!

The American Society of Anesthesiologists Committee on Obstetric Anesthesia (COBA) has had another productive year on your behalf. To support last year's Statement on Post Dural Puncture Headache, COBA developed a user friendly Post Dural Puncture Headache Toolkit with sample consult notes and patient education materials. New committee statements which go to the House of Delegates for October 26, 2022 approval include: Oral Intake in Labor (supported by SOAP and support in process for ACOG), Anesthesiologists Role in Reducing Maternal Mortality and Severe Maternal Morbidity, and Quality Metrics in Obstetric Anesthesia. The Quality Metrics statement is intended to offer obstetric anesthesia teams potential measurements and suggestions to assess and improve clinical practice. The topic of oral intake during labor has generated many queries and will provide clinical guidance based on available scientific evidence. Any member of ASA may provide comments for all committee statements at Reference Committees on the afternoon of Sunday, October 23<sup>rd</sup>. After ASA House of Delegates approval and after any adjustments to the content, the statements will be available on the ASA website; I will give more details about individual statements in a future column. The PDPH Toolkit should be posted soon, please check under committee work products. Thank you to all the ASA, SOAP, ACOG members and others who provided input and assistance.

Other ASA COBA resources available include the ASA COBA working group educational piece on nitrous oxide.

A peek behind the curtain: preparations for the 2023 ASA COBA year have already begun. My process involves soliciting suggestions from individuals within COBA, as well as outside the committee – including select members of ASA, SOAP, ACOG, OAA and SMFM. COBA had an initial discussion of all ideas and priority ranked the suggested topics. After approval of statement topics from COBA and final approval from ASA leadership, working groups will start research and writing in October/November.

Another opportunity for understanding processes includes membership on the ASA COBA (or most other ASA Committees). Becoming an ASA committee member starts with YOU! Please apply at the ASA website when the self-nomination process is open in December and the first week of January. Please notify the individuals you list who will be providing references – it is the individual's responsibility to ensure references are submitted. Committees are generally somewhat limited in size, and ASA seeks many types of committee diversity including geography (state, rural/urban), practice type, academic/non-academic and race/ethnicity as self-identified. Applicants are ranked and reviewed at four levels with individuals appointed by the ASA president-elect. Active committee member participation is required. Note that the individual state components of ASA are allotted delegate positions based on the number of members from each state component. Each state component designates their chosen voting delegates to the ASA House of Delegates.

Looking forward to hearing from you and having another great year working closely with you.

Mahalo!



# Mark your Calendars!

## **SOAP Center of Excellence Applications**

are open until October 3, 2022.

Submit your application today!

## **Inaugural SOAP Research Network Symposium**

October 23, 2022 (At the ASA Annual Meeting)

10:15am – 12:45pm

Hilton New Orleans Riverside

Register to attend!

## **Virtual Fall Forum: Professional Development Series**

Pathways to Success in Anesthesia

November 4-5, 2022

Register to attend! Fellows & Residents attend for free!

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## **ANNOUNCING THE SOAP-FAER MENTORED RESEARCH TRAINING GRANT**

The Society for Obstetric Anesthesia and Perinatology is excited to be partnering with the Foundation for Anesthesia Education and Research on a joint SOAP-FAER Mentored Research Training Grant (MRTG) to develop the next generation of obstetric anesthesiology and perinatology physician-investigators.



This two-year, \$250,000 award aims to help anesthesiologists develop the skills and preliminary data they need to become independent investigators in the area of obstetric anesthesiology and perinatology. Research Areas: All areas of research that contribute to knowledge about and advance and advocate for the health of pregnant women and their babies through research, education, and best practices in obstetric anesthesia care.

- Eligibility: Anesthesiologist faculty member who is within 10 years of their first faculty appointment.
- Funding Amount and Duration: \$250,000 over two years
- Research Time: 75%
- Applications Open: December 1, 2022
- Application Deadline: February 15, 2023

Application instructions for the SOAP-FAER MRTG are not yet available but will become so before applications open in December.

If you have any questions, please contact the FAER office at 630.912.2554 or FAER@faer.org.