

PPAI is met by participating in one of three categories of activities in each of the three-year segments composing years one to nine of the MOCA 10-year cycle. The three PPAI activity categories are: 1) participating in a practice improvement activity from one's own practice, by comparing baseline clinical outcomes to published benchmarks or to evidence-based standards, implementing a change in practice, and then measuring the improvements in patient care; 2) completing an ABA-approved patient safety education module, currently from the ABMS; and 3) participating in a human patient simulator education course. The ASA Committee on Simulation certifies simulation education centers to offer courses that meet the ABA MOCA PPAI requirement.

Like the initial ABA certification Part 1 written examination, the SE for MOCA is administered at commercial computerized testing sites. It is administered during one-week testing windows, twice a year. Following acceptance by the ABA that all SE prerequisites have been met, the SE may be taken any time after the seventh year of the 10-year MOCA cycle. If the examination is taken and passed prior to the end of the 10-year MOCA cycle, the certification period still extends to December 31 of the tenth year following the prior certification. The subsequent MOCA cycle will start on January 1 of the eleventh year after the prior certification was achieved.

If an ABA diplomate fails to complete a MOCA cycle before the end of their 10 years of certification, his or her certificate will expire, the ABA website will no longer list that physician as a certified anesthesiologist, and he or she can no longer represent himself or herself as a board certified anesthesiologist.

The ABA also administers subspecialty certification programs for ABA diplomates who are graduates of ACGME-approved subspecialty fellowship programs in either pain management or critical care. Fellows in those subspecialties similarly are enrolled with the ABA and have CCC reports submitted to the ABA every six months during their fellowship. After a candidate meets all of the other ABA subspecialty prerequisite requirements, the ABA may admit the candidate to its subspecialty examination systems. The subspecialty certification examinations are written examinations administered in commercial computerized testing centers. Following initial certification in an anesthesiology subspecialty, the subspecialty diplomates are eligible to become recertified prior to the tenth year expiration of their subspecialty certificate, by demonstrating satisfactory PS and taking a recertification examination. It is expected that the subspecialties that have ABA certification programs will also come to have fully developed subspecialty MOCA programs, including the LL-SA and PPAI components.

All of the details of the ABA examination programs are updated annually in the spring of each year and are published online in the ABA's Booklet of Information, which may be accessed at the ABA's website (www.theABA.org). Residency programs also have helpful information for residents regarding how to ensure that the appropriate ABA prerequisite requirements will be met in order for their graduates to be eligible for acceptance into the ABA's examination systems. Residency programs also regularly assist residents to prepare for both the primary anesthesiology certification Part 1 and Part 2 examinations.

The ASA, on behalf of its members, works with the ABA to facilitate the board certification and MOCA processes. First, the ASA and the ABA together administer the ASA-ABA in-training examinations for residents at the end of the CB and CA-1 to CA-3 years, to assist residents in assessing their progress during residency, as well as for preparation for the ABA Part 1 examination. Second, the ASA has representatives participating on the Council for the Continuous Professional Development of Anesthesiologists (CCPDA). The CCPDA advises the ABA on the structure and content of the MOCA program. Third, the ASA has a Patient Safety Education Editorial Board that develops and maintains a patient safety education module to meet MOCA PPAI requirements. Finally, the ASA Committee on Simulation is identifying and approving simulation centers that can offer simulations education sessions to meet the MOCA PPAI simulation education requirement.

CHAPTER 29

The Society for Obstetric Anesthesia and Perinatology (SOAP) and Its Relationship With ASA

Joy L. Hawkins, M.D.

Director of Obstetric Anesthesia
University of Colorado School of Medicine
Denver, CO

The Society for Obstetric Anesthesia and Perinatology (SOAP) is a group of roughly 1,000 members who share an interest in the care of the pregnant patient and newborn. Founded in 1968, SOAP provides a forum for discussion of problems unique to the peripartum period. To quote from the SOAP website: "The mission of the Society is to promote

excellence in research and practice of obstetric anesthesiology and perinatology. Through the newsletter, Internet site, and annual meetings, this Society allows practitioners of several specialties to meet and discuss clinical practice, basic and clinical research, and practical professional concerns.”

SOAP is the official obstetric anesthesia subspecialty society of the American Society of Anesthesiologists (ASA), representing those members who include care of the pregnant woman in their practices. As a subspecialty society, SOAP chooses a delegate and alternate delegate who attend the ASA House of Delegates’ meetings at the annual meeting. SOAP members plan the obstetric anesthesia track at the ASA annual meeting. Additionally, SOAP has a journal affiliation with *Anesthesiology*; a journal-sponsored, scientific, oral-presentation session at the ASA annual meeting highlights the best research in the subspecialty area. Furthermore, the *ASA Monitor* (formerly *ASA NEWSLETTER*) has a yearly article authored by the SOAP president that describes issues addressed and activities organized within SOAP, keeping the general ASA membership updated on topics and concerns in obstetric anesthesia practice.

The ASA also has a Committee on Obstetric Anesthesia whose members are virtually always active in SOAP. The chairperson of the ASA Committee sits on the SOAP board of directors and also serves as the liaison to the American College of Obstetricians and Gynecologists (ACOG). This liaison activity with ACOG has led to collaboration on an excellent ACOG practice bulletin, “Obstetric Analgesia and Anesthesia,” and a joint ASA/ACOG patient education pamphlet entitled “Pain Relief During Labor and Delivery.” Through the ASA Committee, several additional documents related to obstetric anesthesia have been produced and are available at the ASA website. These include: “Pain Relief During Labor” (jointly with ACOG), “Optimal Goals for Anesthesia Care in Obstetrics” (jointly with ACOG), and the “Guidelines for Regional Anesthesia in Obstetrics.” Having the chairperson of the ASA Committee on Obstetric Anesthesia sit on the SOAP board of directors ensures these documents are developed with close collaboration. Thus the activities of ASA and SOAP are intertwined on many levels.

SOAP has a variety of activities centered on its annual meeting in the spring. A variety of research presentations, pro-con debates on controversial issues, panel presentations and discussions, case-based learning, and “What’s New” lectures educate and invigorate members. Obstetric anesthesia practice includes labor analgesia, cesarean anesthesia, postoperative pain management and critical care management of obstetric patients. The scope of active research includes safety and outcomes measurements, genomics and physiology of labor pain.

An affiliation with the Obstetric Anaesthetists Association (OAA) brings its president and many of our British colleagues to the SOAP meeting, as well as sending the SOAP president to the OAA meeting each year. Cooperation with the North American Society of Obstetric Medicine (NASOM), a group of internists specializing in medical care of pregnant women, has led to obstetric anesthesia speakers at their annual meeting and a “What’s New in Obstetric Medicine?” lecture at the annual SOAP meeting.

Obstetric anesthesia is a unique part of an anesthesiologist’s practice that differs from typical practice in the general operating room setting. We become an integral part of an intimate event, one of the most important in a woman’s life. We interact with the woman’s spouse, family members and friends for hours or days and even bring them into the operating room during cesarean delivery. We rarely use sedatives or hypnotics, instead relying on various regional anesthetics and our interpersonal skills for their comfort. We often perform these regional anesthetics in the presence of a spouse or family member. Many or most of our patients on labor and delivery come with preconceived ideas of how they wish their care to be provided, including an array of opinions (valid or not) about anesthesia. Although these may have come from the Internet, friends or magazines rather than medical sources, we need to be aware of what our patients are reading and hearing. Women may have a desire to experience “natural childbirth” and may be using a variety of complementary and alternative therapies that can have importance for drug interactions. Despite their initial intentions, over 90 percent of women will ultimately require some kind of pain medication and roughly 60 percent of those will receive a neuraxial (spinal and/or epidural) anesthetic. About 30 percent of deliveries in the United States are now performed by cesarean, and all of those women will require our services. Our goal is to help all these women achieve the childbirth experience they desire.

References:

1. Society for Obstetric Anesthesia and Perinatology (SOAP) website. <http://www.soap.org>. Unknown accessed date.
2. Goetzel LM. ACOG Committee on Practice Bulletins-Obstetrics. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician-Gynecologists Number 36, July 2002. Obstetric analgesia and anesthesia. *Obstet Gynecol.* 2002;100(1):177-91.
3. North American Society of Obstetric Medicine (NASOM) website. <http://www.nasom.org>. Unknown accessed date.
4. Camann W. Obstetrics – never a dull moment. *ASA Newsletter.* 2003;67(10):13-14,28.
5. Hepner DH, Harnett MJ, Segal S, et al. Herbal medicine use in parturients. *Anesth Analg.* 2002;94(3):690-3.
6. Kannan S, Jamison RM, Datta S. Maternal satisfaction and pain control in women electing natural childbirth. *Reg Anesth Pain Med.* 2001;26(5): 468-72.