

CONTENTS:

PRESIDENT'S MESSAGE
pages 1-2

EDITOR'S CORNER
page 2

ANNUAL MEETING HOST UPDATE
pages 3

FELLOWSHIP COMMITTEE:
REAPING THE REWARDS OF AN
OBSTETRIC ANESTHESIOLOGY
FELLOWSHIP
page 4-6

SOAP LEGACY COMMITTEE:
PIONEER'S CORNER - OTTO C.
PHILLIPS, MD (1917-1981)
page 7

EDUCATION COMMITTEE:
UPDATE ON VENOUS
THROMBOEMBOLISM
PROPHYLAXIS
pages 8, 11

PATIENT SAFETY COMMITTEE:
SIMPLIFYING MOCA 2.0 PART 4 –
HOW TO CAPITALIZE ON SAFETY
AND QUALITY ACTIVITIES ON
LABOR AND DELIVERY
page 9-11

SOAP REFLECTIONS
page 11

ANNOUNCEMENTS
page 12

ENDOWMENT FUND
CONTRIBUTORS
page 13

President's Message: Time to Reassess Strategy

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The Society for Obstetric Anesthesia and Perinatology is approaching its fiftieth birthday. From the late 1960s, SOAP has grown from a group of six professionals with a common academic interest to a moderately-sized subspecialty society. Certainly our clinical practice has changed substantially in that time period but so has our organization's function. SOAP has grown from a small forum for sharing developments in subspecialty science to become an educator of a broad community of practitioners. We are increasingly looked to as a source for administrative support such as the dissemination of clinical protocols. SOAP is asked to provide endorsements for a wide variety of guidelines and statements from other societies. We now support research through some of our own grant processes. And SOAP has developed a more global presence in recent years and engages with many international societies. So as SOAP has grown from a small club in the 1960s to a major international voice in obstetric anesthesia, it becomes very clear that it is time to reformulate our strategic plan.

The SOAP Board of Directors last conducted a strategic planning session in 2008. Our execution of that plan has been generally good but there have been missed opportunities and redirected priorities in the interim. I think our successes in education include now running east and west coast obstetric anesthesia refresher courses, although our most recent addition in Washington DC likely would benefit from more marketing and reputation development. We've taken up only a limited space in the arena of on-line continuing medical education as perhaps was envisioned in 2008. SOAP makes a moderate amount of refresher course material free to the public with the goal of disseminating information and building the SOAP brand, but we have debated whether this represents the right balance between public service and benefit to the organization. In 2008, we felt that we did not have the resources to write clinical

guidelines and the board has shifted to some degree in that realm, particularly in response to changes in thromboembolic prophylaxis and struggles adapting guidelines not well-suited for obstetric practice.

I think we've met and perhaps exceeded our goals for fostering international relationships by conducting joint meetings with global partners. International meetings with a focus on obstetric anesthesia seem to be growing around the world with frequent SOAP participation; the World Congress of Anesthesia on Obstetrics this February in Bali, Indonesia serves as a prime example with several SOAP members on the faculty. Although I should point out that SOAP had set the aspirational goal of hosting a World Congress by 2015, which we clearly did not execute.

SOAP has successfully initiated several grant lines to support research but we still have not achieved the perhaps more important goal of establishing a multi-institutional research network. This remains a major priority for my remaining term as President. SOAP was successful in developing the SCORE project, a repository of serious complications related to our care, but we still have work to perform in further refining outcome metrics in our field. Our plan from 2008 was silent on goals for fellowship training, despite the foundational work that was being conducted at that time which has become our ACGME-approved training pathway.

So with all of the changes that have occurred in our practice and with our organization, the time seems ripe to reevaluate our mission, processes and governance. Thoughtful organizations invest substantial time to planning for the future. I hope that we will be able to set new aspirational goals for SOAP that will be impactful for our patients and the professional lives of members. After all, it is our practice and our mission that continue to inspire me and make me feel honored to be an obstetric anesthesiologist.

It has also become clear that we may have outgrown our process for selecting our annual meeting sites. Many of our members feel strongly about having a voice as to where we will spend an upcoming week of our professional and personal lives; I certainly include myself as one of those individuals. But we are also in the minority of subspecialty societies that proceed in this fashion. Attendance at our annual meeting fluctuates mostly due to location. Revenue from these meetings which supports our missions and growth is driven primarily by attendance and contractual costs. It is the complex cost part of this financial formula that is not evident to our members at the business meeting when voting on meeting site. In fact, a substantial amount of future society resources may be gained or lost by a charismatic meeting host and an effective pitch. It may be more thoughtful to approach this with a different process going forward if we really think this is in the best interest of our society. This idea, and other proposed changes that will result from a strategic planning process, will require bylaws changes voted on by the membership.

Editor's Corner

Heather C. Nixon, MD

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In this issue of the SOAP newsletter, our authors introduce us to new directions in obstetric anesthesiology. Dr. Sullivan provides us with a call to action to reevaluate our societal strategic goals including expanding our continuing medical education presence and redesigning our annual meeting selection process. Dr. Butwick provides us a teaser on this year's upcoming meeting which promises to be filled with educational opportunities, new technologies while giving attendees an chance to experience the local culture of Seattle. Please be sure to follow announcements and information for this meeting on Twitter by following @SOAPHQ (#SOAPAM2017). Our Fellowship Committee provides us a perspective for the future of our specialty in their compilation piece featuring several recent graduates of obstetric anesthesiology fellowships. This piece explores the

value of the fellowship and the career opportunities awaiting graduates. Drs. Elterman and Leffert provide us with an update on the changing obstetric venous thromboembolism prophylaxis practices and how obstetric anesthesiology providers can help to coordinate care of these patients.

We also take a look into our history. The Legacy Committee gives us a look into the past with a short tribute to Otto C. Phillips, a pioneer in our field. In a new section entitled "Member Reflection". Dr. Reynolds adds her own heart-felt sentiments about her experiences as a SOAP member.

Finally, the Patient Safety Committee provides us guidance on using MOCA requirements and how to use quality improvement projects in your practice or simulation centers to maintain your certification.

Annual Meeting Host Update

Alexander J. Butwick, MBBS, FRCA, MS

Stanford University School of Medicine

Stanford, CA



On behalf of our society, I am delighted to be your host for the 2017 SOAP Annual Meeting. The 2017 Annual Meeting takes place at the Hyatt Regency hotel in Bellevue, Washington State between May 10th and May 14th, 2017. Based in the heart of Seattle's Eastside, the Hyatt Regency provides an ideal venue for our main meeting as well as the workshops and poster presentations. The first-class AV facilities and comfortable surroundings provide a perfect environment for conference attendees and presenters. In addition, the hotel boasts modern guest rooms, a 7,000 square foot gym, excellent dining options, and a heated 25 meter lap pool. As the hotel is also located in the heart of the Bellevue district, you won't have to venture too far for fine dining, shopping, and entertainment. For those wishing to check out downtown Seattle, we will also be providing a shuttle service for accessing Seattle must-see sights, including: the Space Needle, Pike Place Market, the EMP

Museum, and ride on one of the Washington State Ferries. And of course, no trip to Seattle would be complete without a stop at one of the many excellent Washington State breweries or wineries located in the Seattle area.

We welcome attendees to join us for the Welcome Reception in the hotel on Wednesday, May 10th where you can catch up with friends and colleagues. We will also be hosting our SOAP Banquet on Friday, May 12th at the Bellevue Arts Museum. Because Seattleites pride themselves on the quality of the local cuisine, the dinner will showcase local vendors for a culinary night to remember. So this event should definitely not be missed!

I look forward to catching up with you all in Bellevue next May!

Kind Regards,
Alex

Save the Date

**SOAP 49TH
ANNUAL
MEETING**

**May 10-14, 2017
Hyatt Regency Bellevue
Bellevue, Washington**



Fellowship Committee: *Reaping the Rewards of an Obstetric Anesthesiology Fellowship*

Holly Ende, MD

*Vanderbilt University Medical Center
Nashville, TN*

Elizabeth Ellinas, MD

*Medical College of Wisconsin
Milwaukee, WI*



A resident's decision to enter a fellowship can be difficult. After so many years of training and sacrifice – both physical and financial – residency graduates are rightfully eager to enter the job market. If they complete a fellowship, will the benefits of subspecialty skills gained, and potential increased competitiveness in the job market, balance the additional year of lower-wage training? According to the Accreditation Council for Graduate Medical Education (ACGME) database, the percentage of graduates completing fellowships has steadily increased from 9.6% in 2003 to 26.2% in 2007, and it continues to rise.¹ With increased competition of fellowship trained job seekers entering the workforce, the choice of subspecialty becomes a crucial decision. While residents should ultimately choose an area that piques their clinical and intellectual interest, there is also merit in choosing a fellowship that will produce a secure job in a rapidly changing medical job market.

Obstetric (OB) fellowship trained anesthesiologists are in high demand, and the available pool is small. Obstetric anesthesiology became an ACGME-accredited fellowship as of 2012, with approximately 70 graduates entering the workforce nationally each year (*data from SOAP*). Furthermore, with the increasing age and severity of comorbidities in the pregnant population, prominent professional societies such as the American Congress of Obstetricians and Gynecologists (ACOG) have recommended that anesthesiologists with special training or experience in obstetrics be available at any center providing care beyond basic uncomplicated deliveries.² Thus while the supply of obstetric anesthesiologists remains low, the demand for such training will continue to rise over the coming years. Residents should be aware of these favorable market forces and the opportunities for rapid career advancement within the field of Obstetric anesthesiology.

The authors collected several recent graduating fellows' personal insights into the advantages of an OB anesthesiology fellowship that are not frequently discussed with residents. While the stories are unique, each demonstrates common themes – the ability to provide superior clinical care to parturients with complex comorbidities as well as extensive career opportunities in a rapidly growing field.

Jennifer Gerber, MD

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Obstetric Fellowship: Cedars
Sinai, 2015-2016*



In beginning my job search during fellowship, my goal was to find a position that had at least 50% obstetric (OB) time,

but also allowed me to practice general anesthesia in a broad range of cases, so that I would not lose skills over time. I looked at both private and academic practices, but ultimately chose the job that not only gave me exactly the case range that I wanted but flexibility and leadership potential. I received multiple offers from multiple states, all of which had a growing OB anesthesia department and desired an OB anesthesiology fellowship trained graduate. Ultimately, I chose a position starting a new labor and delivery coverage unit for a private practice group that covers the majority of the deliveries in Portland outside of Oregon Health and Science University (OHSU) campus. The OB anesthesia services had previously been covered by a group of Certified Registered Nurse Anesthetists (CRNAs). In this new position, over half of my time will be spent doing OB anesthesia and helping set protocols and standards with that new coverage. I will also have the opportunity to do a broad range of general cases as well – including gynecology, pediatrics, cath lab, neurosurgery, and regional anesthesia.

I gained a great deal from completing my OB anesthesia fellowship, most importantly leadership skills from managing and coordinating care for difficult cases and communicating with different members of the care team. I think the most helpful things were being exposed to many interdepartmental meetings and introduced to how difficult cases or new projects should be collaborated.

In terms of future directions of the fellowship, I feel that there will be a greater need for obstetric critical care. Currently, when a woman requires critical care in the ante- or postpartum period, it is difficult to place them in an appropriate intensive care unit, as many critical care physicians are not comfortable

Fellowship Committee continues on next page

dealing with the physiological changes or pathological conditions that can occur peripartum. Obstetric fellowship training may one day fill this void of physicians capable of bridging obstetrics and critical care.

Linda Demma, MD, PhD
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Obstetric Fellowship: Emory, 2015-2016

Upon completion of my obstetric (OB) anesthesia fellowship, I was unsure whether I wanted to pursue a career in private practice or academic medicine. Having previously completed a PhD and worked as a researcher and molecular biologist, I considered myself strong in that aspect of medicine. However, being later in life than most at fellowship completion, having no savings for retirement, and having a family to look after, my goal was to prioritize lifestyle and geographic location. I applied to only two positions, one academic and the other my current position, and withdrew my second application once accepting this job. I am currently at a hospital system affiliated with Columbia University, and a model for the hospital-based, bundled-payment system.

The starting salary was competitive, although growth potential will be limited. In addition, hours and call schedule are ideal for my young family. There are opportunities for research, but clinical requirements are emphasized and research and teaching are not incentivized.

During the job application process, my OB anesthesia skills were highly desirable. The hospital's current model includes CRNAs administering the majority of labor epidurals, with no OB anesthesia expert on staff. My arrival was timely, as one of the local hospitals was closing their labor and delivery unit, and thus our unit was expecting a 2-3 times increase in their current delivery rate. They were seeking an OB Anesthesia expert to deal with the increased volume of high-risk cases. I am now the primary contact for OB Anesthesia and provide all high-risk consult services. Completing an OB anesthesia fellowship prepared me for this new role. During fellowship, I cared for extremely complicated parturients, saw a much wider variety of obstetric pathology than can be seen in residency alone, and learned skills of importance in evaluating and caring for pregnant patients with severe comorbidities.

I feel that OB Anesthesia training is currently under-valued, as some anesthesia providers feel that you "don't need a fellowship to practice OB." But I have found that there is a remarkable difference between being able to practice OB anesthesia and to do it well. This makes a huge impact on the way you are perceived by patients and providers, and enables you to have so many more "tools in your pocket" to practice thorough, careful, effective anesthesia/analgesia of all types. Fellowship gave me the confidence to be a better clinician, to be a better consultant, and to provide valuable insight with respect to my role as primary OB Anesthesiologist.

Holly Ende, MD
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Obstetric Fellowship: Brigham and Women's Hospital,
2015-2016

In choosing whether or not to pursue a fellowship, I sought guidance from faculty and senior residents, completed as many subspecialty rotations as I could, and ultimately did what most of us type-A personalities do and made a pro and con list for each. Foremost, I decided on obstetric anesthesiology because I enjoyed the patients, the collaborative team atmosphere, and the variety produced by spending a portion of my clinical days on the labor floor. In addition to enjoying the field itself, OB anesthesia also offered abundant job prospects and opportunities for career advancement. Within a few weeks of beginning fellowship, I had received emails from two large academic departments and at least three smaller private practice groups located on the east coast and New England, specifically seeking obstetric fellowship-trained applicants. Many academic centers sighted conversion of their obstetric coverage model to a unit exclusively staffed by OB anesthesiologists – thus necessitating accelerated hiring within the division over the years to come. In other academic institutions, no obstetric anesthesia providers were yet fellowship trained, and so they sought fellowship graduates with interest in leadership, including positions as division chief, OB fellowship director, or OB resident rotation director. In my own job search, which was self-limited to large academic centers in the southeast due to family considerations, I applied to and interviewed with six departments and ultimately was able to pick the job which best suited my personal and professional goals. Being married to a physician who was also searching for his first job out of fellowship, the geographic freedom provided by being in a highly sought after specialty helped us to ultimately both find ideal jobs.

I am now only a few short months into my new position, yet I feel absolutely prepared for the clinical situations in which I daily find myself while working at a tertiary care, high volume labor and delivery unit. Learning to quickly manage peripartum maternal complications, the implications for safely delivering anesthetic care, communicating with multidisciplinary teams – these are what I see as the greatest benefits of my fellowship training. These are the qualities for which I was recruited, and which I will continue to utilize daily with my patients and colleagues.

Amy Ohen Mauritz, MD
Chief of Obstetric Anesthesia
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Obstetric Fellowship: Duke University Hospital, 2014-2015

Upon beginning my obstetric anesthesia fellowship, I was

unsure if I wanted to work in private practice or academics. My only requirements were to move back to my hometown to be near family and to find a position that involved some degree of OB anesthesia. Ultimately I applied to 3 positions and was offered employment at all three places! All of my job offerings were in women's hospitals or academic centers with an OB anesthesia division.

The position I chose was in a private practice community hospital whose leadership wanted me to eventually become Chief of Obstetric Anesthesia, and serve as a liaison between the anesthesia department and the hospital. It was a new position created because strong anesthesia leadership was needed in this women's hospital with over 4000 deliveries yearly. I am responsible for overseeing and instituting changes in anesthesia practice, including promoting evidence-based practice. Recently we updated our epidural delivery method to using patient-controlled epidural analgesia (PCEA) pumps. I've also spent the last year creating written policies and procedures to address anesthetic practices and complications such as management and follow up of patients with post-dural puncture headache. I am on several hospital committees, including pharmacy committee and the obstetric performance review committee. In addition I give obstetric anesthesia lectures to the obstetric residents and medical students.

During my obstetric anesthesia fellowship, I gained the leadership skills, communication skills, and training in quality measures necessary to succeed in my new position. I am expected to be a leader in my position as Chief of Obstetric Anesthesia. The quality improvement projects I completed as a fellow were invaluable as there were numerous opportunities for improvement in anesthesia practice at my new place of employment. My OB fellowship also gave me credibility in advising the Texas Perinatal Advisory Council regarding recommended anesthesia service availability in the different levels of maternal care designation for hospitals.

My fellowship certainly gave me a unique skill set that my current employer was actively seeking. I have been able to use my fellowship experience to foster a stronger working relationship between the anesthesia department and the obstetrics department at my institution. It has also helped me to assist my colleagues in striving for evidence-based practice in taking care of our obstetric patients. Overall, I feel that the greatest benefit of obstetric anesthesia training is that it positions graduates to be leaders in women's health care! In the future, even more intense leadership training may be required, as hospitals are expecting obstetric anesthesia fellowship trained graduates to be able to lead Obstetric anesthesia departments and divisions.

Cesar Padilla, M.D.

**Combined Obstetric-Critical Care Fellow, 2016-2018
Brigham and Women's Hospital
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I am currently completing a two-year dual fellowship, with one year of obstetric anesthesiology and an additional year of critical care training. Following graduation I plan to continue my career at an academic institution. Specifically, I hope to care for critically ill obstetric patients and help to incorporate critical care into the obstetric fellowship curriculum. Obstetric patients are becoming increasingly complex, and new ways of assessing patients such as, but not limited to, transthoracic echocardiography will soon become standard of care. Furthermore, the training of fellows will need to adapt to meet the demands of our changing patient demographic. I am very excited to be an advocate for critical care training in obstetric anesthesiology. In addition, having the chance to make a difference in our field through research, physician and patient education, and policy advocacy are some of the most important reasons why I am choosing a career in academic anesthesiology.

Obstetric anesthesiology is far from just performing epidurals and spinals. A multidisciplinary team approach, from early prenatal anesthesiology visits to early critical care intervention, is quickly emerging as standard of care, and our value in these teams is evidenced by ACOG's guidelines that specifically include OB fellowship-trained anesthesiologists in the care teams for all but the simplest patients. I believe that having this experience and training is crucial for caring for obstetric patients now and in the future. Childbirth is one of the most momentous events in a woman's life, and obstetric anesthesiologists have the privilege to offer the tools and skills to ensure maternal safety, comfort, and satisfaction.

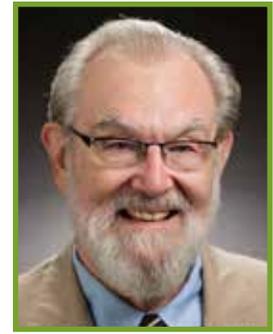
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SOAP Legacy Committee: *Pioneer's Corner - Otto C. Phillips, MD* (1917-1981)

Bradley E. Smith, MD

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Until about 1960, virtually the only voices speaking about the woeful state of anesthesia care in obstetrics were Hingson, Hershenson, Apgar, Bonica, Moya, Marx, and Otto C. Phillips. Otto became my friend and mentor, who I still miss 35 years after his death!



Beginning in 1957 Otto and associates began a series of eye opening surveys of the causes of obstetric anesthesia mortality. These reports revealed shocking mortality and morbidity from anesthesia care. He took these findings before committees of the AMA, the ASA, and the ACOG and got them to listen! He became the third anesthesiologist in history to be awarded an Honorary Fellowship in ACOG.

After WWII military service and anesthesia residency at Leahy Clinic, Otto returned to his native Baltimore, initially in the private practice of anesthesiology, later as Chief of Anesthesiology at the (then called) Baltimore City Hospital, and then, Head of Anesthesiology at Magee Women's Hospital in Pittsburgh. Finally in 1968 he became Chair of Anesthesiology at Western Pennsylvania Hospital in Pittsburgh. Eventually he was voted hospital Chief of Staff, and recipient of their "Golden Headed Cane" award to their physician who most exemplified the classic characteristics of physician, teacher, and investigator.

Otto became the third Chair of the ASA's (then called) Committee on Maternal Welfare (longer than any other person). Governmental agencies called him for consultation frequently, and he was a consultant to the NIH "Maternity and Infant Care" Projects during their formative and organizing period, beginning in 1966.

Most of his journal publications deal with obstetric anesthesia matters and public health. He is particularly remembered for his still quoted paper on neurologic complications following lidocaine intrathecal anesthesia for saddle block, and for introducing (along with R.L. Duerksen) the "Phillips Laryngoscope". He was an invited speaker at many universities and before many professional organizations and Continuing Medical (and Nursing) Education Seminars.

Otto was very encouraging and helpful to the formation of SOAP (see "Beginnings"; <https://soap.org/first-40-years.php>), but did not join the "Founders" in organizing SOAP only because he was too busy as President of the Pennsylvania Society of

Anesthesiologists at that exact juncture. However, he returned to full participation in 1969, was a "Charter Member" of SOAP and attended most SOAP annual meetings until near his death.

Until his terminal illness he kept himself surprisingly fit. I well remember one night at the Denver SOAP meeting, at over 5,000 feet, a "jock" young man challenged Otto to a push-ups contest! As I remember it, Otto won easily at something around 30 pushups. He was a wonderfully skilled jazz pianist and jazz composer, but never played unless sincerely coaxed. (As I write this I have turned on a DVD of Otto playing one of his many compositions.)

Tragically, he acquired viral cardiomyopathy in the O.R. and suffered a prolonged decline from inadequate heart action at a time before heart transplants were commonplace.

Otto truly was one of those proverbial "giants" upon whose shoulders SOAP stands!

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Education Committee: *Update on Venous Thromboembolism Prophylaxis*

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Venous thromboembolism (VTE) is a well-known cause of morbidity and mortality among obstetric patients. While rates have declined in recent years,¹ VTE remains a leading cause of peri-partum complications, occurring in approximately 1-2 per thousand pregnancies.² Interestingly, while rates of cause-specific mortality for hypertensive disease of pregnancy and post-partum hemorrhage have decreased, cause-specific mortality for VTE has increased.² Importantly, thromboprophylaxis is the most implementable means of reducing VTE.

The National Partnership for Maternal Safety (NPMS) has recently released a consensus bundle on VTE, synthesizing recommendations after critically reviewing guidelines set forth by the American College of Obstetricians and Gynecologists (ACOG), the American College of Chest Physicians (ACCP), and the Royal College of Obstetricians and Gynaecologists (RCOG).³ The bundle consists of four sections: Readiness, Recognition, Response, and Reporting.

The Readiness component focuses on risk assessment at the first prenatal visit, at any hospital admission, immediately postpartum, and again prior to discharge home. The Recognition component reviews current guidelines set forth by other professional societies. The recommendations differ slightly between societies, but essentially all agree that 1) pneumatic compression is indicated for all women undergoing Cesarean delivery, and 2) pharmacologic prophylaxis in addition to pneumatic compression is indicated for women at high-risk, specifically those with a history of VTE or thrombophilia. The ACOG and ACCP guidelines for vaginal delivery and obesity are less clear, with those of RCOG favoring expansion of pharmacologic prophylaxis. The Response component recommends pharmacologic prophylaxis with unfractionated heparin (UFH) or low molecular weight heparin (LMWH) for antepartum patients hospitalized greater than 72 hours, use of pneumatic compression devices for Cesarean deliveries and high-risk vaginal deliveries, and postpartum pharmacologic prophylaxis for post-operative and high-risk patients. Lastly, the Reporting component urges labor and delivery units to review all VTE events to assess protocol compliance, monitor outcomes, and evaluate for complications of thromboprophylaxis.

The goal of this bundle is to decrease VTE risk and improve obstetric care. It is vital to appreciate how implementation of these guidelines may affect the use of neuraxial techniques. It is well-known that neuraxial techniques are of the most effective form of labor analgesia and that they are preferred over general anesthesia for cesarean delivery. The use of pharmacologic VTE prophylaxis as currently recommended may limit the use and timing of neuraxial techniques, potentially resulting in increased labor pain, increased circulating catecholamines in patients with complex comorbidities, and increased use of general anesthesia for Cesarean delivery.⁴ Importantly, the NPMS VTE bundle does address these concerns, for example, suggesting that in some instances the benefit of pharmacologic VTE prophylaxis in addition to mechanical prophylaxis may be outweighed by the risks of restricting access to neuraxial anesthesia.



The key to successful implementation and evolution of this bundle will be continued communication and collaboration between multidisciplinary teams, including obstetric and anesthesia providers. This partnership was present in the development of the NPMS VTE bundle and is incorporated into the SOAP Taskforce on the Anesthetic Implications of the bundle.* Optimal communication and collaboration must be present on each and every labor floor, in the development of institutional VTE thromboprophylaxis protocols as well as in the care of individual patients.

*A multidisciplinary taskforce comprised of obstetric anesthesiologists, CRNAs, hematologists, and obstetricians specializing in maternal fetal medicine working to create a consensus statement and tactics for maximizing the safe use of neuraxial anesthesia in obstetric patients in the setting of VTE thromboprophylaxis.

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Education Committee continues on page 11

Patient Safety Committee: *Simplifying MOCA 2.0 Part 4 – How to Capitalize on Safety and Quality Activities on Labor and Delivery*

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The American Board of Medical Specialties implemented Maintenance of Certification (MOC) in 1999 with the goal of “protecting the public and patients by attesting to the quality, safety, and effectiveness of US medical practitioners”.¹ Overall the standards for MOC are common across all specialties in order to address professional standing and professionalism, lifelong learning and self-assessment, assessment of knowledge, skills and judgment and improvement in medical practice, but each specialty board has liberty to customize the experience of diplomates engaged in MOC.² Participation in MOC in Anesthesiology (MOCA) is required for American Board of Anesthesiology (ABA) board certified anesthesiologists with primary certification after 2000 and voluntary (but encouraged) for those with a non-time limited certification. Regardless of the reason for MOC activity, patients may see involvement as a commitment to providing the highest quality care.³ Interestingly, in a 2012 survey of ABA diplomates, over 80% of respondents indicated that their practice requires board certification or eligibility for employment.⁴

The MOC process was reviewed and updated in 2012-2013 with significant emphasis placed on patient safety and professionalism. In addition, the opportunity for cross-disciplinary quality improvement work in the context of MOC activities was highlighted.⁵ The ABA recently updated the requirements for MOC in “MOCA 2.0” to reflect these priorities. As a result, there are several options for MOCA activities that relate closely to what many obstetric anesthesiologists do on a daily basis on labor and delivery. Currently there is no OB anesthesia- specific MOCA because at this time there is not a separate subspecialty certification.

MOCA Part 4 is based on continued “Improvement in Medical Practice”. Within a 10-year re-certification period, ABA diplomates must demonstrate involvement in practice improvement projects and reflection and evaluation of their clinical practices.⁶ A minimum of 50 points (25 points from years 1-5 and 25 from years 6-10) is required from completion of Part 4 activities during that timeframe. Simulation has garnered much of the press for Part 4 and can be worth up to 25 points if participants complete the follow-up practice improvement plan, thus satisfying the requirement a

full 5-year period. ASA-approved MOCA simulation courses provide the opportunity to identify system issues and reflect on communication and teamwork implications for patient safety, but do require potential travel to one of the approved simulation centers and a high cost of attendance. However, Steadman and colleagues found that 94% of participants sampled completed at least one of their process improvement plans following a MOCA simulation course, demonstrating the potential value of attendance.⁷

While diplomates can in theory complete 2 simulation courses (one in each 5-year block) to satisfy the 10-year re-certification cycle Part 4 point requirement, there are many other options that provide high point value. Labor and delivery is an environment ripe for process improvement, quality improvement and patient safety-related efforts. There are many endeavors obstetric anesthesiologists undertake on a daily basis that could be written up and submitted to the ABA to gain MOCA Part 4 credit. Table 1 lists the different activities, the point value per hour, the maximum points possible and 1-2 examples that apply to obstetric anesthesiologists.

See next page for Table 1

Registration for MOCA 2.0 can be completed by verifying personal information, medical license(s), practice profiles and paying the annual \$210 fee on the ABA physician portal. More information can be found on the ABA website (<http://www.theaba.org/MOCA/MOCA-2-0-Registration>). Full descriptions of Part 4 activities and the reporting templates are available at: <http://www.theaba.org/MOCA/MOCA-2-0-Part-4>.

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Patient Safety Committee continues on next page

Table 1. Examples of Maintenance of Certification in Anesthesiology Part 4 qualifying activities relevant to obstetric anesthesiologists.			
Activity	Points	Maximum Points	Example from Labor and Delivery/ OB Anesthesia
Simulation (ASA MOCA Center)	20 + 5	25	During simulation course, gap in obstetrician and nurse blood estimation knowledge is identified. Diplomate creates brief educational presentation on quantitative blood loss estimation and gives 6 month updates to Labor and Delivery care team.
Quality Improvement Project Leader (Institution/ Department)	1/ hour	25	Standardize timeout process for neuraxial procedures on labor and delivery to address potentially unknown information (for the anesthesia team) such as pending laboratory analysis or concern for elevated blood pressure in triage. Create a template, educate anesthesia and nursing teams and assess ease of use, compliance and any near-misses identified.
Complete an Improvement Plan to improve patient outcomes based on: Quality data registry, JCAHO FPPE/OPPE, 360 review or patient experience of care survey.	1/ hour	25	Review patient care surveys that mention dissatisfaction with not meeting anesthesiologist or learning about epidurals until request for placement of neuraxial block. Create plan for L&D nurses to offer to contact anesthesiologist upon patient admission to L&D room (if patient is interested), write an FAQ on labor analgesia options that is distributed during prenatal appointments to introduce patients to options, develop a description of the obstetric anesthesia team for the L&D unit website.
Clinical Pathway Development Leader	1/ hour	25	Act as leader of multidisciplinary team to create a maternal early warning system and delineate the criteria for when a physician should be notified of a change in patient vital signs in antepartum, intrapartum and/ or postpartum women. Lead review of relevant literature, protocols from other institutions and coordinate input and contribution of obstetricians, midwives, nursing staff and anesthesiologists on implementation of protocol. Track appropriate use and patient outcomes such as need for IV antibiotics, need for transfusion, ICU admission, etc.
Clinical Pathway Development Participant	1/ hour	15	Serve as a member of multidisciplinary group that develops standardized pre-operative huddles on labor and delivery prior to all non-emergency cesarean deliveries. Review relevant literature and work to create environment and protocol that allows regular and expected input from every member of the care team to address any anticipated patient, anesthetic, surgical, system or other safety issues during the procedure.
ABMS Multi-Specialty Portfolio Program (Leader/ Participant)	1/ hour	25/15	Healthcare organization gains approval for a quality improvement process involving care of pregnant or post-partum women in the intensive care unit (ICU). Act as leader (or team participant) of multi-specialty group of anesthesiologists, obstetricians, critical care physicians to address care in this setting. Lead review of existing intra-organizational protocols or guidelines and outside literature, develop criteria for ICU admission versus sending an ICU nurse to labor and delivery for intrapartum management, define the subset of patients who require post-partum ICU monitoring (significant cardiac disease, etc), describe the process for and simulate emergency vaginal and cesarean delivery in the ICU, and identify a group of ICU physicians who are experienced in caring for this patient population. Collect data regarding ICU care of pregnant/ post-partum women before and after the project to evaluate outcomes such as number of ICU admissions, length of stay, diagnoses that necessitated admission, etc.
Point-of-Care Learning	1/ hour	15	Following care of a Jehovah's Witness patient with thrombocytopenia (platelets 62,000) who refused blood product transfusion and suffered postpartum hemorrhage with blood loss of >2000 mL and required ICU admission, you identify need to review considerations for care in this group of patients. Specifically review recent articles related to Jehovah's Witness patients and pregnancy, options to prevent and/ or treat obstetric hemorrhage when transfusion is contraindicated. Also review how thrombocytopenia during pregnancy is evaluated and the implication for neuraxial blockade. Reflect on if/how the gained knowledge changed clinical care and/ or patient outcomes.
Present Case at Morbidity/ Mortality Conference Case Discussion Self-directed Case Evaluation"	1/ hour	15	A colleague reports a case of delayed arrival by the anesthesiology team in the operating room for an emergency cesarean delivery due to inadequate communication regarding the urgency of the surgery that led to an unanticipated NICU admission for the neonate. The case is reviewed and either presented at an M&M conference, a small peer-review discussion or personal review session for thought on what could be learned from the case and what can be improved. Reviews/ discussions reveal no one called the central paging system to call and OB Rapid Response and thus no one realized that the anesthesia team was unaware of the events. A plan to link the OB RRT to the code button in labor rooms and OB triage was implemented and test pages are sent daily moving forward.

Submitted by Dr. Felicity Reynolds:

I attended my first SOAP meeting in 1984 in San Antonio, Texas and my last in 2009 in Washington D.C. (I felt I had gone full circle as the next one was again in San Antonio.)

I would like to give a big thank you to SOAP, as I gained so much from these meetings. There were useful clinical insights, plenty of science, ideas for how to organize good obstetric anesthesia meetings, so many new friends, a wonderful welcome each year, a Distinguished Service Award and, above all, a lifetime supply of T-shirts.

Education Committee continued from page 8

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Patient Safety Committee continued from previous page

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Announcements

SOAP/Kybele International Outreach Grant

The Society for Obstetric Anesthesia and Perinatology (SOAP) is pleased to announce that it is seeking applications for the SOAP/Kybele International Outreach Grant. The application deadline will be April 7, 2017 with expected funding of the grant in spring/ summer 2017.

The goal of this program is to provide funding needed to get involved with international outreach projects to identify and train future leaders in international outreach from SOAP members. Specifically, the grant is designed to encourage research in collaboration with host countries with the goal of enhancing the practice of obstetric anesthesia in those countries.

Information regarding the 2017 SOAP/Kybele International Outreach Grant application process can be found at: <https://soap.org/kybele-international-outreach-grant.php>

Call for Nominations: Teacher of the Year, Media Award

The deadline for nominations for SOAP Teacher of the Year and SOAP Media Award is fast approaching (March 10, 2017). Don't miss out on your opportunity to acknowledge someone special who has contributed to the world of obstetric anesthesia. The categories and criteria are:

SOAP Teacher of the Year Award

- **Over 10 Years of Experience Award**
- **Less than 10 Years of Experience Award**

The SOAP Teacher of the Year Award was created to recognize outstanding practitioners of obstetric anesthesiology who have demonstrated superior teaching primarily of anesthesiology residents and fellows, and secondarily of obstetricians, nurses, midwives, and the lay public.

The SOAP Education Awards Subcommittee is charged with the task of evaluating candidates and would like nominators to consider the following attributes of the candidates: clinical teaching, mentoring, and the advancement of obstetric anesthesia outside of our own community. Any SOAP member may nominate a candidate. Please forward your nominations to Joy Schabel, joy.schabel@stonybrook.edu. Nominees will be contacted by the SOAP Awards Committee and will be asked to provide the following: CV and/or teaching portfolio, teaching evaluations and a letter of recommendation from their department chair.

SOAP Media Award

The goal of the SOAP Media Award is to acknowledge the contribution of a member of the media in furthering public awareness of the important role obstetric anesthesiology plays in the care of the parturient.

Journalists, photographers, producers, directors and any other media professionals involved in the development and advancement of the above content will be considered. All relevant media genres including but not limited to print, radio, television and the Internet are eligible. The award is given for merit, and may not be awarded every year. Any SOAP member wishing to submit a candidate for consideration should send relevant information to Joy Schabel, joy.schabel@stonybrook.edu.

Board Nominations

SOAP is calling for nominations for the elected positions of 2nd Vice President, Treasurer, ASA Delegate, ASA Alternate Delegate and Director At Large. Interested members should send a short statement and picture to kelli@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.

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