1) In addition to learning to give technically safe and effective OB analgesia and anesthesia, the focus of this rotation is on working well as a team member in a unique patient care environment and on understanding basic obstetrics and maternal fetal medicine.

2) Come to the Labor & Delivery (L&D) nursing station at 0700. OB anesthesia attending should be there. Get report from outgoing resident and coordinate plans for the day with the incoming attending. Ensure that the two ORs are ready for emergent cases.

3) Get your OB anesthesia kit from the L&D Pyxis. Here is how: Tap screen, Enter user ID and password or fingerprint, Touch “Remove”, Touch “Anesthesia OB only”, Touch “Override”, Touch “Anesthesia Kit OB”, Remove the kit. If you need extra fentanyl during your shift, you must get it from the main OR Pyxis—do not take it from the L&D Pyxis unless it is a dire emergency.

4) Check out the two CS rooms. Warm room to 70 degrees F. Lower OR table as low as it will go. Put step stool at right side of the OR table. Do machine checkout. Does suction reach far enough and does it work? Do you have: vaspressors, oxytocin, propofol, sux, atropine? Are there spinal and epidural kits stocked in the room? Is everything required to manage the airway available and functioning?

5) There is no need to always have cefazolin drawn up. Cefazolin is not an emergency drug. Many non-emergency drugs (such as cefazolin) that are drawn up in advance get thrown away.

6) Do not trust hand labeled syringes of pressors that are not timed and signed. Much better to re-draw new phenylephrine than to give non-diluted phenylephrine, which has happened many times. “When in doubt, throw it out!”

7) Do not draw up anything that will be injected neuraxially ahead of time (this includes narcotics).

8) Do a focused checkout of the epidural carts: Are there an Ambu bag, a functioning laryngoscope and appropriate airway supplies on the cart? Is the cart locked when you leave it?

9) OB anesthesia attending may want to quickly round on the current patients with you. Goal is to meet the current patients, get baseline H&P and evaluate quality of ongoing analgesia.
10) OB “Board Rounds” starts at 0745. You should attend these rounds and participate in them, unless urgent patient care (e.g. epidural placement or CS) prevents you. They are usually an excellent learning experience about obstetrics and maternal fetal medicine. They are a key part of your experience on this rotation.

11) CS patients should get famotidine (Pepcid) 20 mg IV at least 30 minutes before induction of anesthesia. Some attendings (e.g. Dr. Archer) will want metoclopramide (Reglan) 10 mg slow IV to be given 30 minutes before induction, along with the famotidine. Some attendings (e.g. Dr. Suresh) will only want you to give metoclopramide if there is an increased risk of aspiration or a planned GA. Patients should get oral Bicitra 30mL, 10-15 minutes before induction. Unless they are allergic, patients should receive cefazolin 1 gm IV before incision (if > 80 kg, give two gm).

12) Prior to bringing elective cesarean section (CS) patients back to the OR, make sure that 1) the IV works, 2) the patient has socks on her feet. If the patient feels cold, get warm blankets for her shoulders and front once she is on the OR table. When you first interview the patient, ask if she feels cold, and if so, consider pre-warming measures. It is good practice to help the nurse accompany the patient back to the OR, if you have time.

13) Ask the OB anesthesia attending about possible use of upper body warmer and fluid warmer and be prepared to provide them if requested. Prevention of perioperative hypothermia is an essential part of anesthesia care.

14) With respect to all patients in L&D: try to see patients who may need our services in advance. This requires careful communication with nursing and obstetrics staff, as well as “reading the board”. This is a matter of judgment and should be discussed with your attending. An essential aspect of being part of the L&D care team is knowing what is going on with the patients in the unit, in order to foresee and prevent problems from developing. When you have evaluated a patient without starting a block, please write “seen” in the anesthesia column on the board. This lets everyone knows that we (anesthesia) have already talked with her.

15) The best time to interview an epidural candidate (and any other patient) is before she is in pain. After evaluating the patient, contact your attending with a proposed analgesia plan for the patient. Whenever suggesting a course of action, be ready to answer the question "why?".

16) The OB anesthesia faculty want you to periodically check on patients who have epidural blocks in place, even if you are not called to do so. We do not want to set an arbitrary frequency of visits that must be performed, but somewhere between q 1-2 hours is reasonable. The visit can be very brief—the goal is to see if the patient is still comfortable, check on BP and make sure the patient can still move her legs. You should chart vitals for each visit and these vital sign recordings help the department to collect reimbursement.

17) We do not want you to place a block and then not check on the patient unless you “are called”. Epidurals should not be “place and forget”. The reason for this is that nurses may a)
not call you until the pain due to a bad epidural is severe and b) we want you to be proactive in managing pain and detecting poor blocks, in case the patient has to go to CS, and c) you may be able to pick up other developing complications (e.g. excessive block) before the nurse notices a problem.

18) Each anesthesia evaluation form needs 6 pre-printed stickers on it—one on each of the six sections. Please do not just write in the three identifiers by hand (name, date of birth and medical record number). These are often illegible and people forget to be complete, so this makes a lot of extra work for Anesthesia Billing. PLEASE USE STICKERS! The unit secretary will rapidly print out six stickers for you if you ask her nicely. Pre-printed stickers make the job of our Anesthesia Billing Office much easier. PLEASE USE STICKERS!

19) Anesthesia records in progress, and records for patients we have seen and might be caring for soon, go in the red cardboard folder. Anesthesia records that are complete, including all attending signatures, will be put into the green cardboard folder by the OB anesthesia attending. If the patient leaves the floor before the anesthesia record can be placed in the chart (which is usually the case), you should go on a “chart run.” This means you should separate the completed anesthesia records in the green folder into white and yellow/pink copies, deliver the yellow/pink copies to the PACU for billing and the white copies to the 4th floor “Anesthesia record” box (attending will show you where that is). You should do at least one “chart run” per day. Encourage the attendings to sign the charts before you do a chart run.

20) When a labor epidural patient goes to CS, you must start a new anesthesia record. End the labor epidural record when the patient goes to the OR. Start the CS record at that same time. On the CS record you can just write “See CLE record” on the H&P page.

21) If you administer neuraxial morphine (epidural or intrathecal), fill out the top part of the Postoperative Pain Visit note, affix two patient stickers to the sheet (one to white copy, one to yellow copy) and leave in the red cardboard folder. These patients will be the “post-ops” that need to be seen the following day for the “Post-operative pain management visit.” This visit is important for patient care and for your education and training and is also billable.

22) Please communicate well with your attending and with the OB and nursing staff. Let them know what you are doing, where you are, what your plans are, find out what they are doing and what they need, etc. This is a very important skill and attitude to be developing for your future as a member of any medical care team.

23) If you are unfamiliar with a procedure, drug, clinical scenario, or just unsure of ANYTHING, call your attending. That is why we are in house 24/7.

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