



# SLEEPY TIMES

VOLUME 12, ISSUE 3 MARCH 2018



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**MESSAGE FROM THE CHAIRMAN: FACULTY VICTORIOUS -SCOTT T. REEVES, MD, MBA**

On February 20th, the annual faculty vs. resident bowling tournament was played at the Alley. Personally, I was optimistic for the faculty’s chances with the departure of the resident ringer, Tony Lawson. For those not familiar with the format, the rules are simple: no warm up and the faculty member or resident with the highest score in first game wins the tournament for their group.

It was a very competitive event. It came down to the final frame. Rob Mester pulled it out for the faculty with a score of 186 compared to resident Kevin Draper’s high score of 184. I knew that Dr. Mester would be a good faculty recruit!

For the next year, faculty have bragging rights. Enjoy the pictures below.



COUSE	1	2	3	4	5	6	7	8	9	10	Total							
IAN	-	3	1	64	-	X	6	-	3	7	-	6	6	-	4	2	94	
ERIC	7	-	8	-	9	9	6	6	5	4	9	7	1	7	9	-	127	
RYAN	6	6	1	X	8	-	5	-	6	1	X	8	1	7	1	9	5	112
REEVES	6	2	1	6	X	9	2	6	7	2	9	5	1	6	-	1	8	100
SAM	1	4	13	22	22	22	29	36	41	41	42	-	-	-	-	-	42	
POP	1	6	5	7	2	6	-	X	X	X	X	X	X	9	-	-	186	
IAN											661							
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**BOWLING CONTINUED...**



## MUSC TERMINATES EMPLOYEES WHO 'SNOOP' IN PATIENTS' MEDICAL RECORDS BY MARY KATHERINE WILDEMAN AND LAUREN SAUSSER, POST & COURIER

*"With the continued movement of medicine to electronic platforms (EHR), it is critical that we understand the issues concerning inappropriate access to patient data." - Dr. Scott Reeves*

Thirteen employees were fired in 2017 from the Medical University of South Carolina after administrators determined they had broken federal law by using patient records without permission, spying on patient files or disclosing private information. Some of these privacy breaches involved high-profile patients.

MUSC staff explained to the hospital's Board of Trustees during a recent meeting that designated employees monitor the news media for any potential privacy breaches. Sometimes, they said, health care providers will "snoop" in patient records after a case makes the news. Eleven of 58 privacy breaches at MUSC in 2017 were categorized as snooping.

While other Lowcountry hospitals reported they fired no employees for such violations in 2017 or would not disclose any personnel data, the punitive actions taken at MUSC shed light on human resources decisions made by leaders at the state's top academic medical center, and more broadly, the security of confidential health care information in the digital age.

But patients shouldn't worry excessively about the security of their own information. Experts agree that digital medical records are more secure than paper ones. Elizabeth Willis, the corporate privacy officer at Roper St. Francis, said the ability to track each employee who opens a record makes patient files less vulnerable to a security breach. "Employees are granted access to medical records based on their jobs," Willis said. "Everything they do online is traceable back to them."

### 'DRACONIAN' POLICY?

Steven Cardinal, a senior information security analyst at MUSC, told The Post and Courier most people characterize security breaches as the massive kind that make the news, such as the hacking that affected 79 million Anthem customers in 2015. But Cardinal's team has been communicating to MUSC's practitioners how small breaches can be harmful to patients, too.

"We just try to stress that a one-person breach is a bad thing for that one person," Cardinal said. "That's someone who came to us and trusted us." All MUSC providers, including medical students, who have access to health records are required to complete annual training. Cardinal said his department has been investing more resources into this training, including in-person forums open to everyone, to communicate the importance of the issue. "This isn't going to go away," he said. "The risks are going to keep increasing."

At the recent MUSC Board of Trustees meeting, staff explained that the hospital was required to report all 58 patient privacy breaches in 2017 to the federal government. Thirteen of those breaches resulted in firings. One board member questioned whether the policy was "draconian."

Staff explained that the threat of a federal audit prompted leaders to take swift action against employees who violated the Health Insurance Portability and Accountability Act of 1996. Commonly called HIPAA, the law created national standards for protecting patient records and privacy. The U.S. Department of Health and Human Services has been auditing more than 100 institutions for potential HIPAA violations, MUSC staff said, and MUSC is preparing for the possibility that it, too, might be audited.

In cases where HHS finds wrongdoing, it may impose fines, require the institution to develop a plan of correction and monitor the institution for a set period of time. MUSC spokeswoman Heather Woolwine issued a statement underscoring that the hospital takes patient privacy seriously and deals with any breach quickly and decisively. "Some breaches are simply a case of information being faxed to the wrong clinic location, whereas others can involve misplaced curiosity or malice," Woolwine said.

She provided further information about security breaches and terminations at MUSC dating back to 2013. Since then, MUSC has identified 307 breaches and 30 employees have been fired. Nearly half of all those firings occurred last year. None were physicians, Woolwine said. "Transparency is incredibly important, and necessary, to prevent and discourage future breaches," she said. "While we know intellectually that we can't prevent every breach, we will continue to try."

## MUSC TERMINATES EMPLOYEES WHO 'SNOOP' IN PATIENTS' MEDICAL RECORDS BY MARY KATHERINE WILDEMAN AND LAUREN SAUSSER, POST & COURIER

### OTHER HOSPITALS

Federal law requires health care providers to use electronic medical records. And while [high-profile security breaches](#) occasionally make national news, health care experts agree that digital records are less likely to be lost, stolen or rifled through in an electronic format. Sharon Harper, a registered nurse and owner of Coastal Patient Advocates, explained that patients may request to see who has accessed their information. "And if they couldn't get it, their attorney certainly could," Harper said.

At MUSC, some employees have violated the law when they poked around patient files where they weren't supposed to be looking. In one case, an ex-spouse repeatedly accessed his former wife's private information. Dr. Joseph Vanlear Dobson was suspended from MUSC for 29 days without pay in 2016 for looking at his ex-wife's records 15 times between 2008 and 2014. MUSC found out through an additional investigation he had snooped on his ex-girlfriend's records 70 times between 2014 and 2016. Dobson's ex-wife said she "did not believe that he did it with malicious intent" and his ex-girlfriend gave the pediatrician "retroactive" permission to look at the information. But retroactive permission does not count as far as the law is concerned.

Dobson, who resigned from MUSC in 2016, was fined \$440 and was required to take a HIPAA course, according to records published by the S.C. Board of Medical Examiners. Dobson now works part time at Summerville Medical Center and confirmed in a prepared statement that he resigned from MUSC. "I have proudly served patients and families in South Carolina for more than 15 years," Dobson said. "With reference to the Board of Medical Examiners matter, I completed all requirements, and the matter is closed. My license to practice medicine is in good standing."

A spokesman for Trident Health, which owns Summerville Medical Center, would not disclose how many employees have been terminated for HIPAA violations at the hospital system in recent years. Likewise, a spokesman for Roper St. Francis said the hospital system would not provide the number of employees fired for HIPAA violations.

A spokeswoman for East Cooper Medical Center said no one at the hospital has been fired for such a violation in the past five years, and a spokeswoman for the Ralph H. Johnson VA Medical Center offered data showing one employee in 2013 and one employee in 2018 were removed for HIPAA violations. More often, employees at the VA were reprimanded or suspended for violations. "Violators are subject to administrative action and possible criminal prosecution for misuse," said Meredith Hagen, a spokeswoman for the Charleston VA hospital, in a statement. "The Privacy Officer and Information Security Officer continuously monitor for any inappropriate access to the records."

The federal Department of Health and Human Services, which polices the HIPAA law, did not respond to questions for this story.

### LARGE BREACHES

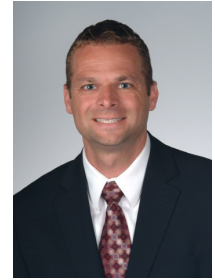
Large HIPAA breaches — defined as those that affect more than 500 individuals — are [searchable online](#). The federal database currently shows no large breaches under investigation in South Carolina. In the past five years, 23 large breaches have been reported in the Palmetto State. The most recent one took place at a Roper St. Francis facility and affected 576 individuals in January 2017.

That month, a digital camera used to take photos of newborn babies at Roper St. Francis Mount Pleasant Hospital was reported missing. The pictures and identifying information for approximately 500 babies were stored on the camera's memory card. The loss constituted a privacy breach, and the hospital was required to report the incident to the federal government. In another large case, a South Carolina Medicaid employee transferred private records to a personal email account, compromising information for 228,435 people in 2012.

And while the federal government may levy large fines for HIPAA violations, [a 2015 ProPublica investigation](#) found it rarely issues financial penalties. In fact, among the 23 large breaches reported in South Carolina since 2010, the federal database does not indicate any fines were ever imposed.

## FINAL THOUGHTS ON THE MISSION TRIP TO GUYANA BY ERIC NELSON, DO AND IAN OSBORN, MD

From late January to early February, Ian Osborn and I had the opportunity to travel to Georgetown Public Hospital in Georgetown, Guyana through the American Society of Anesthesiologists Global and Humanitarian Outreach Program. The purpose of this trip was to help teach the anesthesia residents in the country of Guyana. This partnership has been going on for 5 years, and the program graduated their first resident in 2017! Through this partnership, the ASA and the Canadian Society try to send an anesthesiologist each month from 2-4 weeks to teach curriculum to the Guyanese Residents.



After a long journey, we arrived in Georgetown and hit the ground running. We started each day in the ORs with the residents and just went from room to room teaching and helping with cases much like attendings do here. In the afternoon, we had lecture time with the senior residents. The first week we focused on cardiothoracic anesthesia as part of the curriculum, and the second week we did oral board review. We also did a lot of OB and regional lectures as the residents there had a lot of questions and requested these talks.

One of the more fulfilling talks we did was an in service on the defibrillator. None of the residents knew how to use it and confessed they were scared if they ever had to! After the in service they went to the ICU and OB to make sure the defibrillators there were functional and had all the necessary defibrillator pads! The whole exercise turned into a mini QI project!

Guyana is a country with a population of about 750,000, the majority of which live in cities near the northern coast. The rest of the country is essentially untouched amazon rainforest. It was a British Colony until 51 years ago and currently identifies as a Caribbean nation. Other than Georgetown Public Hospital, there are smaller district hospitals that treat patients throughout the country, and also private hospitals that see patients with insurance and money to pay for treatment.

The ASA/GHO program is great and really symbolizes the "pay it forward" model of mission work by training workers in their home country to expand capacity and make surgery and anesthesia more accessible and stable. The program is always looking for volunteers who can give 2-4 weeks and they make it easy by funding the trip and helping organize housing and providing a curriculum based on your sub specialty! For more information about the Guyana trip and other opportunities check out: <http://www.asahq.org/gho>



The trip to Guyana was definitely unique, filled with interesting experiences and challenges. Unlike other medical mission trips I have gone on in the past, I feel the design of this trip was special and longer lasting. Normally during medical mission trips, we simply are providing a service to a community with limited capabilities. The effect is small, with little long term benefit other than the few people we are able to serve during the short stay. This trip, however, was different, as it was focused on teaching and education. By doing so, we escalate the capabilities of the population served, and in my opinion, truly create a long lasting benefit to the population.

The work days were filled with supervising in the ORs in the morning and doing teachings and lectures in the afternoon. Much of the topics were developed through our observation of what could be improved, plus the anesthesia residents were very active in expressing their shortcomings and areas they wanted additional education. It was very motivating to have the residents so outgoing and thirsty for knowledge. Dr. Nelson and I would spend our evenings creating new lecture plans for the following days. We did some hands on workshops on operating the defibrillator. The residents knew where they were located, but had never been shown how to operate them. We also did some ultrasound teachings in the OR; unfortunately, they only had a limited supply of local anesthetic, so were unable to actually do any nerve blocks. We could have stayed a month and still come up with new topics and new things to show them, both preoperatively, intraoperatively, and in the ICU.

The most common cases we saw were Ortho, Trauma, Gyn, General, Plastics (Burns), and ENT. It was easy to see why 2/4 ORs were dedicated to Ortho when you walk around the city. After 2 weeks, I still cannot say for sure I truly understand their driving laws. Instead of braking at intersections, you simply had to honk the horn multiple times. No sidewalks either, so your only option is to walk along the road. There is no yielding to pedestrians, which makes for some exciting walks at times. It seems everyone has a side gig as a taxi driver and every ride costs \$2.50, regardless of the distance traveled. There are also "disco party" vans (buses), but there are no actual bus stops—they simply honk at every pedestrian to see if they want a ride. They cram you in, turn on some green inside lights, blast music, and drop you off "near" your final destination. It was a very interesting experience for sure. All in all, we had a great trip, got to see a lot of the history and sites of the city during our off hours, and explored the largest single drop waterfall in the world. Very cool! I hope these trips are continued so other people can share this unique experience.

## DEPARTMENTAL UPDATES OF MISSION TRIP TO GUYANA BY ERIC NELSON, DO AND IAN OSBURN, MD

January 22, 2018

Scott,

We arrived in Guyana safely this morning. The trip was long, including an overnight at the airport in Trinidad. These trips never fail to amaze me. Someone from the hospital met us at the airport and then brought us to a hotel rather than the guest house. Apparently the guest house was full, but we have good accommodations for the next couple of weeks and it turns out we're close enough to safely walk to the hospital. We went to the hospital after resting up and found the ORs and met the residency program director. We'll be able to hit the ground running first thing in the morning. We'll be doing a mixture of teaching in the ORs and also have lectures we'll be giving and doing some mock oral boards.

I'll email over the next couple days and hopefully have some pictures to include as well. Thank you for all your support!

Eric



January 23, 2018

Hello Dr. Reeves,

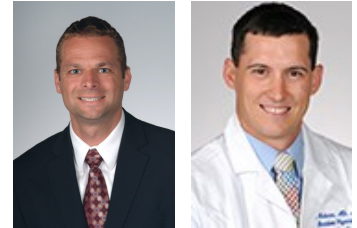
I thought I would give an update on the exciting adventure Dr. Nelson and I are having here in Guyana. The adventure began with a large amount of time spent in the airport and trying to sleep in airport chairs. In Trinidad, the only couches were located right in front of a 100" TV playing Carnival celebration videos, LOL. After our three-day airport travel adventure, we finally made it. Our accommodations wound up being changed without us knowing, so that is always exciting, but I think it worked out for the better as now we are only two blocks away from the hospital.

Today was our first day in the OR, and it was exciting from the start. The first case of the day was a difficult airway that we got to watch them troubleshoot through. The patient was a 16-year-old female with extensive burns to chest and neck, and she was coming in for a contracture release. Due to contractures, she had reduced movement, and it was difficult to try to get her in good sniffing position. With the severity of her burns, I am sure her internal anatomy was altered from scarring as well. They used inhaled induction to keep the patient spontaneously breathing during their attempts. After they tried several different ways, they finally broke out a handheld video laryngoscope, and we were like, "You had this all along?" LOL. The case started off nicely, that is until it was realized the anesthesia machine did not work and the ventilator part would not turn on. We got to see them roll in another anesthesia machine and replace it during the middle of the case. I have never seen that before; that was impressive on its own.

The rest of the day was filled with teaching their Anesthesia residents, both in and out of the OR. It has been a great experience so far, and I am excited to see what other adventures the rest of our stay will bring. I am helping to create some more lectures for the residents so our visit is filled with meaningful education curriculum.

Please see the pics attached :)

Ian Osburn



## DEPARTMENTAL UPDATES OF MISSION TRIP TO GUYANA CONTINUED... BY ERIC NELSON, DO AND IAN OSBURN, MD

January 25, 2018

Hello Dr. Reeves,

Guyana continues to be a very rewarding experience for both Dr. Nelson and myself. The training structure is very different from our own. I guess that is to be expected but still surprising in regards to certain details. Anesthesiologists only require two years of training here, after which they receive their Anesthesia certificate and are free to do "bread and butter" anesthesia cases. If you want to do more complex anesthesia, or work in a training hospital, you have to become a Consultant, which basically means you go back and complete two additional years of training. Residents are required to be much more independent here; if there is no anesthesiologist for their room, then there simply is no anesthesiologist, and they do the case themselves. After seven months of anesthesia training, they take in house call for trauma and OB completely by themselves with no supervision. The residents tell me it builds your confidence very quickly those first few calls, LOL, I imagine it would. I would be terrified.

It is interesting to see what they have and don't have here. For example, they have an ultrasound, but no one really has the training to teach them how to use it for regional anesthesia, so they simply do not do regional other than spinals. I have created a lecture I will be giving them next week on the most common blocks for the cases they do and what to look for on ultrasound. The residents are excited for this training. Dr. Nelson did a talk on pacers/ICDs, which the residents have received very little training on, and really did not know how to manage a patient with one of these devices. This is especially important as these devices become cheaper and the residents comment that they are starting to show up more and more here. Tomorrow, we will be doing training on how to use the cardioverter/defibrillator and ACLS, because they have never received formal training on these either. When I first came, I wondered what I was going to be able to contribute, but as each day shows me, there are a lot of things I see commonly that they never see/do, and they are excited for the extra training. I really feel this has been an eye-opening and beneficial experience for both myself and the anesthesia residents of Guyana.

I found it interesting they do not have "air" as a gas, so everyone is run on 50% nitrous, unless there is a contraindication (then they are run on 100% FiO<sub>2</sub>, but with low flows). They use halothane here for inhaled inductions, then convert to Iso. They have to incorporate thiopental every now and then because they simply run out of propofol. It's very interesting to see how they adapt to various shortages. It does remind me of home though, with our new and growing list of drug shortages, but definitely not to the same degree. They do have IV valium here, and I would have loved this when I was in MSICU dealing with alcohol withdrawals. I will give more updates as the week goes on, discover new topics to teach, and the various work arounds they deal with on a daily basis. I feel this is expanding my toolkit for how to provide anesthesia in a variety of situations. This trip has been very cool so far, and continues to be so each day.

Ian Osburn



## DEPARTMENTAL UPDATES OF MISSION TRIP TO GUYANA CONTINUED... BY ERIC NELSON, DO AND IAN OSBURN, MD

January 31, 2018

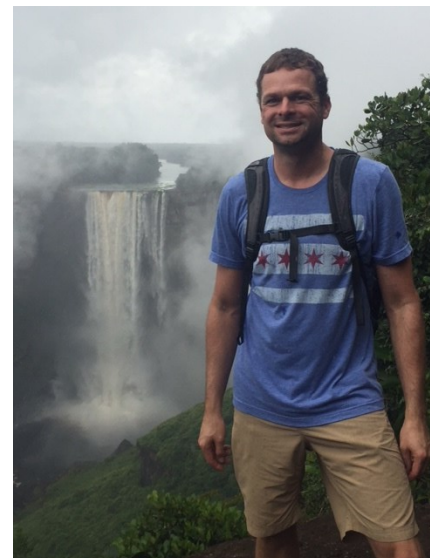
Hello Dr. Reeves,

We are getting near the conclusion of our visit here to Guyana. What a great trip and rewarding experience it has been. Dr. Nelson and I decided to explore the rainforest here a little and chartered a flight out to Kaieteur Falls, the largest single drop waterfall in the world at 741 ft (4x height of Niagra for comparison). The only quick way to get there is by plane. Theoretically, you can take a boat or hike our guide tells us, but the nearest village is 59km away. The guides themselves stay at the Falls for three months at a time, coming back in for a week at a time—talk about being totally secluded and isolated! The experience was very cool. We even got to see their rare and famous golden frog, which is a tiny frog that lives in the bromeliads surrounding the waterfall. We also saw a very rare orange bird called "Cock of the Rock," and it is probably my new favorite bird of all time! LOL

We are past our halfway point through our final week, and it is really bittersweet. We're excited to come home to a warm shower, but sad to leave this place for sure. The Anesthesia residents have been fun to work with and are very proactive in seeking out new information. I really want to send a shout out to Drs. Hebbar, Mester, and Fields, who helped supply us with various lecture topics during our stay. The residents very much appreciated the information provided. The residents were excited to incorporate some of the nerve blocks for post operative pain control, however, they currently do not have any long acting LAs for the blocks. They do have a small collection of 2ml vials of 0.75% bupiv, but it is reserved for their spinals. We are leaving a flash drive behind with all of the slides and lectures so they can refer back to it once they have additional local available. In the mean time, we are practicing with the ultrasound with each case where we could apply regional, just to familiarize them with using the ultrasound and identifying where they would want to inject the local.

Every day brings new challenges and excitement. Today, for example, they ran out of sterile gowns, so all the cases were canceled except for emergencies. Resource management is by far the biggest challenge here. They do get creative when they can and try to conserve resources to the best of their abilities. It's pretty amazing, really. One surgeon did joke that we should just cover the patient with an iodine wash and he would be good to go, doesn't need the sterile gown—at least I think he was joking, LOL. Our week is coming to an end, we are cranking out a lot of topics for the residents these next 2 days, and focusing a lot on Oral Board Prep. I find it 1000x more enjoyable to be on the side of the examiner and not the testee! It has been a truly awesome experience, and I hope we are able to continue being a part of this training program for years to come. I think it is beneficial for both the Anesthesia residents and the patient population of Guyana. Thank you for allowing us this opportunity to serve!

Ian Osburn





## DEPARTMENTAL UPDATES OF MISSION TRIP TO GUYANA CONTINUED... BY ERIC NELSON, DO AND IAN OSBURN, MD

February 4, 2018

Scott,

We're back in the US on a layover in Houston. This trip was amazing! I feel like Ian and I were really able to make an impact. We spent the mornings in the operating rooms teaching and talking with the residents during cases, and then every afternoon we had lectures. We were able to get through the curriculum given to us by the ASA the first week, so the 2nd week we focused on lectures the Guyana Residents asked for. Thankfully, we had time in the evenings and WiFi to help us prepare these lectures. We were also able to do some oral board review. They have an oral board at the end of their 2nd and 4th years given to them by their faculty. It seemed to really help, especially when we used cases that they hadn't seen before, such as vascular surgeries.

The last couple days we focused on the junior residents. The head of their program, Dr. Harvey, commented to me that all the residents were making an effort to come to teaching sessions, which I guess usually doesn't happen.

This trip reminded me a lot of the old Tanzania trips we used to do in that it's mostly teaching based, and we're really filling in gaps in the resident education. I think Ian got a lot out of it as well, and I know the residents in Guyana enjoyed interacting with one of their peers from the US and learning from him.

As I mentioned before, the ASA and Canadian Society each try to send someone at least once a month to help teach. A couple of times this past year, someone has either backed out or there just wasn't a volunteer. My understanding is that during those months, the residents don't really get any teaching. Without the volunteers, the residents' learning is pretty much on their own with whichever textbook they happen to have (if they can afford one). My hope, maybe even dream, is that MUSC can commit to sending someone once a year to Guyana on this trip. I think it'd be great for the residents to have an international rotation that involved teaching as well.

Hopefully, we can get together in the next couple weeks for a full debrief.

I'm tired and somewhat drained, but as I said, this trip was better than I imagined, and I feel really encouraged about the work we did. Thank you again for all your support.

Eric



## CLEMSON, MUSC SHARE GAINS MADE IN OR DESIGN PROJECT BY TARA ROMANELLA, CLEMSON UNIVERSITY RELATIONS

Lead investigators on the joint MUSC-Clemson project titled, "[Realizing Improved Patient Care Through Human-Centered Design in the OR](#)" (RIPCHD.OR) are Scott T. Reeves, M.D., the John E. Mahaffey, M.D. endowed chair and MUSC Department of Anesthesia and Perioperative Medicine chairman, and [Anjali Joseph](#), Ph.D., the Spartanburg Regional Health System endowed chair in architecture and director of the [Center for Health Facilities Design and Testing at Clemson University](#).

The goal of RIPCHD.OR is to analyze every aspect of the current OR standard and redesign it with efficiency and improved patient care in mind. Surgical leaders from the South Carolina Surgical Quality Collaborative, led by Mark Lockett, M.D., will help vet the group's findings.

"We've taken a comprehensive, evidence-based approach to redesigning operating rooms to create an evidence-based design solution that simultaneously tackles problems related to workflow, equipment design and the built environment – major areas that impact patient safety outcomes," Joseph said.

The new operating room design aims to:

- improve staff safety by reducing clutter and trip hazards;
- reduce surface contamination through material selection and improving ergonomics;
- support team communication by refining sightlines and visibility within the O.R; and
- adapt as care delivery and technology change without significant cost or disruptions through use of modular wall panels.

The team of researchers, engineers and clinical specialists involved in this project received a four-year, \$4 million research grant from the Agency for Healthcare Research and Quality in 2015 to research and develop a safer, more efficient OR.

"We want to establish a new standard on what should be considered when you build an OR, and the first two years of this project have been dedicated to that end," Reeves said. "Now in our third year, we've designed and constructed a simulation of this future state OR, complete with mannequins and software that will enable comprehensive testing of the design. It's exciting to be at this point in the project, and we are eager to start collecting more data and feedback."



MUSC's Scott Reeves '83 and Clemson's Anjali Joseph view the high-fidelity mockup OR on display in the Clemson Design Center.

## **CLEMSON, MUSC SHARE GAINS MADE IN OR DESIGN PROJECT CONTINUED... BY TARA ROMANELLA, CLEMSON UNIVERSITY RELATIONS**

Most ORs across the nation consist of a cramped, square white room with a patient bed in the middle of the space; they are antiquated, confined spaces that do not accommodate today's high-tech surgical equipment, complex processes and human interactions. Distractions and interruptions are major causes of errors during surgery and often lead to patient harm. Additionally, up to five percent of patients who undergo surgery will develop a surgical site infection. Smarter, evidence-based design has the potential to make operating rooms safer for patients and health care personnel alike.

"The standard OR does not support the needs of the patients, nurses or surgeons, so we're excited to have reached the testing point for these new concepts and to demonstrate what we've learned through this mock OR and simulation experience," Joseph said.

The first-of-its-kind project covers three specific areas of research designed to improve patient care and efficiency in a future OR design: unmasking of anesthesia-related alarms and communications, traffic flow and door openings, and an integrated OR suite design. The design and fabrication of the prototype room was developed by a team of graduate students in the Architecture + Health program at Clemson under the direction of Alumni Distinguished Professor David Allison, in collaboration with the research team, MUSC clinicians and industry partners.

Reeves and Joseph agree — this groundbreaking project would not have become a reality without multidisciplinary, collaborative forces teaming up to improve patient safety and care.

"When institutions of excellence align their interests and work together to achieve a common goal, patients win," Reeves said.

"It has been a really wonderful relationship between Clemson and MUSC that has made this all possible," Joseph explained. "We have the researchers, expertise and the manpower to do all of this, and MUSC has the leadership and know-how it takes to implement it."



Drs. Joseph and Reeves during the Jan. 25 unveiling of RIPCHD.OR in Charleston.

## CLEMSON ARCHITECTURE PROGRAM TEAMS UP WITH MUSC TO DESIGN A BETTER OR BY LAUREN SAUSSER FOR THE POST AND COURIER

As hospitals around the country increasingly focus on improving patient safety, a group of doctors and architects are teaming up in Charleston to design a better operating room.

"In the United States, in particular, we've done a lot with patient safety in the last 20 years, but we've never really looked at the space in which we work," said Dr. Scott Reeves, chairman of anesthesia and perioperative medicine at the Medical University of South Carolina. "We basically build the same boxes over and over again."

MUSC doctors and Clemson University architects want to change that. The group won a four-year, \$4 million grant to study the issue and identify solutions.

"We're really trying to figure out how to make the operating room safer," Reeves said.

For three years, the group has been busy dissecting the layout and flow of hospital operating rooms. They identified six variables, including communication failures, interruptions and design flaws that impede optimal efficiency. Then, they set out to fix them.

For example, historically, operating room tables have always been placed in the middle of the room. But by shifting the table off-center toward the left-hand side of the room, doctors and support staff can move around each other more easily.

"We think it's going to make a big difference in how the support staff flow around the room," Reeves said.

Anjali Joseph, director of Clemson's Center for Health Facilities Design and Testing, said her group has identified other fixes, too, such as moving the storage space for medical equipment and designating a corner of the room for the anesthesiologist.

These changes will cut down on unnecessary movement, she said, and eliminate the potential for error.

In 2016, researchers at Johns Hopkins University identified medical error as the third leading cause of death in the United States, accounting for more than 250,000 deaths each year.

"There is such an urgent need to design a safer operating room," Joseph said.

This month, Joseph's team is building a mock operating room inside the Cigar Factory on East Bay Street, where Clemson's Charleston Architecture Center is located.

The room's design and layout will be further studied when the mock-up is finished. Eventually, a version of it will be built inside the new \$50 million MUSC Children's Health Ambulatory Campus in North Charleston.

"This award-winning research in health facility design is a perfect example of collaboration across multiple disciplines," said Richard Goodstein, dean of Clemson's College of Architecture, Arts and Humanities. "Our Clemson researchers and their partners from other institutions are combining their expertise and talents to completely reimagine surgical spaces that are more efficient — and safer."

Anjali Joseph is the director of Clemson University's Center for Health Facilities Design and Testing.



**CLEMSON ARCHITECTURE PROGRAM TEAMS UP WITH MUSC TO DESIGN A BETTER OR  
BY LAUREN SAUSSER FOR THE POST AND COURIER CONTINUED...**

**Anesthesia Workstation**

Located in the corner away from the OR entry with ample space to minimize interruptions

**Anesthesia Storage**

Located within anesthesia work area and across the monitor to provide quick access for the anesthesia team with minimal obstruction.

**Angled OR table position**

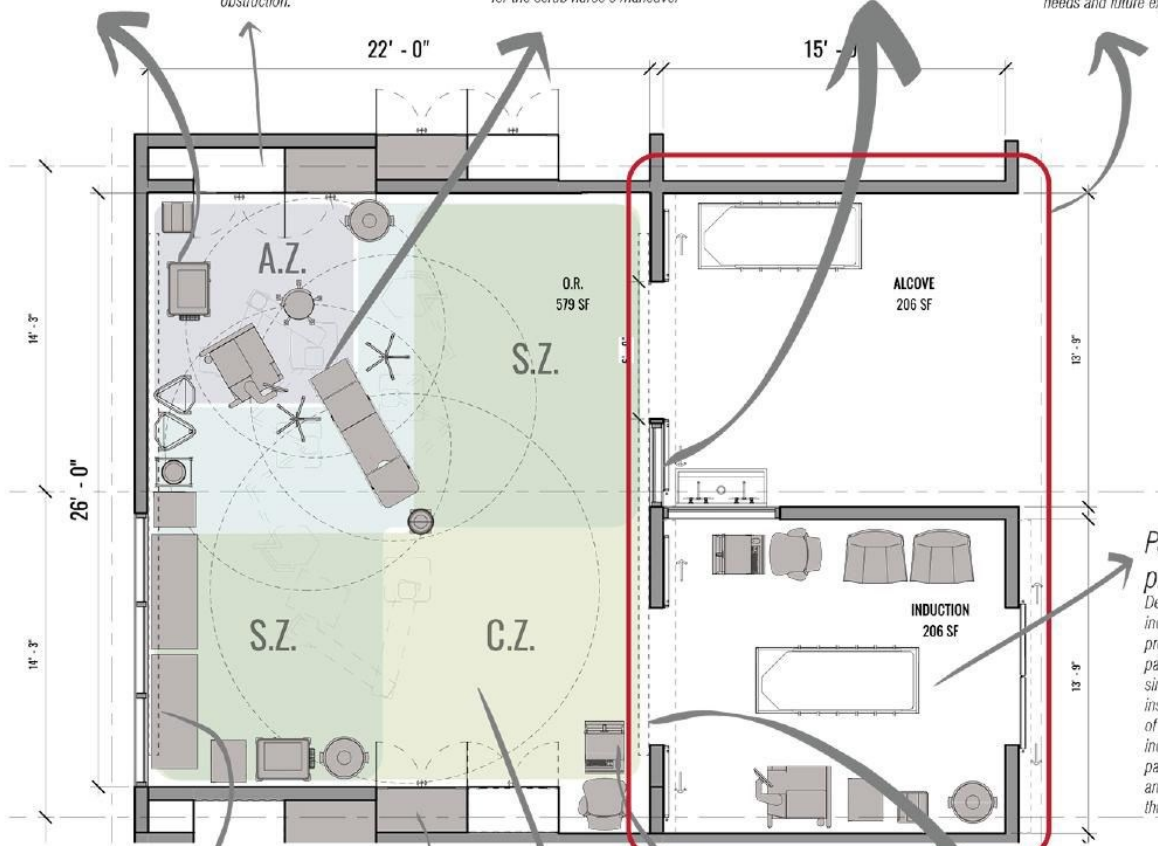
OR table angled to accommodate sidedness of surgery and ample space for the scrub nurse's maneuver

**Scrub Sink Window**

Scrub sink strategically located and equipped with a window to provide view into the OR

**Flexible room/suite chassis**

Flexibility, adaptability and expandability to accommodate changing needs and future expansion



**Parallel processing**

Dedicating an induction room to process two patients simultaneously inside and outside of the OR can increase patient and parent satisfaction and patient throughput

**Integrated Digital Information Displays**

Wall mounted screens to maximize visual awareness

**General Storage**

Located near CN's workstation to accommodate quick access to supplies and material by the CN

**Provision of sufficient circulation area**

Optimize movement and flow in the operating room

**Circulating Nurse Workstation**

Mobile CN workstation provided flexibility with rotation and move of the workstation as needed.

**Integrated Digital Information Displays**

Conveniently provide information needed on vitals and patient information with minimal body movement and adjustment

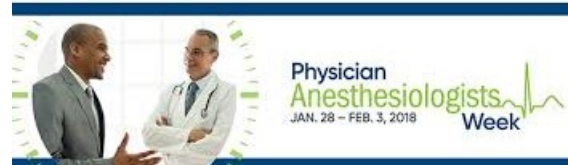
**NEW BABY IN THE DEPARTMENT**



Please congratulate Marianna and Patrick Ross as they welcome Owen James, 7lb 8oz, 20 inches, born on 2/21/18!



PHYSICIAN ANESTHESIOLOGISTS WEEK 2018



**MUSC ON FORBES FIRST-EVER LIST OF AMERICA'S BEST EMPLOYERS FOR DIVERSITY****PRESS RELEASE**

PUBLIC AFFAIRS &amp; MEDIA RELATIONS

135 Cannon Street, Suite 403 | Charleston, SC 29425 | 843-792-3621 | Fax: 843-792-6723

The Medical University of South Carolina (MUSC) has been ranked No. 53 out of 250 organizations on the Forbes 2018 list of America's Best Employers for Diversity. In addition, MUSC ranked No. 6 among the 20 institutions listed in the education category.

In collaboration with Statista, Forbes asked 30,000 employees working for large U.S. companies and organizations to evaluate their employers on issues of diversity in the workplace. Participation in the survey was voluntary, and respondents were recruited from thousands of sources to maximize reach and representation of the U.S. workforce. A company's score is determined by four parts: direct employee recommendations, a public perception score, percentage share of women who fill top executive and board positions, and an index of objective and publicly available diversity KPIs (key performance indicators). One of the KPIs used in the scoring is proactive communication of diverse company culture.

"We take great pride in this recognition from Forbes because it acknowledges noteworthy progress toward achieving one of the five goals of our strategy for the future – to Embrace Diversity and Inclusion," said MUSC President David J. Cole, M.D., FACS. "Together the D&I implementation teams led by our two chief diversity officers are pushing MUSC forward as an institution in a thoughtful, strategic and measurable way. The work these teams are doing is vital to the continued success of MUSC, and we need the ongoing commitment and engagement of our entire institution if we are going to succeed – not just in the short term but long term as well."

"Diversity has become a business imperative, because it makes businesses better places and richer in every sense of the word," said Forbes' Leadership Editor Fred Allen. "We hope that by introducing the definitive listing honoring the top performers we will stir discussion of the importance of diversity and inclusion and reinforce employers' determination to do the best at it they can."

"Our large survey of employees has shown that diversity is a highly relevant factor when choosing an employer," said Statista CEO Dr. Friedrich Schwandt.

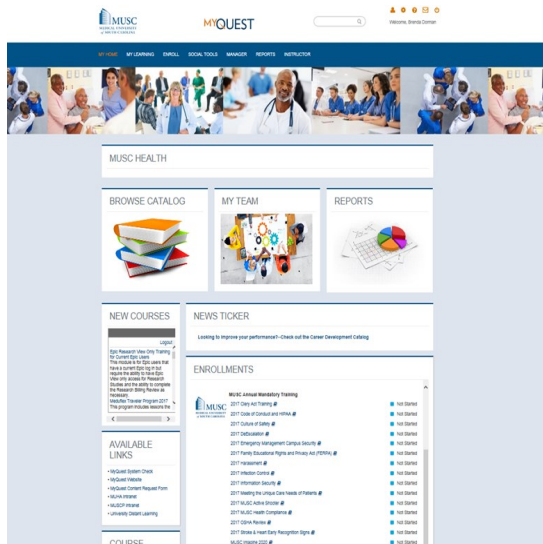
MUSC has two chief diversity officers (CDO) -- Willette Burnham-Williams, Ph.D., CDO for the university, and Anton J. Gunn, MSW, CDO for the health system. In addition, each of the six colleges at MUSC has a diversity officer, focused on achieving shared institutional D&I goals. With the active commitment of the most senior leaders throughout the enterprise, Burnham-Williams and Gunn collaborate across a workforce of more than 13,000 employees, along with nearly 3,000 students and 700 residents, to address the strategic D&I goals and outcomes identified in the organization's five-year strategic plan, titled Imagine MUSC 2020.

Dr. Cole and his leadership team have consistently stated that at MUSC, there are three reasons why embracing diversity and inclusion is of pivotal importance:

- It is who we should be as an institution. We are creating an environment where all individuals – students, faculty, staff, patients and visitors – truly believe they are in the right place and they belong here.
- It is how we build upon who we are and what we can achieve together. MUSC aspires to change the future through innovation in all of our domains – education, research and patient care.
- It affects the bottom line. It is about being our most productive and effective. People who feel valued are empowered to contribute and to be at their best.

To read more about MUSC efforts in support of Diversity and Inclusion, please access the article from a nationally recognized publication that tracks the details of Diversity in Higher Education. MUSC was profiled in 2016 and won a National Award in 2017: <http://www.insightintodiversity.com/medical-university-of-south-carolina-transforms-its-culture-through-accountability/>

## ANNUAL MYQUEST TRAINING DUE BY JUNE 30, 2018



It is time again to complete our MUSC Annual Mandatory Training courses which can be accessed through MyQuest. Training modules are tailored for specific roles in the organization and are due on or before June 30, 2018.

To access your required training modules, use the MyQuest icon found on your desktop and login using your netID and password. Your specific modules will be displayed in the *Enrollments* section of your home screen as seen below.

Remember, these are mandatory and must be completed by June 30.



## WELCOME TO THE DEPARTMENT

Please welcome Aaron Huber to the department! Aaron is originally from Myrtle Beach, SC. He attended Clemson University and graduated with a Business Management degree in 2010. Aaron then moved to Charleston, SC and attended nursing school at MUSC, graduating in 2012. He worked as a nurse at MUSC on 9 East and in the STICU for 3 years before being accepted into MUSC's Anesthesia for Nurses program. Aaron graduated in 2017 and accepted a job here at the Main OR. Four months ago, Aaron and his wife welcomed their first son, James, and he means the world to them! Aaron is very excited to start working here and can't wait to meet everyone!

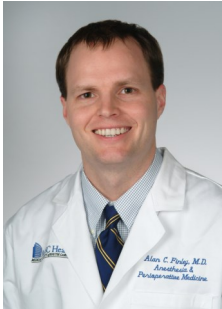


Allyn S. Miller-James recently relocated to the Charleston area from the Philadelphia suburbs to be closer to family and enjoy better weather. Originally from South Central Pennsylvania, she attended the Lancaster General Hospital School of Nursing (DIN, AST), the University of Maryland, Baltimore (BSN), the University of Pittsburgh (MSN, CRNA certificate), and University of Kansas Medical Center (Ph.D. program-candidate). Allyn has been in many different types of working environments, from academics to critical access. Her most recent position was at a physician-owned ambulatory surgery center as a CRNA/equipment manager/research liaison. Her research interests include using Structural Equation Modeling/Path Analysis for model testing of NDNQI data in APRNs. Allyn has completed multiple QI programs focusing on ERAS, PONV, equipment evaluation and competitive contracting, and benchmarking. She previously served as an elected school board director and hopes to become involved with the school board here in Charleston. Allyn is married to Matthew, an attorney, and they have three children, twins Faye and Rayna (4.5 years old) and a son, Aaron (2.5 years old), along with two mini schnauzers and a Dutch Au Pair. In her spare time, Allyn enjoys cooking, sailing, and target/skeet shooting.



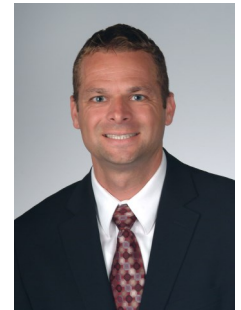


**GRAND ROUNDS FOR THE MONTH OF MARCH**



**“Implementation of a Bleeding Management Program”  
March 6, 2018  
Alan Finley, MD, Associate Professor  
Dept. of Anesthesia & Perioperative Medicine  
Medical University of South Carolina**

**“Morbidity & Mortality Conference (CT Cases)”  
March 13, 2018  
George Guldán, MD, Associate Professor  
Eric Nelson, DO, Associate Professor  
Dept. of Anesthesia & Perioperative Medicine  
Medical University of South Carolina**



**“Topic TBA”  
March 20, 2018  
Kelly Ural, MD, Cardiothoracic Anesthesiology  
Fellowship Program Director  
Dept. of Anesthesiology  
Ochsner Medical Center**

**“Topic TBA”  
March 27, 2018  
Timothy Heinke, MD, Assistant Professor  
Dept. of Anesthesia & Perioperative Medicine  
Medical University of South Carolina**





DEPARTMENT OF ANESTHESIA AND  
PERIOPERATIVE MEDICINE

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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

March 8th—Anesthesia for Peds,  
Dr. Sabbagh, SEI 314

March 22nd—Hematologic Disorders,  
Dr. Finley, SEI 314

#### CA 1 Lecture Series

March 7th—Obstetric Anesthesia PBL,  
Dr. Tobin, SEI 314

March 14th—Pediatric Anesthesia PBL,  
Dr. Redding, SEI 314

March 21st—Anesthesia for Cardiovascular  
Surgery, Dr. G. Whitener, SEI 314

March 28th—Special Problems or Issues in  
Anesthesiology PBL, Dr. Moore, SEI 314

#### CA 2/3 Lecture Series

March 5th—Pericardial Diseases & Cardiac  
Trauma PBLD, Dr. Heinke, Moodle

March 12th—Heart Failure & Cardiomyopathy  
PBLD, Dr. Francis, CSB 429

March 19th—Visiting Professor Lecture, All  
Residents, Dr. Ural (Ochsner), CSB 429

March 26th—Anesthesia for Heart & Lung  
Transplantation, Dr. Heinke, Moodle

#### Grand Rounds

March 6th—Implementation of a Bleeding  
Management Program, Dr. Finley

March 13th—Morbidity & Mortality Conference  
(CT Cases), Drs. Guldan & Nelson

March 20th—Visiting Professor Lecture, All  
Residents, Dr. Ural (Ochsner)

March 27th—Topic TBA, Dr. Heinke



### I HUNG THE MOON

Please 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. Thank you!

Michael Marotta, MD—For helping out in DDC when another provider was out sick. His support on a very busy day was much appreciated, a true team player!

Lisa Crusenberry, Anesthesia Tech—Offering to pick up overnight shifts—thank you!

Izzy James, Ashli Fender, Lucy Cofran, Jaime Sayers, Anesthesia Techs—Volunteering to come in to during the snow storm. Thank you!

Brian Byrne, Savana Howe, Treffle Beupre, Brittney Whaley, Anesthesia Techs—Volunteering to come in during the snow storm and for relief. Thanks so much!



### *Save the Date!*



Resident Graduation 2018  
Friday, June 22, 2018  
Founders Hall

Holiday Party 2018  
Saturday, December 1, 2018  
Carolina Yacht Club



MUSC Leading Health Innovation for the Lives We Touch

### [Imagine 2020 Strategic Plan](#)

#### **We Would Love to Hear From You!**

If you have ideas or would like to contribute to *Sleepy Times*, the deadline for the April edition will be March 16, 2018.