



SLEEPY TIMES

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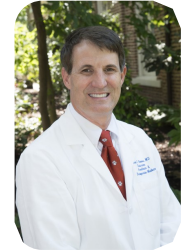
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MESSAGE FROM THE CHAIRMAN: EULOGY VIRTUES

-SCOTT T. REEVES, MD, MBA

The following is a brief synopsis of my parting words to our graduating residents and fellows. They will all be missed but we are excited to present them to the world as MUSC alumni.



This May, I had the opportunity to represent the department and the College of Medicine at the University's 187th commencement ceremony. For those of you who are not local, it is the big graduation event that occurs in the horseshoe in front of our library. This year we graduated over 700 students into the fields of nursing, physical therapy, dentistry, and medicine amongst others. The keynote speaker was the former City of Charleston Mayor, the Hon. Joseph P. Riley Jr.

His theme focused around the "calling" that we all have as physicians. He wanted to emphasize that with our position in society, we have the opportunity to teach our fellow citizens a lesson in *character and moral responsibility*. He went on to say:

In our quest to find moral equilibrium, we often look to books, historical figures, to our churches...but we also, perhaps unconsciously, look to those who care for us. You, our dear graduates, have accepted a vocation that holds great power, and the profound results of your work elevate you among us. For you not only care for our bodies, but you also can be one of our teachers.

He discussed what I would describe as the education rat race. You worked hard to optimize your curriculum vitae. You carefully selected where you would go to college and your undergraduate degree to optimize your chances of getting into medical school. You competed against each other in medical school to get into your coveted specialty discipline of anesthesiology and residency location at the Medical University of South Carolina. These are the credentials that you will bring with you to your new job. According to David Brooks in his book, The Road to Character, these resume virtues will help you achieve wealth, status, and fame.

I would encourage you all now to modify your approach to not only working on furthering your career, but also more importantly, to devoting your time to things that are more eternal. Major Riley described this transition as working on your *eulogy virtues: kindness, bravery, honesty, faithfulness; these are deeper*. It's what those who knew us well will talk about at our funerals. *These are the virtues that exist at the very core of our being. They are our true lasting legacy.*

MESSAGE FROM THE CHAIRMAN CONTINUED...

Look at those around you and also remember those who have helped you to reach your goals that were not able to attend graduation. We all have the same collection of people who walked beside us on our long journey. The list is endless but includes our spouses, parents, grandparents, friends, co-residents and fellows, and faculty. As you enter into the real world of work, **WORK** to find that difficult balance between your calling and your family. In the end, it will not be the long hours in the hospital that you will be remembered for, but rather the kind word, the touch on the hand, the cheering at your kid's game or the crying at your daughter's wedding. Nurture your spouse and children and dedicate time daily working on your eulogy virtues.

As I finish, I, along with the faculty, staff and junior residents, want to thank you for these past years. Each one of you truly will make a difference in this world. To the class of 2016, good luck and God bless you.

CLASS OF 2016

GRADUATION AWARDS AND RECOGNITION FOUNDERS HALL, JUNE 17, 2016



MUSC Dept. of Anesthesia
The Dr. Laurie Brown
Resident Teacher of the Year
2015-2016
Benjamin Kightlinger, MD



MUSC Dept. of Anesthesia
The Dr. J. G. Reves
Resident Research Award
2015-2016
John Fox, MD



MUSC Dept. of Anesthesia
The Dr. John E. Mahaffey
Resident of the Year
2015-2016
Benjamin Kightlinger, MD



Dr. Jason Taylor
CA-1 Teacher of the Year



Dr. Jake Freely
CA-2/3 Teacher of the Year



GRADUATION PICTURES



GRADUATION PICTURES



MUSC/CLEMSON PATIENT SAFETY COLLABORATIVE RIPCHD.OR

Our collaborative effort with Clemson was recently highlighted in the spring edition of Glimpse Magazine, which is designed to inform the Clemson community of its research and creative discovery achievements.



A SCIENTIFIC
DESIGN

BY JEMMA EVERYHOPE-ROSER
PHOTOS BY CRAIG MAHAFFEY

SARA RIGGS,
ASSISTANT
PROFESSOR
OF INDUSTRIAL
ENGINEERING

MUSC/CLEMSON PATIENT SAFETY COLLABORATIVE RIPCHD.OR CONTINUED...

A video popped up on my Facebook feed.
 Could I count the number of passes the basketball players wearing white made?
 I watched, and I counted. And I did not see the man in the gorilla suit march through players,
 beat his chest, and then stomp onward.

Called a “selective attention task,” this video meme began as a real-world experiment measuring human perceptual limitations. Derren Brown, a well-known British magician, gave a nod to the test in his stage magic show, *Enigma*, in which he used perceptual limitations to trick his willing audience. I missed the man in the gorilla suit that time too.

Sara Riggs, an assistant professor in the Department of Industrial Engineering, designs and tests systems in which we can’t trick ourselves. Her work in the field of cognitive ergonomics focuses on accounting for human cognitive and perceptual limitations, and developing displays that support people in various work environments.

“There’s a lot we have to take into account,” Riggs explains. “It’s actually very methodical in the way that we go about doing this, because it’s based on science, on findings from previous studies that inform how we go about doing things. We’re pulling from different studies, from multiple disciplines, including, but not limited to, psychology, engineering (e.g., industrial, systems), human-computer interaction, and ethnography.”

But what are the cognitive and perceptual limitations Riggs considers?

Well, for one thing, a human being can only viably process so much perceptual information at one time.

“For data overload, there is a threshold that may vary slightly from one person to another of how much visual information we can attend to at once,” Riggs says, “while also keeping it in working memory so that we can use it later on.”

This can be applied to auditory limitations as well. Over time it becomes easy to “tune out” repetitive sounds so that we can focus on the task at hand. But if the sound we tune out is the beep-beep-beep of a heart monitor, and that beeping flatlines without a doctor or nurse noticing, then that’s a case of a human limitation that could put a patient at risk.

“So we have to have the right attention, and if there’s a change, we have to be able to notice that,” Riggs says. “Based on our ability to perceive the world, we have certain limitations in how we can perceive it.”

Cognitive limitations can be categorized as biases or heuristics. As an example, Riggs cites confirmation bias, where a person starts out with a hypothesis and searches the environment for clues to support it. Confirmation bias exists because it has benefits. It’s a shortcut that speeds up the deduction process. But, Riggs says, “If you’re going in the wrong direction, this will work against you.

“That’s usually the purpose of these heuristics and biases in terms of how we view the world,” Riggs continues. “Rather than processing all of the information and stimuli around us, we become more efficient. So this is something we have to take

into consideration when we design displays, especially in terms of information and how information is presented. How do we account for these biases, these limitations, these heuristics, in terms of how people are perceiving the world around them?”

Basically, where a stage magician will use our perceptions and cognitive limitations against us to create the illusion of magic, Riggs uses scientific data to flip that paradigm—so that we can make our limitations work for us.

WHAT DO BOEING PILOTS, ANESTHESIOLOGISTS, AND MILITARY PERSONNEL HAVE IN COMMON?

In high-stress environments, where a lapse puts lives at risk, how can we best present information so that the right decision is made at the right time? As technology multiplies and data maxes us out, designers must confront that question for the Boeing pilots, anesthesiologists, and military personnel of the future.

Current state-of-the-art displays are visual and auditory, and an operating room, with its many beeping machines, screens, and readouts with zigzagging lines, is no exception. But a visual display must be watched. And an auditory alert affects everyone within hearing range.

Riggs proposes what might be an answer: a tactile display. With a tactile display, Riggs says, “You can create more or less private displays that don’t disrupt everyone.”

Having reviewed the literature, Riggs has developed a multi-disciplinary team of computer scientists and industrial engineers to help the head of anesthesiology at the Medical University of South Carolina devise the future of anesthesiology. “What we’re planning on testing, just to see if it works,” Riggs says, “is a vest where we place a lot of these tactor devices so that a potential anesthesiologist in the future can wear it and get their information via the tactile channel.”

The tactors, similar to the technology that makes a cell phone buzz, are slightly larger than those in a mobile device, but they’re designed so that Riggs can manipulate more of their parameters. The tactors can provide information with a combination of three methods: amplitude, frequency, and pulse pattern.

“Just by manipulating those parameters, you can convey a lot of different information if you assign them appropriately,” Riggs says.

The vest itself would have similar parameters set for everyone—rather than every anesthesiologist being able to custom-design their own—so that anesthesiologists could move from vest to vest with greater ease. The personalization would occur in an adjustable strength of stimuli, so that people of differing body types and sensitivities would be able to set the vest so that it buzzes at a comfortable level. Riggs says, “We’re trying to find a nice medium of how to individualize this but keep it consistent

MUSC/CLEMSON PATIENT SAFETY COLLABORATIVE RIPCHD.OR CONTINUED...

RIGGS (CENTER) WORKS WITH STUDENTS ON A PROTOTYPE OF A VEST THAT COULD HELP ANESTHESIOLOGISTS SAVE LIVES. THE VEST CONVEYS INFORMATION THROUGH THE TACTILE CHANNEL, ENABLING QUICKER RESPONSE TIMES.

so that if we go from one operating room to another there isn't confusion as to 'what do these tactile stimuli mean?'"

When asked about the prototype's first trial, Riggs admits, "I'm kind of a guinea pig in terms of when my students are testing these things. I'm pretty active in the lab."

In order to test the vest, Riggs and her students will create a mock-up operating room, bring in participants, train them on the task, and then ask them to perform that task (a) with the current state of technology vs. (b) with the new technology they're testing.

Participants, whether they're pilots or lit majors, have similar perceptual and cognitive limitations, so Riggs intends to start them out with doing a simplified version of what an anesthesiologist would do before bringing an actual anesthesiologist. Once they get to that stage, Riggs will be able to present a very polished product.

Right now, Riggs nears the end of a different study. She's working on displays for military personnel to control unmanned aerial vehicles (UAVs). Currently it takes three people to monitor one UAV: They watch its status, reroute as necessary, and respond to chat messages. But the military's grand vision is to have one person monitoring up to nine UAVs.

"If you want to talk about data overload, that's a prime

example," Riggs says. "So the challenge is how we can best support the operators so that they are best able to do that."

In Riggs's UAV experiment, one person tracks the health status and chat messages, and reroutes sixteen UAVs. "So it's a lot of tasks," Riggs says, which to me sounds like an understatement. But, she says, skilled gamers have one up on the rest of us and find this level of multitasking relatively straightforward.

Working under the assumption that most people must look at a display to engage with it, Riggs uses an eye tracker to determine how people juggle these UAVs. The eye tracker not only collects data on where people look and for how long, but it can also provide insights on participant accuracy and response times.

After the participants have taken part, Riggs debriefs them to discuss what their strategy was when managing these sixteen UAVs. Soon Riggs will be analyzing the data and the participant feedback to understand how her proposed design worked.

Previously, Riggs worked with Boeing pilots on designing next-generation cockpits. Current technology is still radar-based, and the industry would prefer to shift that to satellite-based information that can show real-time changes regarding weather data, for example. Riggs found tactile displays could convey information—though less information than visual or auditory

MUSC/CLEMSON PATIENT SAFETY COLLABORATIVE RIPCHD.OR CONTINUED...

displays, which can convey language, because there is no tactile language. Yet most importantly, she also discovered that, “the response times in the tactile channel can trump that to auditory and visual.”

In high-stress environments, when a split-second decision determines life or death, that could be a critical finding indeed.

Work continues in determining which sensory channel should be used to convey what information. Riggs will be “using a sense of touch to augment visual and auditory displays, which are state of the art for most environments now, and honing in on the benefits of a sense of touch to convey different types of information in the most appropriate manner.”

BRIDGING THE BOUNDARIES BETWEEN SCIENTIFIC DISCIPLINES, MAN, AND MACHINE

“The main part of being an engineer is fixing a problem,” Riggs says. But these days, the multifaceted problems of our increasingly technology-dependent culture aren’t something that one person can tackle alone. They require a team from multiple disciplines and across many agencies.

Riggs seeks “collaborations with external funding agencies outside the university.” Her anesthesiology project works in combination with the Medical University of South Carolina. Her UAV project receives military funding. NASA and the FAA actively look for academic partners to work with them on the future of aviation.

Then there are the teams that Riggs puts together. The anesthesiology project, for example, draws on the expertise of computer scientists, industrial engineers, and medical professionals. As Riggs says, each experiment is “a combination of science and technology.”



THIS TACTOR, SIMILAR TO THE TECHNOLOGY THAT MAKES A CELL PHONE BUZZ, IS DESIGNED SO THAT RIGGS CAN MANIPULATE PARAMETERS LIKE AMPLITUDE, FREQUENCY, AND PULSE PATTERN.

The experiments themselves draw on previous studies in multiple disciplines. Controlling for variables in each experiment requires a regimented process and methodical procedures, so that Riggs can be sure they’re testing the variable they wish to test.

“Getting all of the pieces to come together can be a hurdle,” Riggs says. “But I feel at the end of the day that’s very rewarding.”

What Riggs is searching for from all of these experiments is information that’s applicable to more than one domain. Whether it’s telemedicine in the ICU environment or monitoring UAVs, Riggs wants to extract principles.

As technology becomes more and more complex, more scientists like Riggs will be working to determine the best interfaces to bridge the gap between man and machine. Riggs says that her experiments give her “hope that my work will solve the lingering questions that will need to be addressed in a future with the advent of new technology.”

Whether it’s in the operating room or in a cockpit, it’s guaranteed our future selves will be processing and picking out patterns from more data than ever before. With personalized signals sent to each individual, we’ll respond faster than ever to real-time, changing situations. It’ll be so intuitive, so easy, it’ll look like sleight of hand—but only because it’ll be designed by science to take advantage of human limitations.

Sara Lu Riggs is an assistant professor in the Department of Industrial Engineering at Clemson’s College of Engineering and Science. Jenma Everyhope-Roser is the interim editor of Glimpse.

ENHANCED RECOVERY AFTER SURGERY (ERAS) GYN INITIATIVE BY LAURA ROBERTS, MD

ERAS for Gynecology/Oncology Surgery – Intraoperative Guide:

1. Preoperative fasting: Encourage **clear** carb-rich beverage prior to midnight day before surgery and 2-4 hours prior to scheduled surgery time. Type and amount of beverage will be clearly defined by surgical service during the preoperative visit. Solid food may be permitted up to 6 hours prior to surgery. ***ERAS encourages no bowel prep prior to surgery; however, if a patient receives a bowel prep prior to surgery please record in the preoperative evaluation.***

2. Preanesthetic meds: Short acting premedication (midazolam/fentanyl) may be given the morning of surgery prior to induction of anesthesia at the discretion of the anesthesia provider, particularly for preoperative procedures (e.g., epidural insertion). Patients may continue to take home opioids/benzodiazepines prior to surgery if they routinely take them on a scheduled basis at home. Other scheduled outpatient medications may be taken as instructed per routine surgical standard of care.

3. Deep vein thrombosis prophylaxis and anticoagulation: Unless contraindicated, patients will receive Heparin 5000 units subq prior to induction and wear a sequential compression device. If Enoxaparin (Lovenox) is required, the maximum prophylactic dose is 40mg daily. As a reminder, twice daily or mg/kg dosing is contraindicated with regional anesthesia. For more detailed recommendations, refer to the **MUSC Anticoagulation and Antiplatelet Guide for Neuraxial Anesthesia.**

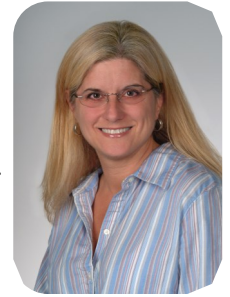
4. Antibiotics: For hysterectomy procedures with or without colon surgery, administer Cefazolin and Metronidazole IV prior to incision per institutional guidelines. Give Cefazolin 2 grams for patients < 120kg, 3 grams for patients > 120kg and Metronidazole 500mg for all patients. If patient has a **major/anaphylactic allergy to penicillin or cephalosporin**, administer Gentamycin 1.5mg/kg and Clindamycin 600mg IV prior to skin incision for hysterectomy procedures. For hysterectomy procedures with colon surgery in patients with anaphylaxis to penicillin or cephalosporin, administer 2 grams Aztreonam and 900mg Clindamycin prior to skin incision. For **MRSA positive** patients, add Vancomycin 15mg/kg IV prior to incision to other prophylactic antibiotics. For all other gynecology procedures, antibiotics are only indicated if the procedure is considered a Class II wound. Refer to SCIP guidelines as appropriate.

5. Intraoperative anesthetic: As there is no definitive evidence for optimal anesthetic method, intraoperative anesthetic technique is at the discretion of the anesthesia provider. Methods to decrease the incidence of PONV should be utilized as appropriate. Non-opiate analgesics should be considered when appropriate.

6. Regional analgesia: For patients undergoing an open gynecology +/- colon procedure, a bilateral TAP (Transversus Abdominal Plane) block should be offered unless **EXPAREL** (a liposome injection of bupivacaine, indicated for single-dose infiltration into the surgical site) is administered by the surgeon. The TAP block should be performed preferably prior to incision but may also be performed before emergence. With a bilateral TAP block, commonly, 20ml of 0.375% Ropivacaine with 1-2mg dexamethasone is administered on each side of the abdomen with ultrasound guidance. Patients undergoing laparoscopic surgery should receive local anesthetic infiltration by the surgeon but may be offered a bilateral TAP block if appropriate.

7. PONV prevention: Unless contraindicated by patient allergies, all ERAS patients should receive 4 mg of Decadron and 4 mg of Ondansetron intraoperatively for PONV prophylaxis. Additional medical prophylaxis (Scopolamine, Propofol, Reglan, Droperidol, Phenergan) is at the discretion of the anesthesia provider and should be based on prior patient experience with PONV.

8. Intraoperative normothermia: At least 1 forced air warmer should be placed on the patient, typically an upper body warmer for lower abdominal surgery. Esophageal or bladder temperature monitoring should be used for every patient intraoperatively. Additional forced air warmers and fluid warmers should be used to maintain intraoperative normothermia as needed.



ENHANCED RECOVERY AFTER SURGERY (ERAS) GYN INITIATIVE BY LAURA ROBERTS, MD CONTINUED...

9. Perioperative fluid management: The goal with ERAS is normovolemia. Use of a Flotrac device with an arterial line or finger cuff (if no arterial line is present) to monitor stroke volume (SV) and stroke volume variation (SVV) will assist with intraoperative goal-directed therapy (**GDT**). As a reminder, arterial lines are invasive procedures and should only be used if warranted by patient condition and surgical requirements.

GDT: 1000ml crystalloid infusion (Lactated Ringers or Plasmalyte) should be started in holding area and then infused throughout induction until finished. Then, administer crystalloid infusion at 3 ml/kg/hr for open cases, 1- 3ml/kg/hr for laparoscopic cases via infusion pump. Record initial stroke volume once Flo-trac device is operating. If the patient becomes hypotensive during surgery (MAP 20% or more below baseline) and SVV > 12, give 250ml of crystalloid bolus over 10-15min and reassess. If SVV decreases but patient remains hypotensive, repeat bolus. If patient continues to be hypotensive after 2 or more fluid boluses with a cardiac index (CI) less than 2.5 and SVV>12, consider adding a vasopressor. At end of case during surgical closure, reduce crystalloid infusion to 1-2ml/kg/hr before transfer to PACU.

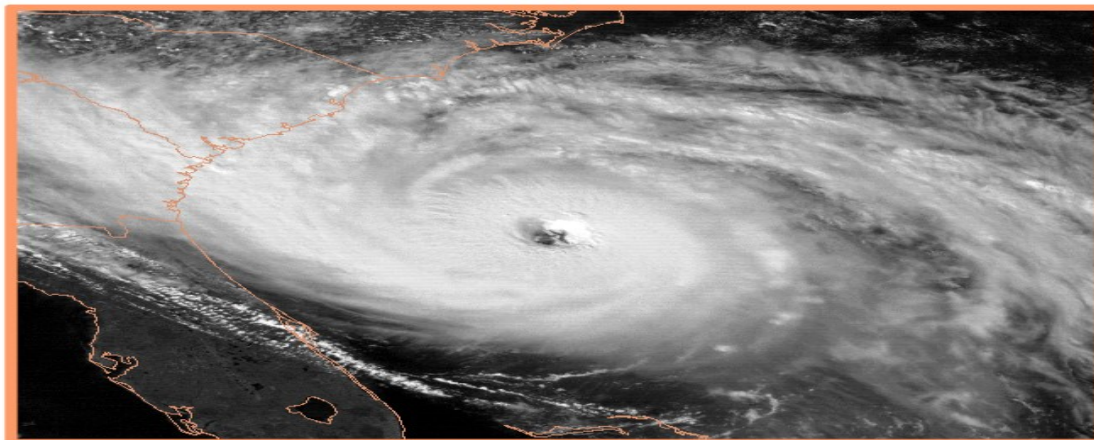
10. NGT placement in perioperative period: With ERAS, NG tubes should be avoided. Placement should be discussed with the surgeon at timeout.

References:

- Nelson, G., et al. Guidelines for pre- and intraoperative care in gynecologic/oncologic surgery: Enhanced Recovery After Surgery (ERAS) Society recommendations – Part 1. *Gynecology Oncology* (2015), <http://dx.doi.org/10.1016/j.ygyno.2015.11.015>.
- Nelson, G., et al. Guidelines for pre- and intraoperative care in gynecologic/oncologic surgery: Enhanced Recovery After Surgery (ERAS) Society recommendations – Part 2. *Gynecology Oncology* (2015), <http://dx.doi.org/10.1016/j.ygyno.2015.11.015>.
- Spanjersberg WR, et al. Fast track surgery vs conventional recovery strategies for colorectal surgery (review). *Cochrane Database*.
- Miller, TE, et al. Reduced length of hospital stay in colorectal surgery after implementation of enhanced recovery protocol. *Anes Analg* 2014; 118(5): 1052-61.
- Horlocker TT, et al. Regional anesthesia in the patient receiving antithrombotic or thrombolytic therapy: American Society of Regional Anesthesia and Pain Medicine Evidence-Based Guidelines. *Reg Anesth Pain Med*. 2010; 35(1):64-101.

[Click Here To View the Hurricane Plan](#)

Department of Anesthesia and Perioperative Medicine



Hurricane Plan

Created: 2007
Updated: 09/2008, 06/2010, 06/2014

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Last saved by:MEK
Revised: May 19, 2015

INTERNATIONAL ANESTHESIA RESEARCH SOCIETY MEETING

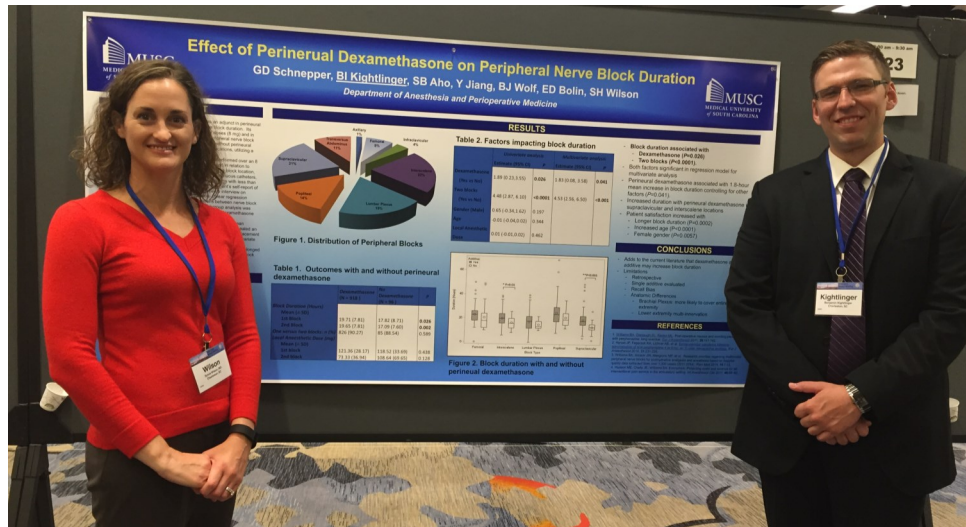
Drs. Sylvia Wilson, Anthony Lawson, and Benjamin Kightlinger presented at the International Anesthesia Research Society (IARS) Annual Meeting May 21-24, 2016, in San Francisco. Dr. Wilson was involved in multiple regional workshops which taught less commonly performed nerve blocks (i.e. obturator, serratus plane block, and more). Drs. Lawson and McSwain presented their poster, a case report entitled, "Intraoperative Management of a Dopamine-Secreting Hereditary Paraganglioma of the Neck Resulting in Unanticipated Intraoperative Tracheostomy." Dr. Kightlinger presented his poster on a study involving Drs. Wilson, Schnepfer, Bolin, Aho, entitled, "Effect of Perineural Dexamethasone on Peripheral Nerve Block Duration: A Retrospective Study." Dr. Wilson also took part in the following lectures:

Ultrasound, Simulation and Stimulation for Peripheral Nerve Blocks

Andrew Rosenberg, MD; Robert A. Altman, MD, BS; Michael Anderson, MD; Sudheer K. Jain, MD; Jung T. Kim, MD; Sunmi Kim, MD, BS; Stephen D. Lucas, MD; Richa Wardhan, MBBS; Sylvia Wilson, MD

Resident Regional Ultrasound Guided Anesthesia Workshop

Andrew Rosenberg, MD; Santhanam Suresh, MD; Michael Anderson, MD; Sudheer K. Jain, MD; Jung T. Kim, MD; Sunmi Kim, MD, BS; Stephen D. Lucas, MD; Richa Wardhan, MBBS; Sylvia Wilson, MD



Drs. Sylvia Wilson and Benjamin Kightlinger



Drs. Benjamin Kightlinger, Sylvia Wilson, and Anthony Lawson



Dr. Anthony Lawson

MUSC AMBULATORY CARE IDEAS WORKSHOP



MUSC Ambulatory Care Ideas Workshop

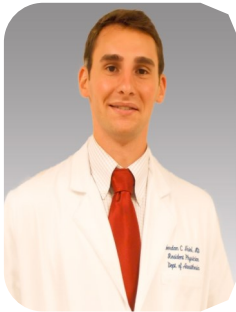
The planning for both a pediatric multispecialty office building (MOB) and ambulatory surgery center (ASC) in North Charleston and an adult MOB/ASC in West Ashley continues. In May, a group of shareholders met with the two architectural firms being considered for the design of the project, LS3P and McMillan, Pazdan, Smith.

The goals of the meeting were to:

- The two facilities must be consistent with the MUSC brand
- Optimize patient, family and staff satisfaction
- Streamline the care experience and processes for both facilities
- Position the buildings and build them in such a way that expansion and renovation is possible over the life of the buildings
- Must embrace child and family centered best practices

David Allison, Chair of Healthcare Architecture at Clemson, lead the discussion. It is expected that an improved design process will be the outcome while incorporating the desires of the physicians and other staff using the new facilities.

DR. JORDAN FRIEL, PHYSICIAN OF THE MONTH FROM THE CATALYST

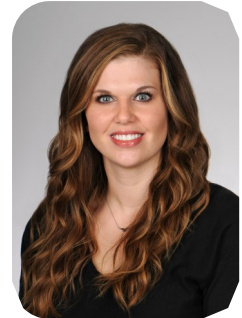


“Jordan Friel has always worked with the nursing staff in MSICU to provide patients with the best care possible. He takes the time to listen to the nurses’ concerns and collaborates with them to help problem solve accordingly. On March 4, we had the perfect example: An MET was called on day shift on the floor. Jordan used his excellent assessment skills to see the urgent need for them to go to CT before being transferred to the unit. After the scan, the mass transfusion protocol was initiated. Though his shift was now up, Jordan stayed with the patient while they were taken to IR to try and stop the bleeding. Jordan worked with Dr. Clark to keep the patient hemodynamically stable throughout the procedure. When they arrived back from IR, it was deemed that they needed to go to the OR. Jordan, now four hours over his shift, continued to stay with the patient (he had to be back on the unit at 6 a.m.) and ensure that excellent care was provided. When the patient was closed, he returned to the unit to give check out, so he could try and get some sleep and stated to the nurses and other physicians to call him if any changes occurred. Soon after Jordan was notified that the patient had passed, he came back to the unit to let the nurses know. His level of compassion and empathy was exemplary. We always enjoy having Jordan rotate through the MSICU because of his dedication towards patient care, compassion for patients and their families, excellent critical care skills, and above all, one of the best advocates for nurses. Big thanks from Katie S., Mia L., Emily B., Veronica M., Haley F., Maggie D., Adam M., Cate Y., Kristin.”

Nominated by MSICU Night Shift Staff

DR. KATIE BRIDGES APPOINTED MEDICAL DIRECTOR OF THE PREOPERATIVE CLINIC

A native of Louisiana, Katie graduated from Southern Methodist University with a B.S. in Political Science. After obtaining her medical degree from the University of Texas – Houston, Katie and her husband Jack, a military physician, moved to Georgia where they were stationed for several years. Katie moved to Charleston in 2012 and completed her upper level residency training here at MUSC. She has been on staff in the department for several years and is looking forward to her new role as Medical Director of the Anesthesia Preoperative Clinic. Katie, Jack, and their two sons Jackson and Alexander live in Mount Pleasant and enjoy traveling, spending time on the beach, and taking part in the many festivals Charleston has to offer.

**WELCOME NEW STAFF MEMBER JACKIE FISHER**

Jackie was born and raised in Southern California, but has lived in many locations thanks to her husband's career in the US Navy, including North Chicago, Illinois and Okinawa, Japan. After being stationed in Charleston in 2002, Jackie and her family fell in love with the Lowcountry and decided to make Charleston their home. She has been with MUSC for just over 10 years and is excited to join the Department of Anesthesia as an Administrative Coordinator.

WELCOME NEW STAFF MEMBER LAUREN BYERS

Lauren is excited to be joining the MUSC Anesthesia Department! Lauren grew up in Buffalo, NY, and graduated from Allegheny College in Pennsylvania with a Bachelor of Arts in Economics in 2008. Lauren spent the last five years at East Carolina University serving in the Undergraduate Admissions office and Student Affairs division, while also completing her Master of Arts in Adult Education in 2012. She is excited to be joining her fiancé Will in Charleston, spending time at the beach, and exploring all that Charleston has to offer.



JOHNS HOPKINS' PREOPERATIVE ROADMAP

A group from MUSC consisting of Drs. Katie Bridges and Scott Reeves, along with Sharon Turner (Rutledge Tower Clinical Director Perioperative Services) and Dee Sans (Quality Director, Perioperative Services) went to John Hopkins in June to learn about their preoperative process. John Hopkins is approximately 25% larger in bed capacity compared to MUSC. They currently see approximately 40% of their surgical patients and very few NORA patients. We are all struggling with the same issues. From the visit, we identified a few MUSC opportunities for improvement:

- Update our website
- Consider a single preoperative instruction packet to be distributed by all surgical clinics
- Make NPO guidelines more prominent
- Re-educate about lab tests
- Formulate standards for morning of surgery drug withholds
- Work with Hopkins to be a part of a new EPIC based screening tool

During the day-long event, we were also shown the historical areas of the hospital and had the opportunity to have lunch with their cardiac anesthesiology faculty and fellows.



Johns Hopkins ACCM

@HopkinsACCM

 Follow

Our Cardiac Anesthesia folks enjoying a visit from MUSC's Dr. Scott Reeves



JOHNS HOPKINS' PREOPERATIVE ROADMAP PHOTOS



Drs. Reeves and Bridges at the Alfred Blalock Clinical Science Building at Johns Hopkins



Command Center at Johns Hopkins



Drs. Reeves and Bridges with statue of Jesus and painting of Dr. Blalock



WELCOME SUMMER STUDENTS!



Madeline Nykamp is a rising second year medical student at Creighton University working on research for Dr. McSwain through the FAER program. She has an interest in anesthesiology as a future specialty. This is her first time in Charleston and she is having a fantastic experience at MUSC thus far!

Stewart Trask is a rising senior at the Governor's School for Science and Mathematics and she is from Beaufort, South Carolina. She's doing research with Dr. Catchpole on human factors in anesthesiology and will be here for the next three weeks. She loves MUSC and Charleston and hopes to return someday as a medical student.



DEPARTMENT CELEBRATION & NEW RESIDENT WELCOME

Please join us for the Anesthesia Department's
New Resident and Fellow Welcome Celebration

Saturday, August 20 at 6:00 p.m.

360 Fishburne St., Charleston, SC 29403



Charleston Riverdogs
Baseball Game

Tickets, BBQ, and beer will be provided.
Families and kids are welcome to attend!

*Please RSVP by August 1st to Tara Chauhan
chauhant@musc.edu or (843) 792-4316*

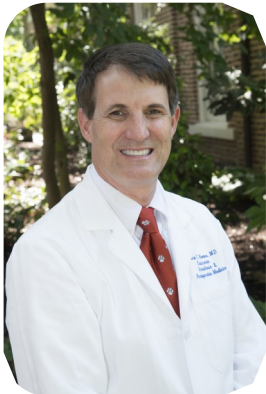
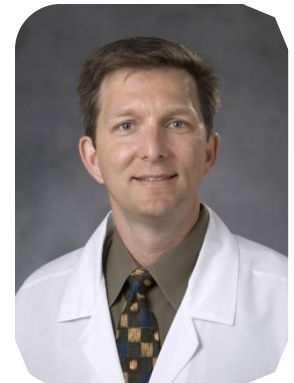


GRAND ROUNDS FOR MONTH OF JULY



**Topic to be Announced
July 5, 2016
Ryan Nobles, M.D.
Medical University of South Carolina
Assistant Professor**

**“Opioid Hyperalgesia: Perioperative & Clinical Implications”
July 12, 2016
Thomas E. Buchheit, M.D.
Duke University School of Medicine, Anesthesiology
Associate Professor, Division of Pain Management Chief**



**State of the Department Address
July 19, 2016
Scott T. Reeves, M.D., MBA
Medical University of South Carolina
Chairman**

**“Morbidity & Mortality Conference”
July 26, 2016
George Guldán, M.D., Assistant Professor
Ryan Gurselman, M.D., Assistant Professor
Medical University of South Carolina**



DEPARTMENT OF ANESTHESIA
 AND PERIOPERATIVE
 MEDICINE

Medical University of South Carolina

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Fax: 843-792-9314

 CHECK OUT OUR WEBSITE AT:
[HTTP://WWW.MUSC.EDU/ANESTHESIA](http://www.musc.edu/anesthesia)
Future Events/Lectures
Intern Lecture Series

 July 28th—Ischemic Heart Disease, Dr. Guldan,
 ART 4044

CA 1 Lecture Series

 July 6th—Perioperative Emergencies & ACLS,
 Dr. Hand, CSB 429

 July 13th—Patient Prep & Handoff PBL,
 Dr. Clark, CSB 429

 July 20th—Airway Management, Dr. Hassid,
 CSB 429

 July 27th—Inhalation Anesthetics, Dr. Nelson,
 CSB 429

CA 2/3 Lecture Series

July 4th—Holiday

 July 11th—Chronic Pain Management (Ch. 58),
 Moodle, Dr. Smith

 July 18th—Sympathetic Nerve Blocks (Ch. 26),
 Moodle, Dr. Nobles

July 25th—To be announced

Grand Rounds

July 5th—Topic TBA, Dr. Nobles, BE 110

 July 12th—Visiting Professor—Opioid
 Hyperalgesia: Perioperative & Clinical,
 Dr. Buchheit, BE 110

 July 19th—State of the Department Address,
 Dr. Reeves, BE 110

 July 26th—Morbidity & Mortality Conference,
 Drs. Gunselman & Guldan, BE 110

I HUNG THE MOON

Don't forget to nominate your co-workers for going 'Beyond the Call of Duty'. I Hung The Moon slips are available at the 3rd floor front desk, and may be turned in to Kim Pompey. Thanks so much!!

DJ Beckman, Anesthesia Tech—#1 Picking up a last minute shift after working that day! #2 Great team work during trauma!

Zach Halewood, Anesthesia Tech—Picking up a very last minute call shift! Thanks so much. Great team player!

Chris Devine, CRNA—Great team support. Thanks for getting case started for trauma!

Christopher Skorke, MD—Great team effort during trauma!

Macy Uebelhoer Belt, Anesthesia Tech—#1 Thank you for all your hard work in several busy rooms and OR2; we appreciate you! #2 Great team support during trauma!

Kari Platts, Anesthesia Tech—Good team support during trauma!

Alexandra Lataille, MD—Good working; stepping up and helping out in trauma. Thanks for your help!

Marcus Berry, Anesthesia Tech—Great team support during trauma!

Heather Highland, CRNA—Great team coordination during trauma. Always cool and collected!



**Department Celebration &
 New Resident Welcome, August 20th
 Riley Park**

**Department Holiday Party, December 2nd
 Carolina Yacht Club**

July 2016
Standard of the Month

**Contribute my ideas for the
 purpose of continuous
 improvement, problem
 solving and learning.**

We Would Love to Hear From You!

If you have ideas or would like to contribute to *Sleepy Times*, the deadline for the August edition will be July 22, 2016.