President’s Message

Manuel C. Vallejo, MD, DMD
West Virginia University
Morgantown, WV

The 2016 SOAP 48th Annual Meeting will be at the Seaport Boston Hotel in Boston, Massachusetts from May 18-22, 2016. A robust scientific program is planned with the presentation of 182 science abstracts and 175 case reports where a majority will be by e-poster presentation, which is new to SOAP this year. Two sites, the JW Marriott in Austin, Texas, and the JW Marriott in Phoenix, Arizona are being considered for the 2019 SOAP 51st Annual Meeting Site. These sites will be voted on during our business meeting at the annual meeting.

Congratulations to Jill Mhyre, MD for being selected as Anesthesia and Analgesia Obstetric Anesthesiology Section Editor. As a result, Dr. Mhyre will be stepping down as SOAP Journal Liaison and SOAP Patient Safety Committee Chair. Brian Bateman, MD will become our new SOAP Journal Liaison, and we will name a new SOAP Patient Safety Committee Chair at the annual meeting. Mark Zakowski, MD was elected to SOAP 2nd Vice President at our annual meeting in 2015 and hence will be stepping down as SOAP Education Committee Chair. May Pian-Smith, MD will make the transition to become our new SOAP Education Committee Chair.

Research is an important mission of SOAP. The 2016 SOAP Gertie Marx Education Research Grant was awarded to Allison Lee, MD, from Columbia University with her project entitled “The High Fidelity Patient Simulation (HFPS) as an Assessment Tool”. New this year, SOAP implemented a Young Physician Investigators Award, which is a FAER-SOAP co-sponsored $10,000 grant targeted for a young investigator from their fellowship up to and including 2 years post-graduation from
President’s Message continued from previous page

fellowship. There were many interesting applications of which three investigators were selected:

- Marie-Louise Meng, MD from Columbia University, “Epigenetics of Post-Partum Preeclampsia.”
- Anthony Chau, MD, from Harvard University-Brigham & Women’s Hospital, “The effect of combined spinal epidural, dural puncture epidural and standard epidural labor analgesia techniques on maternal plasma catecholamine levels – A pilot study.”
- Annemarie DeTina, MD from Harvard University-Brigham & Women’s Hospital, “Oxytocin in the Obese Parturient: A pilot study on the pharmacokinetics of oxytocin during induction or augmentation of labor.”

Future SOAP meetings include the 1st annual 2016 SOAP Clinical Update in Obstetric Anesthesia held at the Grand Hyatt in Washington, D.C. from November 4-6, 2016. Please update your calendar and I look forward to seeing you in Boston.

Sincerely,
Manuel C. Vallejo, MD, DMD
President, Society for Obstetric Anesthesia and Perinatology

Editor’s Corner
Heather C. Nixon, MD
University of Illinois Hospital and Health Sciences System
Chicago, IL

For the last five years, the SOAP newsletter has been part of my life. With each release I would eagerly read the printed and more recently the electronic versions of the newsletter to learn about societal initiatives, educational meetings and to hear from experts on current and often controversial topics. I want to take this opportunity to thank Dr. Michael Froelich for his efforts as the previous Newsletter Editor and Media Committee Chair. His dedication and service to SOAP was remarkable. As the newly appointed SOAP Newsletter Editor and Media Committee Chair, I hope to continue his initiatives and expand the media presence of the society. I am thrilled and humbled to now be a part of the team that ensures that SOAP members get the information they need and feel connected to the society.

This Spring Newsletter focuses on the upcoming 48th Annual SOAP Meeting, which will be held in Boston, Massachusetts from May 18th-22nd. Event schedules and timelines are included to help you plan as well as an introduction to the meeting’s educational events by the Scientific Program Chair, Dr. John Sullivan. Dr. Wlody provides us with an article on the proposed changes to the bylaws and in the Treasurer’s Report, Dr. Segal updates us on SOAP’s finances.

In addition, this Newsletter contains several informational and educational articles. The Patient Safety Committee provides an overview of NPO practices from it’s experts in another installment of the “This is How We Do It” series edited by Dr. Rachel Kacmar. Drs. Lim, Thurston and Bauchat tackle the complex topic of Empathetic Care in their article from the Education Committee. Finally, Dr. Nicole Higgins provides us with a brief summary of the Resident Affairs Committee’s initiatives and goals.

If you are attending the meeting, use the Twitter Hashtag - #SOAPAM2016 to follow us on Twitter for event reminders, highlights of educational or scientific discussions and any schedule changes. For those of you new to Twitter, simply go to the website https://twitter.com/signup?lang=en to sign up for an account prior to the meeting.

Finally, I want to encourage members to feel free to contact me (hnixon1@uic.edu) with suggested topics for the newsletter or ideas concerning how SOAP might use technology and media more effectively to serve it’s members and to promote the societal mission.

Sincerely,
Heather C. Nixon, MD
As Scientific Program Chair of the upcoming SOAP 48th Annual Meeting in Boston, I would like to highlight the reasons why you should be excited about attending. First of all, the program contains expert speakers from SOAP, but also thought leaders from a number of other specialties addressing contemporary topics important to the practice of our specialty. Secondly, we are highlighting several new formats to share scientific information including small group poster discussion using electronic monitors, abstract blogs and twitter feeds. Thirdly, Boston is just a wonderful city to visit and should serve as the perfect backdrop to cultivate your important professional relationships and friendships within our subspecialty.

Our keynote speaker is Dr. Mary D’Alton, the Chair of Obstetrics and Gynecology at Columbia University and Past President of the American College of Obstetrics and Gynecologists (ACOG). She is known within the ACOG community as the leader in the effort to put the ‘M’ back in the practice of Maternal Fetal Medicine and she will address the impact of successful collaboration in obstetric care. The “What’s New in Obstetrics” talk will be given by Dr. Neel Shah, an obstetrician at Beth Israel Deaconess Medical Center and expert in health care economics and innovation at Harvard University. Dr. Shah was profiled as one of the “40 Smartest People in Healthcare” in the New York Times and will speak on the subject of delivering value-based healthcare. Dr. Terri Inder, an internationally renowned neonatologist and Chair of Newborn Medicine at Brigham and Women’s Hospital, will present new developments in the multidisciplinary care aimed at improving neonatal outcomes. Our own Dr. Phil Hess will present the annually anticipated Ostheimer lecture, which is particularly noteworthy in that he is simultaneously serving as the local meeting host.

In keeping with the multidisciplinary meeting theme, we have paired obstetric anesthesiologists with other specialists to address the topics of anticoagulation, blood management, sepsis, echocardiography and quality measures. Dr. Errol Norwitz, the Chair of Obstetrics and Gynecology at Tufts Medical Center, will present the background work leading to new venous thromboembolism prevention guidelines created by the National Partnership for Maternal Safety. Dr. Rich Smiley will subsequently address the challenges with employing neuraxial anesthesia in the setting of these expanded recommendations for anticoagulation. Dr. Walter Dzik, a widely published pathologist with expertise in transfusion medicine will present new concepts and challenges in managing obstetric hemorrhage. His talk will be paired with one from Dr. Roshan Fernando, the President of the Obstetric Anaesthetists Association (OAA) in the United Kingdom, addressing the use of point of care coagulation testing in guiding hemorrhage management. Dr. Alicia Dennis from University of Melbourne in Australia and early proponent of the use of transthoracic echocardiography in obstetric management will present applications of this technology in our practice followed immediately by Dr. Feroze Mahmood from Beth Israel Deaconess Medical Center describing best practices in teaching the transthoracic echocardiography skills to practicing anesthesiologists. On Sunday morning Dr. Jill Mhyre will lead a panel comprised of Drs. Scott Segal and Barbara Scavone debating the value of several proposed quality measures for obstetric anesthesia. We will then focus on one of the rising causes of maternal mortality, maternal sepsis, with an overview of management by Dr. Nuala Lucas from the OAA. Dr. Andrea Ciaranello, an infectious disease specialist at Massachusetts General Hospital will then discuss advances in treatment in sepsis. Dr. Katie Arendt will close out the plenary sessions by leading a Best Practices Panel consisting of Drs. Robert D’Angelo, Brendan Carvalho and Roshan Fernando.

We will present two pre-meeting workshops and one symposium on Wednesday May 18th. Because of the demand from the previous years, we will be once again offering ultrasound and echocardiography workshops run by Drs. Jose Carvalho and Laurie Chalifoux. Drs. Vilma Ortiz and Mauricio Vasco will be conducting a Spanish language pre-meeting symposium on Wednesday afternoon which will cover a range of provocative topics presented by an international faculty. These lectures will be translated into English. And I would like to remind you that the lectures during the plenary sessions will be translated into Spanish for all four days of the meeting. Dr. May Pian-Smith has organized a debriefing workshop on Friday afternoon May 20th to be held at the Boston Center for Medical Simulation. If you have an interest in introducing more simulation into your practice, I would encourage you to enroll in this course led by a team of thought leaders in the simulation community.

In our attempt to bring more innovative educational practices to SOAP, I would like to highlight our electronic poster presentations, abstract blog discussions, and twitter feeds. This is the first meeting featuring all posters being presented on electronic screens thus eliminating the need to transport
continued from previous page

physical posters from your home institutions. As always, the highest scored scientific abstracts will be highlighted in four oral presentation sessions and the remainder will be featured as poster presentations. For these abstracts, forty small group scientific and case report poster discussions will be moderated by our faculty with a goal of enhancing the opportunity for authors to showcase their work. We will also be experimenting with online blog discussions for the highest scored posters. The goal for this venue will be to extend the discussions around some of our work to both precede and follow the meeting itself. We expect that 100 posters will be available to be viewed online in the two weeks preceding the meeting and continued until the end of June. We hope this will encourage an electronic dialogue between authors and interested viewers outside the time constraints of the meeting itself. We will also be using a twitter feed to advertise certain aspects of the scientific and social programs over the course of our five days in Boston. I’m looking forward to seeing all of you at the annual meeting!
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
</table>
| 4:00 p.m. - 5:00 p.m. | New ACOG Thromboprophylaxis Guidelines*  
*Speaker: Errol Norwitz, M.D., Ph.D. |
| 6:00 p.m. - 8:00 p.m. | Fellows’ Reception (By Invitation)                                                          |

**Friday, May 20, 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00 a.m. - 1:15 p.m.</td>
<td>Registration Hours</td>
</tr>
<tr>
<td>7:00 a.m. - 8:00 a.m.</td>
<td>5K Fun Run/Walk</td>
</tr>
<tr>
<td>6:00 a.m. - 8:00 a.m.</td>
<td>Continental Breakfast &amp; View Posters - Exhibits Open</td>
</tr>
</tbody>
</table>
| 7:55 a.m. - 8:00 a.m. | Opening Remarks  
*John T. Sullivan, M.D., M.B.A.; Philip E. Hess, M.D.; Manuel C. Vallejo, Jr., M.D., D.M.D.* |
| 8:00 a.m. - 9:30 a.m. | Best Paper Session  
*Moderator: David H. Chestnut, M.D.*                                                      |
| 9:30 a.m. - 10:30 a.m. | Gertie Marx/FAER Education Lecture*  
*Introduction: Richard M. Smiley, M.D., Ph.D.*  
*Speaker: Mary E. D'Alton, M.D.* |
| 10:30 a.m. - 11:15 a.m. | Coffee Break, Exhibits & Poster Viewing                                                    |

**Saturday, May 21, 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00 a.m. - 5:00 p.m.</td>
<td>Registration Hours</td>
</tr>
<tr>
<td>6:00 a.m. - 8:00 a.m.</td>
<td>Continental Breakfast &amp; View Posters - Exhibits Open</td>
</tr>
</tbody>
</table>
| 7:55 a.m. - 8:00 a.m. | Opening Remarks  
*John T. Sullivan, M.D., M.B.A.; Philip E. Hess, M.D.; Manuel C. Vallejo, Jr., M.D., D.M.D.* |
| 8:00 a.m. - 9:00 a.m. | Oral Presentations 2  
*Moderator: Erica N. Grant, M.D., M.Sc.*                                                    |
3:00 p.m. - 4:00 p.m.
Blood Management in Obstetrics*
Speaker: Walter H. Dzik, M.D.
Point of Care Coagulation Testing*
Speaker: Roshan Fernando, M.B., Ch.B.
4:00 p.m. - 5:00 p.m.
Research Hour - Of Bacteria and Babies: Determinants and Impact of Infant Gut Microbiota
Moderator: Richard M. Smiley, M.D., Ph.D.
Speaker: Caroline Mitchell, M.D., M.P.H.
6:00 p.m. - 10:00 p.m.
SOAP Awards Banquet

6:00 p.m. - 12:00 p.m.
Registration Hours
6:30 a.m. - 8:00 a.m.
Continental Breakfast
7:55 a.m. - 8:00 a.m.
Opening Remarks
John T. Sullivan, M.D., M.B.A.; Philip E. Hess, M.D.; Manuel C. Vallejo, Jr., M.D., D.M.D.
8:00 a.m. - 9:00 a.m.
Panel: Obstetric Anesthesia Quality Measures
Moderator: Jill M. Mhyre, M.D.
Panelists: Jill M. Mhyre, M.D.; Barbara M. Scavone, M.D.; B. Scott Segal, M.D., M.S.
9:00 a.m. - 10:00 a.m.
Sepsis in the Parturient *
Speaker: Nuala Lucas, M.D.
Advances in Sepsis Treatment *
Speaker: Andrea L. Ciaranello, M.D.
10:00 a.m. - 11:00 a.m.
Best Practice Panel - Case Report Review with the Experts*
Moderator: Katherine W. Arendt, M.D.
Panelists: Katherine W. Arendt, M.D.; Brendan Carvalho, M.B.B.Ch., F.R.C.A., M.D.C.H.; Robert D'Angelo, M.D.; Roshan Fernando, M.B., Ch.B.
11:00 a.m. - 12:00 p.m.
Poster Session 4
12:00 p.m.
Adjournment
* Translated into Spanish
The Society’s Bylaws require prior notification of the membership before any proposed Bylaws changes can be considered at our annual Business Meeting. Here follow amendments that were considered and approved by the Board of Directors, and which will be voted upon by the membership in Boston. New language appears in boldface, deleted language is struck through.

1. Prior service as President
In the interests of insuring that the more junior members of the Society will have the opportunity to serve in leadership positions, the Board supports the following amendment.

9.1.7-No Past President of the Society shall be eligible to run for Second Vice President.

2. Selection of Meeting Site and Meeting Host
The following proposed changes are designed to separate the selection of the Annual Meeting site from the selection of a meeting host. For the first time, provisions are made for an electronic vote prior to the Business Meeting.

11. THE ANNUAL MEETING
11.1 The Annual Meeting Site and the Annual Meeting Host will be chosen in two separate stages.

11.1.1 Meeting locations are chosen three years in advance.

11.1.2 Any SOAP member may propose a meeting location.

11.1.3 Proposals must be submitted by October 1st, so that SOAP management and the Board of Directors can properly evaluate the proposed sites.

11.1.4 A maximum of the two best proposals judged to be acceptable by the Board of Directors in consultation with management will be presented to the membership via e-mail by January 1.

11.1.5 Votes will be cast electronically and accepted until midnight January 15.

11.1.6 The meeting site will be chosen by majority vote of active SOAP members.

11.1.7 The results of the election will be distributed electronically to all members of SOAP via e-mail and posted to the SOAP website as soon as the vote count is complete.

11.2 Meeting Host
11.2.1 Upon announcement of the winning meeting site, nominations for meeting host will be accepted until February 15.

11.2.2 At the earliest opportunity after closure of nominations, the names of the nominees for meeting host will be distributed to the membership via e-mail and posted to the SOAP website.

11.2.3 Nominees for meeting host will be accepted from the floor at the Business Meeting.

11.2.4 The Meeting Host will be chosen by majority vote of active SOAP members present at the Business Meeting. (See footnote #2)

11.3 The Annual Business Meeting of the SOCIETY shall take place during the Annual Meeting.

11.4 Notice of the time and place of the Annual Meeting of the SOCIETY shall be distributed to the members of the SOCIETY.

11.5 Parliamentary and Procedural Authority
The official parliamentary authority of this Society shall be the latest edition of the American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

Footnote #2: If three or more candidates are nominated for a single position, the winner will be chosen in a single “instant runoff vote”, which shall be conducted as follows: voting members present and voting at the Annual Business Meeting of the SOCIETY will be allowed to vote for a maximum of three candidates for any one elected position. These votes will be ranked in order of preference as #1, #2, and #3. If no candidate receives a majority of #1 votes cast, the candidate with the fewest #1 votes is eliminated and those voters’ #2 votes are distributed among the remaining candidates and the total votes are recounted. The process continues until one candidate gets a majority of the votes.

Report from the Bylaws Committee:
Proposed Amendments to SOAP Bylaws
David J. Wlody, MD
State University of New York-Downstate Medical Center
Brooklyn, NY
I am pleased to present this Treasurer’s report for our society, reflecting our financial status as of the end of 2015. While our performance last year did not match the banner years of 2013 and 2014, we nonetheless recorded a small positive margin (profit) for the year despite some significant challenges.

SOAP’s revenue comes principally from three sources: annual dues, Sol Shnider meeting registration fees, and Annual Meeting fees. By far our largest line item is the Annual meeting. As shown in Figure 1, our Colorado Springs meeting showed a significant positive margin of approximately $75,000. This is better than average, though not as robust as the last two years, where we enjoyed especially profitable meetings. The meeting, however, did not reach budgeted revenue, due largely to significantly lower attendance than expected. Excellent expense management kept expenses within budget, but the meeting did not quite generate the profit that had been expected.

Many SOAP annual meeting attendees who have allowed their memberships to lapse often re-join in anticipation of the meeting. Perhaps because attendance was down, annual dues revenue also was less than budget by approximately $27,000.

The Sol Shnider meeting had another successful year financially. Though income was also less than budget, so were expenses, and the meeting produced an historically average margin of approximately $35,000. Figure 2 shows the Shnider meeting performance over the last several years.

Overall, the society finished the year nearly break-even, with an overall margin of approximately $5000. This compares to the unusually profitable years of 2013 and 2014, when the society earned over $150,000 per year (Figure 3). SOAP’s assets are now recorded in two separate accounting systems, one for the endowment funds, and one for our operating accounts. As of the end of January 2016, the Society had $2,016,394 in endowment assets and $1,165,762 in operating fund assets. These totals are slightly increased from our results as of last fall, despite the market volatility the country has experienced. Simultaneously, grant funding has significantly increased, a new East Coast meeting has been launched and will premier this fall, and we have added new member benefits such as the subscription to Obstetric Anesthesia Digest. Thus, while we did not perform at the level of the last few years, we nonetheless continue to enjoy a strong financial status as a Society.
In an emergency, what treatment is given by ear? Words of Comfort.
--Abraham Verghese

Patient satisfaction is a key element in patient centered care that has been associated with improved health outcomes.1, 2 Empathy is one important factor that influences patient satisfaction and leads to better health.3, 4 The importance of the patient-caregiver experience has been increasingly recognized by the Center for Medicare and Medicaid Services, as reflected by the increasing quality metrics in this domain for payment to hospitals.5 Obstetric anesthesiologists are uniquely situated to enhance the patient experience and attenuate the negative ramifications that a traumatic childbirth has on maternal outcomes, and to teach the next generation of anesthesiologists empathetic communication skills.

Empathy: Not Just an Emotional Construct

The word “empathy” is derived from the Greek pathos, meaning “feeling into.” Healthcare professionals tend to view empathy as a purely emotional endeavor; others argue empathy leads to loss of clinical objectivity in the patient-clinician interaction. While empathy certainly contains an emotional component, it is a multidimensional construct that encompasses moral, cognitive, and behavioral facets (Table).6 Clinical empathy is, therefore, a competency in professionalism that can be developed, rather than a subjective emotional experience or an intrinsic personality trait.7

“Therapeutic” Empathy and Health Outcomes

The concept of a therapeutic alliance with patients has historically been leveraged in the areas of psychiatry and nursing, with positive results in such things as addiction and behavior modification.6, 8, 9 More recently, studies in the primary care population demonstrate that enhancing physician communication skills through training has been associated with positive effects on health outcomes including emotional health, cold symptom resolution, functional health status, smoking cessation, weight loss, blood pressure and glucose control, and pain control.10-12 The ability to specifically convey empathy improves health outcomes such as glucose control and weight loss.10, 11, 12 Improving these outcomes are critical to hospital payments in the CMS primary care domains “preventive health” and “at risk population.”13 Not only does empathetic communication affect positive clinical outcomes, it also reduces costs associated with the overuse of diagnostic testing.14 Improving communication, specifically empathetic communication, is clearly an important tool for physicians to improve health and the reportable quality measures for hospital systems.

<table>
<thead>
<tr>
<th>Component</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotive</td>
<td>The ability to subjectively experience and share in another’s psychological state or intrinsic feelings</td>
</tr>
<tr>
<td>Moral</td>
<td>An internal altruistic force that motivates the practice of empathy</td>
</tr>
<tr>
<td>Cognitive</td>
<td>The intellectual ability to identify and understand another person’s feelings and perspective from an objective stance</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Communicative response to convey understanding of another’s perspective</td>
</tr>
</tbody>
</table>

Table. Morse’s Components of Empathy6
The link between communication and empathy has been studied extensively in the primary care setting, but some evidence exists that perioperative outcomes are similarly affected. In certain cases of cesarean delivery, emotional distress, or worse, can result when patients perceive a lack of support from healthcare providers.\(^{15, 16}\) Interestingly, higher patient satisfaction scores with prenatal care providers are associated with lower cesarean delivery rates, which is consistent with known risks for cesarean delivery, including childbirth-specific anxiety and patient anxiety disorder.\(^{17}\) Inadequately addressed emotional status has been known to exert negative effects on perioperative outcomes including cardiac morbidity and mortality, postoperative pain, and hospital length of stay; conversely, adequately addressing preoperative anxiety improves outcomes such as surgical site infections.\(^{18-21}\) It is unclear whether these perioperative benefits can result from the brief but intense clinical encounters between anesthesiologists and patients in the surgical setting, but evidence from the palliative care literature suggests that even short displays of empathy have positive benefits.\(^{22}\) Research is needed to study empathy in the perioperative setting to assess its potential effect on surgical quality metrics.

**Can Empathy Be Taught?**

Despite the myriad benefits that empathetic communication is shown to have on patient outcomes, preliminary work demonstrates that anesthesiology residents perceive communication and empathetic care to be less important than other medical tasks in operating room situations.\(^{23}\) This perception exists despite the fact that the core competencies are not ranked by importance, and that the Accreditation Council for Graduate Medical Education (ACGME) requires: “Patient Care that is compassionate, appropriate, and effective” and “Interpersonal communication skills that result in effective information exchange in teaming with patients, their families, and other health professionals.”\(^{24, 25}\) Therefore, the modern anesthesiology educator is challenged to engage anesthesiology residents in learning communication skills during clinical practice, in the context of learner perceptions that these skills may not be as critical as others.

There is an expectation that through time and clinical experience alone, physicians’ levels of empathy should increase, but in fact the data support the opposite: empathy declines throughout medical training (Figure).\(^{26, 27}\) Empathy training is effective in improving empathy among trainees,\(^{28, 29}\) and there is a critical need to develop more training programs and to incorporate them into anesthesiology residencies to improve these competencies.\(^{30}\) The “NURSE” approach\(^ {11}\) is one effective way to teach empathetic communication skills to physicians (Table). This approach can be adapted to match the fast-paced clinical environment in which anesthesiologists practice, as even short encounters of empathy can have a positive impact.\(^ {22}\) Communication skills, like technical skills, require time and practice to achieve proficiency.

**Table. Clinician Empathetic Behavior Guide: NURSE Acronym\(^ {11}\)**

<table>
<thead>
<tr>
<th>Element</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>State patient emotion</td>
<td>“I wonder if you are feeling worried right now about what is going on.”</td>
</tr>
<tr>
<td>Understand</td>
<td>Empathizing with and legitimizing patient emotion</td>
<td>“I can’t imagine how scary this must be for you.”</td>
</tr>
<tr>
<td>Respect</td>
<td>Praise patient for strength</td>
<td>“You’ve done a great job at keeping everything in perspective.”</td>
</tr>
<tr>
<td>Support</td>
<td>Show support</td>
<td>“I will be with you until the end.”</td>
</tr>
<tr>
<td>Explore</td>
<td>Ask patient to elaborate on emotion</td>
<td>“Tell me more about what is upsetting you.”</td>
</tr>
</tbody>
</table>

**Abbreviation: NURSE, Name, Understand, Respect, Support, and Explore.**

**Mutually Beneficial**

Evidence that empathy declines with time spent in training, stands in concert with data on resident burnout; anesthesiology residents have high risk for burnout (41%) and depression (22%), and these findings are associated with adverse risks to patient care and safety.\(^ {32}\) Physicians, however, may not be aware that empathetic encounters are mutually beneficial; those who have higher empathy scores have lower burnout, report higher senses of well-being, have lower rates of malpractice suits filed against them, and report improved satisfaction with their job.\(^ {33, 35}\) Functional magnetic resonance imaging studies have demonstrated that, during empathetic interactions between patients and physicians, there are synchronous patterns of autonomic activation in the ventromedial prefrontal cortex that lead to an intense feeling of “sharing.”\(^ {36}\) Therefore, not only is the demonstration of empathetic communication skills an altruistic endeavor, but clinicians also stand to benefit from using these skills on a regular basis. Ongoing work at Northwestern University and the University of Pittsburgh is formally investigating this postulated relationship.

**The Anesthesiologist’s Contribution**

When an anesthesiologist exhibits empathy during a preoperative visit, this improves patients’ perception of anesthesiologist attitude, and improves perception of the quality of information exchanged.\(^ {37}\) Many individuals who choose to train in anesthesiology may be attracted to the short, intense, but meaningful relationships that are formed with patients and their families during some of the most important moments in their lives. The practice of obstetric anesthesia embodies social situations in which communication challenges are amplified. Frequently the task of empathetic communication falls upon the anesthesia team members, given our physical proximity to the patient’s face. In the clinical setting, empathy involves the ability
to: 1) understand a patients’ perspective about a particular situation; 2) communicate and verify this understanding with the patient; and 3) act on this understanding in a therapeutic fashion. Anesthesiologists’ ability to teach and practice these skills on a daily basis are key components in the promotion of patient health, in quality care delivery, and in maintaining professional satisfaction.

**References:**


**Figure.** Empathy declines as time spent in medical training increases.

**Education Committee continued on previous page**

**References continued:**

24. ACGME Prigram Requirements for Graduate Medical Educatoin in Anesthesiology. 2014.
30. Bauchat J, Anderson L, Santos J, Park C. Simulation Curriculum for Anesthesiology Residents Improves Empathy as Measured by...
Guidelines for eating and drinking during labor and delivery remains an ongoing debate among anesthesiologists, midwives, obstetricians and labor and delivery nurses. As such, it remains an area of active research and conversation on both the local and national levels. The following summary reflects the opinions and practices of members of the SOAP Patient Safety Committee regarding NPO status and dietary restrictions for patients on labor and delivery.

Strict NPO policies for parturients were originally instituted because of concerns for pulmonary aspiration as described by Mendelson in 1946. However, anesthesia practice has changed significantly since that time with the routine use of endotracheal tubes for general anesthesia (1950s), the introduction of succinylcholine (1951), and rapid sequence induction/intubation (1970). Perhaps most importantly, the use of regional anesthesia for the obstetric patient has increased dramatically over the past 70 years, thus decreasing the need for general anesthetics in this patient population.

Advocates of allowing parturients to eat and drink during labor correctly quote that oral caloric supplementation should decrease the development of ketoacidosis and the catabolic state associated with fasting. Enhanced recovery protocols in colorectal surgery have investigated the use of a preoperative carbohydrate rich drink to reduce postoperative insulin resistance, improve postoperative bowel function, and reduce hospital length of stay. Such benefits would likely be translatable to the obstetric population. Liberalized oral intake may also allow for a reduction in intravenous fluid administration, much of which becomes extravascular. Lastly, allowing oral intake may reduce thirst and improve patient satisfaction.

Oral intake also usually stimulates gastric emptying and decreases the amount volume and acidity of the stomach. Patients who were allowed clear fluids until 2 hours prior to surgery had smaller stomach volumes and higher gastric pH when compared to patients who were allowed clear fluids until 4 hours preoperatively. Pregnant patients presenting for cesarean delivery also can be expected to have increased gastric volume as seen on ultrasound compared to non-pregnant patients. Protein-rich drinks have also been evaluated. Authors found no increase in the incidence of nausea/vomiting or the rate of gastric emptying in parturients consuming protein drinks compared to those limited to ice chips. Conversely, when it comes to eating solid food, studies have shown increased gastric volume at the time of delivery in patients allowed to eat a light diet. In theory, a higher gastric volume would increase the risk of maternal aspiration. However, a recent Cochrane analysis was unable to assess the incidence of Mendelson’s syndrome in pregnant patients as it is such a rare outcome.

While prolonged fasting has never been proven to prevent pulmonary aspiration, best practice in the general surgery population requires following ASA guidelines regarding NPO status for elective surgery. The ASA also maintains guidelines for nutrition in obstetric patients and both the ASA and ACOG recommend that parturients undergoing elective, scheduled cesarean delivery or postpartum tubal ligation adhere to a fasting period of 6-8 hours for solid foods. Similarly, the two organizations agree that patients may continue to consume modest amounts of clear liquids until 2 hours before an elective procedure. However, the consensus remains that during labor although clear liquids are permitted and even encouraged for uncomplicated patients, solid foods should be avoided given that the need for emergency cesarean delivery can occur at any time. The ASA/ACOG stance varies from that of the National Institute of Clinical Excellence (NICE) and the World Health Organization who agree that uncomplicated laboring parturients should be offered a light meal. The Cochrane review on this subject examined trials where women were allowed to eat and drink compared to women with restricted intake. The analysis did not find any statistically significant differences between the groups in rate of cesarean delivery, operative vaginal delivery, APGAR score less than 7 at 5 minutes or any other outcome assessed. All of the above mentioned groups including
the Cochrane authors acknowledge that there is insufficient data to evaluate the effect of dietary restrictions in patients at high risk for complications and thus any liberalization can not be extended to that population.

Members of the Patient Safety Committee who contributed to this article have similar practices in terms of NPO guidelines and dietary restrictions for laboring patients and those presenting for obstetric procedures (Table 1). At MGH uncomplicated patients presenting for induction of labor are permitted to eat food prior to arrival at the hospital and are subsequently restricted to clear liquids only, while at the University of Colorado (CU) some uncomplicated patients who elect an unmedicated delivery continue to eat light meals during latent labor. Any patient requesting an epidural at CU may have only clear liquids. The University of Arkansas (UA) encourages water but does provide alternative clear liquids. Specific clear liquids permitted during labor at contributing institutions include water, pulpless juices (no citrus juices, gum, or candy), carbonated beverages, popsicles (non-particulate, non-dairy), jello, clear tea (no milk), and black coffee (no milk). Further restrictions from the basic “clear liquid diet” are made on a case-by-case basis depending on maternal high-risk co-morbidities or fetal status indicating high risk for cesarean delivery. The adoption of clear liquids during labor was a recent change at both Stony Brook and UA and have been well received by patients and staff.

While there is consensus from ASA and ACOG regarding the benefit of permitting clear liquids for low risk laboring parturients and limiting intake of solid food in laboring patients, this is not a worldwide opinion. Institutions should prepare guidelines for both NPO status for obstetric procedures such as cesarean delivery, cerclage and postpartum tubal ligation and develop specific instructions for dietary intake for laboring patients. In addition, while the risk of aspiration is extraordinarily low, it is not zero, and patients at increased risk for this complication may require modifications to more general recommendations regarding diet and NPO status.

### Table 1

<table>
<thead>
<tr>
<th>NPO requirement (Hours) for the following?</th>
<th>Stony Brook</th>
<th>Massachusetts General Hospital</th>
<th>University of Colorado</th>
<th>University of Arkansas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scheduled, elective cesarean delivery</strong></td>
<td>8 hr for solids, 2 hours for clears</td>
<td>2 hours for small amounts of clear liquids (up to 12 oz), 6 hours for solid food with minimal fat content (i.e., plain toast or a piece of fruit), 8 hours all other solid food</td>
<td>8 hr solids, 2 hrs clears</td>
<td>8 hrs for solids, 2 hrs for clears</td>
</tr>
<tr>
<td><strong>Post-partum tubal ligation</strong></td>
<td>8 hr for solids, 2 hours for clears, BTL usually performed next day after delivery</td>
<td>Same as for elective cesarean</td>
<td>Varies, usually done post-partum as soon as possible, but if next day then same as elective cesarean</td>
<td></td>
</tr>
<tr>
<td><strong>Cerclage</strong></td>
<td>8 hr for solids, 2 hours for clears</td>
<td>Same as for elective cesarean</td>
<td>Same as for elective cesarean</td>
<td>Same as for elective cesarean</td>
</tr>
<tr>
<td><strong>Non-urgent, non-scheduled c/d</strong></td>
<td>8 hr for solids, 2 hours for clears</td>
<td>Same as for elective cesarean</td>
<td>Same as for elective cesarean</td>
<td>Same as for elective cesarean</td>
</tr>
<tr>
<td><strong>Placement of labor epidural</strong></td>
<td>None</td>
<td>Clears</td>
<td>None</td>
<td>Clears</td>
</tr>
<tr>
<td><strong>TOLAC (Diet requirement/ restriction?)</strong></td>
<td>Clears allowed</td>
<td>Clears</td>
<td>None</td>
<td>Clears</td>
</tr>
<tr>
<td><strong>Labor with neuraxial analgesia (Diet requirement/ restriction?)</strong></td>
<td>Clears allowed</td>
<td>Clears</td>
<td>Clears</td>
<td>Clears</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How long do you wait after each of the following for a SCHEDULED or NON-urgent procedure?</th>
<th>Abola</th>
<th>Pian-Smith</th>
<th>Kacmar</th>
<th>Mhyre</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clear liquids</strong></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>NON-clear liquids</strong></td>
<td>6</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td><strong>Gum/ hard candy</strong></td>
<td>2</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
The Resident Affairs Committee

Nicole Higgins, MD  
Northwestern University – Feinberg School of Medicine  
Chicago, IL

The Resident Affairs Committee would like to thank resident co-presidents Katie Seligman and Ali Ebrahimi for their service and contributions this past year. Dr. Seligman is finishing her OB anesthesia fellowship at Stanford University Medical Center and Dr. Ebrahimi is completing his fellowship in pain management at Northwestern University Feinberg School of Medicine. We are looking forward to welcoming the new resident president, Cesar Padilla, who is completing his residency at Cedars-Sinai Medical Center and will pursue an OB anesthesia fellowship. The Resident Affairs Committee continues to be committed to raising awareness of obstetric anesthesiology among anesthesia residents and we are working closely with the membership committee to recruit and retain residents in SOAP. If there are any interested residents in joining the Resident Affairs Committee and/or running for a leadership position on the committee, they are encouraged to join us for our committee meeting at the SOAP annual meeting.

Education Committee continued from previous page

the Jefferson Scale of Physician Empathy. International Meeting of Simulation in Healthcare; 2016; San Diego, CA.
References:

5. ASA Committee Practice guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures: an updated report by the American Society of Anesthesiologists Committee on Standards and Practice Parameters. Anesthesiology. 2011; 114(3): 495-511.

Announcements

Board Nominations

SOAP is calling for nominations for the elected positions of 2nd Vice President and Secretary. Interested members should send a short statement and picture to jenni@soap.org for posting to the SOAP website.

If you have any questions, please do not hesitate to contact SOAP headquarters at (414) 389-8611.
2015-2016 SOAP Board of Directors

President
Manuel C. Vallejo Jr., MD, DMD

Immediate Past President
Robert R. Gaiser, MD

2015 Host
Brenda A. Bucklin, MD

President-Elect
John T. Sullivan, MD, MBA

ASA Delegate
Paloma Toledo, MD, MPH

2016 Host
Philip E. Hess, MD

1st Vice President
Brendan Carvalho, MBBCh, FRCA, MDCH

ASA Alternate Delegate
Katherine W. Arendt, MD

2017 Host
Alexander Butwick, MBBS, FRCA, MS

2nd Vice President
Mark I. Zakowski, MD

Director at Large
Ruth Landau, MD

Journal Liaison
Jill M. Mhyre, MD

Secretary
Lisa R. Leffert, MD

Chair, ASA Committee on OB Anesthesia
Edward A. Yaghmour, MD

Newsletter Editor
Heather C. Nixon, MD

Treasurer
Scott Segal, MD, MS

Chair, Educational Track Subcommittee on OB Anesthesia of the ASA
Robert R. Gaiser, MD