# A pivotal partnership: obstetrics and anesthesiology

ROBERT L. BARBIERI, MD

WILLIAM R. CAMANN, MD

"Stat, section! Call anesthesia!"

Thus begins one of the greatest "routine" challenges faced by anesthesiologists and obstetricians today. When it comes to childbirth—particularly emergent cesarean—anesthesia remains fraught with hazards.

As of 1997, anesthesia complications were the sixth leading cause of pregnancy-related deaths in the United States.[1] Surveys from this country and the United Kingdom suggest that these deaths have begun to decline in recent decades, primarily because of 2 factors: greater collaboration and consultation between obstetricians and anesthesiologists in the intrapartum period, and increasing reliance on regional—rather than general—anesthesia for cesarean delivery.[1,2]

What does this mean in practical terms? First, early prenatal anesthetic consultation for women with medical, cardiac, neurologic, or other disorders is crucial to formulate a safe and comprehensive plan for delivery. Intrapartum collaboration between obstetricians and anesthesiologists is equally critical for high-risk patients, such as women with severe preeclampsia, preterm labor, or other conditions. The evolving controversy over the requirement for immediate availability of both obstetric and anesthetic providers in hospitals performing vaginal birth after cesarean delivery (VBAC) illustrates how these concerns affect both specialties.

At Brigham and Women's Hospital, obstetricians and anesthesiologists attend one another's "board rounds" daily. We regularly hold joint clinical conferences to talk about cases of interest. In addition, we host monthly interdepartmental journal club meetings to discuss recent literature of importance to both specialties. And we have combined representation on departmental executive committees related to administrative and clinical care issues of our labor and delivery unit.

Beyond our institution, the magnitude of collaboration between the specialties is apparent in the variety of joint committees, task forces, and publications sponsored by the American Society of Anesthesiologists (ASA) and the American College of Obstetricians and Gynecologists (ACOG), such as the joint statement on Optimal Goals for Anesthesia in Obstetrics.[3] The recent Practice Guidelines for Obstetrical Anesthesia includes the solicited opinions of both anesthesiologists and obstetricians.[4] And the ACOG Committee Opinion on Anesthesia for Emergency Deliveries further underscores the importance of our alliance.[5] That document describes the "obstetric care

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*Dr. Camann is associate professor of anesthesia at Harvard Medical School and director of obstetric anesthesia at Brigham and Women's Hospital, both in Boston. Dr. Barbieri is editor-in-chief of OBG MANAGEMENT.*

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*team*" and lists risk factors that place the parturient at increased risk for anesthetic complications, particularly those related to general anesthesia and the airway.

Interestingly, consumer interest in anesthesia is more prevalent in obstetrics than in any other specialty. Books, brochures, classes, seminars, and Web sites abound with information (and sometimes, misinformation) about pain relief options for childbirth. Recent evidence that shows up to 60% of U.S. women giving birth receive epidural analgesia during labor is a testament to the involvement of anesthesiologists in prenatal education and childbirth classes, as well as the intense consumer demand for effective pain relief during labor.

Such close collaborations yield many benefits: maternal and fetal safety and personal and professional satisfaction among the medical staff. The ideal labor and delivery unit encourages such collaboration—not just between obstetricians and anesthesiologists—but between all members of the obstetric care team, including pediatricians, midwives, nurses, and doulas.

Many factors determine the quality of an obstetrics department. Among them is a strong, dedicated, and involved department of obstetric anesthesia, which helps ensure state-of-the-art care for all gravidas—both high-risk and routine. ■

REFERENCES

1. Hawkins JL, Koonin LM, Palmer SK, et.al. Anesthesia-related deaths during obstetric delivery in the United States, 1979-1990. *Anesthesiology*. 1997;86:277-284.
2. de Swiet M. Maternal mortality: confidential inquiries into maternal deaths in the United Kingdom. *Am J Obstet Gynecol*. 2000;182: 760-766.
3. American Society of Anesthesiologists and American College of Obstetricians and Gynecologists. *Optimal goals for anesthesia in obstetrics*. Joint statement #256. Washington, DC: ACOG/ASA; May 2001.
4. Practice guidelines for obstetrical anesthesia: a report by the American Society of Anesthesiologists Task Force on Obstetrical Anesthesia. *Anesthesiology*. 1999;90:600-611.
5. American College of Obstetricians and Gynecologists. *Anesthesia for emergency deliveries*. Committee Opinion #104. Washington, DC: ACOG; March 1992.