

SLEEPY TIMES

VOLUME 10, ISSUE 5 MAY 2016



Inside This Issue:

-SCA 38th Annual Meeting and workshops	2
-Resident in training exam results	3
-Departmental Hurricane Plan	4
-Epic's EBAM is Coming to MUSC	5
-Fire Safety Response Plan for Main ORs	5
-MUSC - "Best of Charleston" Once Again!	6
-Best Anesthesiology Department "MUSC"	7
-Ebony Hilton, MD Excel Award	7
-Welcome New Main Anesthesia Techs	8
-Congratulations to Dr. Joe Whiteley on Promotion to Associate Professor	9
-Congratulations to Dr. Tom Epperson on Promotion to Associate Professor	9
-Recollections for Dr. Laurie Brown	10-12
-Perioperative Metrics Update	13-16
-American Board of Anesthesiology OSCE Set	16
-National Anesthesia Tech Day 2016	17
-Department Celebration & New Resident Welcome	18
-New Babies in the Department	19
-Grand Rounds	20
-I Hung the Moon	21

Message from the Chairman: *SCA 38th Annual Meeting & Workshops*

-SCOTT T. REEVES, MD, MBA



This year's SCA annual meeting was held April 2-6 in San Diego with the theme of *Clinical Decision Making in Cardiovascular Anesthesiology and Perioperative Medicine*. The department was well represented throughout the program and leadership structure, as can be seen in the meeting highlights later in *Sleepy Times*.

World-renowned cardiothoracic surgeon, Dr. Tyrone David started the meeting by giving the Earl Wynands lecture on Valve Sparing Aortic Surgical Procedures. The conference was ripe for learning about cutting edge technology. However, patient safety and specifically our role in affecting it also was a prominent theme. Jake Abernathy moderated a session on The Role of Human Factors in CPB Disasters. I sat in on sessions entitled "Turning the Tide on Alert Fatigue" and "Do Cardiac Anesthesiologists Really Make a Difference and at What Cost?"

One of MUSC's former chairs, Joanne Conroy, MD, gave the keynote address entitled, "What Does Moving from Volume to Value Really Mean?" Joanne is currently the Chief Executive Officer of the Lahey Hospital and Medical Center. Her talk really got a lot of us thinking about how well or more likely how not so well we are preparing for this substantial paradigm shift away from fee for service medicine payment (i.e. volume) to an outcome base model. The way MUSC successfully navigates this change in payment structure over the next decade will be a primary driver of the institution's and department's success. As such, we should start educating ourselves on what this means. Answering simple questions on how we deliver high quality care at the lowest price. Value = Quality/Price.

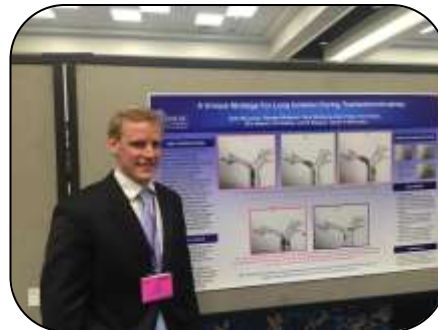
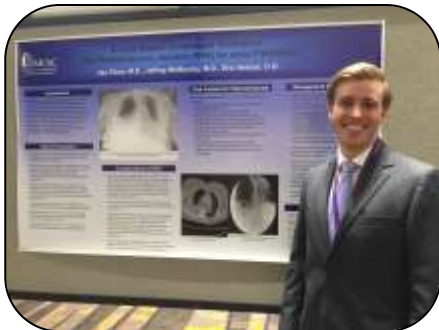
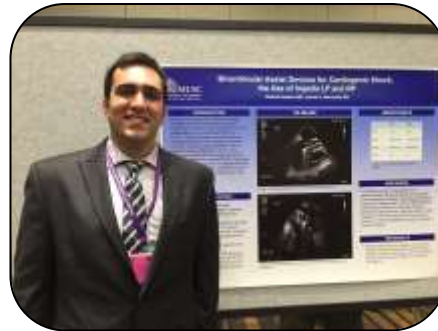
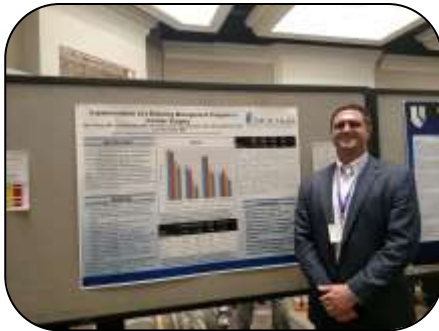


Dr. Joanne Conroy and Dr. Scott Reeves

As Immediate Past President of the SCA, it was a joy seeing the opportunities the SCA continues to provide to our faculty, fellows and residents professional development.



SCA 38th Annual Meeting and workshops



- MUSC ATTENDEES:**
- Jake Abernathy
 - Scott Reeves
 - Tim Heinke
 - George Guldán
 - Eric Nelson
 - Walead Hossami
 - Doug McDonald
 - Jeff McMurray
 - Sam McLaurin
 - John Fox

Friday, April 1

1:15 - 2:00 PM
 A Unique Strategy For Lung Isolation During Tracheobronchoplasty: Sam McLaurin

Saturday, April 2

11:00 - 12:00PM
 Fellow/ Resident Complex Case Poster Presentations Session #1:

Esophageal Perforation after Radiofrequency Ablation (RFA) for Atrial Fibrillation : Jeff McMurray

Endovascular stent exclusion of a pedunculated aortic thrombus using TEE guidance: Doug McDonald / GI Guldán

1:15 - 2:15PM
 (Fellows) Complex Case Discussion with Expert Panel: Scott Reeves, Panelist

2:15 - 3:30PM
 (Fellows) Problem-Based Learning Discussion: Lung Transplantation

4:00 - 5:00PM
 (Fellows) A Career in CT Anesthesiology: Mission Possible

5:00 - 6:00PM
 Fellow/ Resident Complex Case Poster Presentations: Session #2

Emergency Coronary Artery Bypass Graft in an 18 Year Old Male with Anomalous Coronary Artery: Doug McDonald

Bilateral Impella Insertion for Refractory Biventricular Failure: Walead Hossami

Sunday, April 3

12:30 - 1:30PM
 Circulatory Support for Ventricular Tachycardia Ablations, A Case Series: John Fox

1:30 - 4:30PM
 Workshop 6: Percutaneous Valve Problem-Based Learning Discussion: Eric Nelson

6:30 - 9:30 PM
 SCA Gala: Manchester Grand Hyatt

Monday, April 4

11:30 - 12:00PM
 Annual Business Meeting

12:30 - 1:30PM
 Implementation Of A Bleeding Management Program In Cardiac Surgery: Tim Heinke

7:30PM
 Departmental Dinner

Cowboy Star Restaurant & Butcher Shop
 640 Tenth Ave
 San Diego, CA 92101
 (619) 450-5880

Tuesday, April 5

8:00 - 10:00 AM
 Town Hall Debate Moderator: Scott Reeves

3:30 - 5:30 PM
 The Role of Human Factors in CPB Disasters
 Moderator: Jake Abernathy

Wednesday, April 6

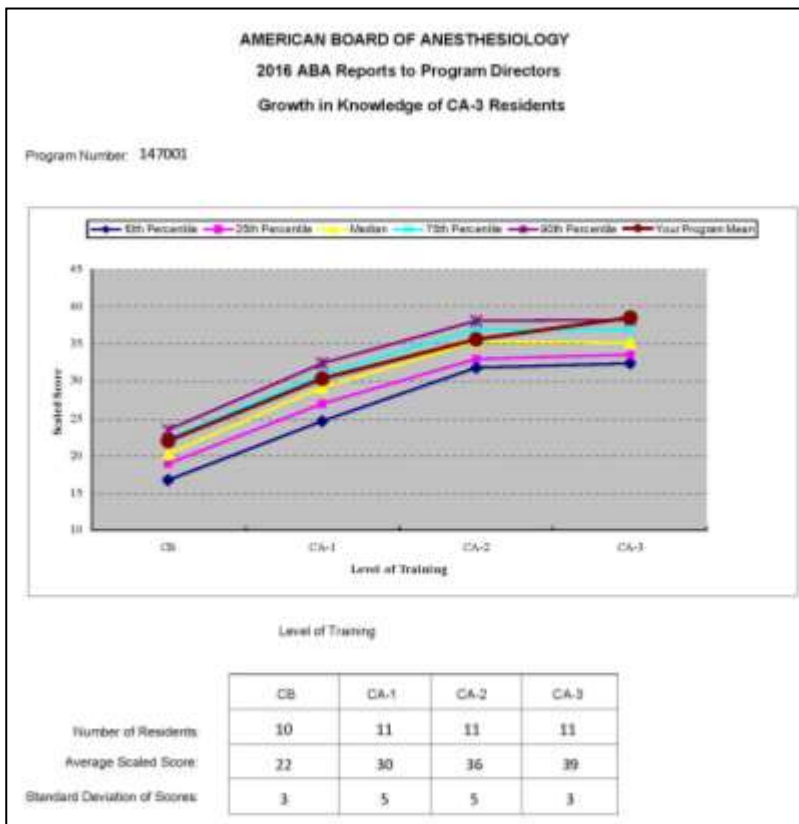
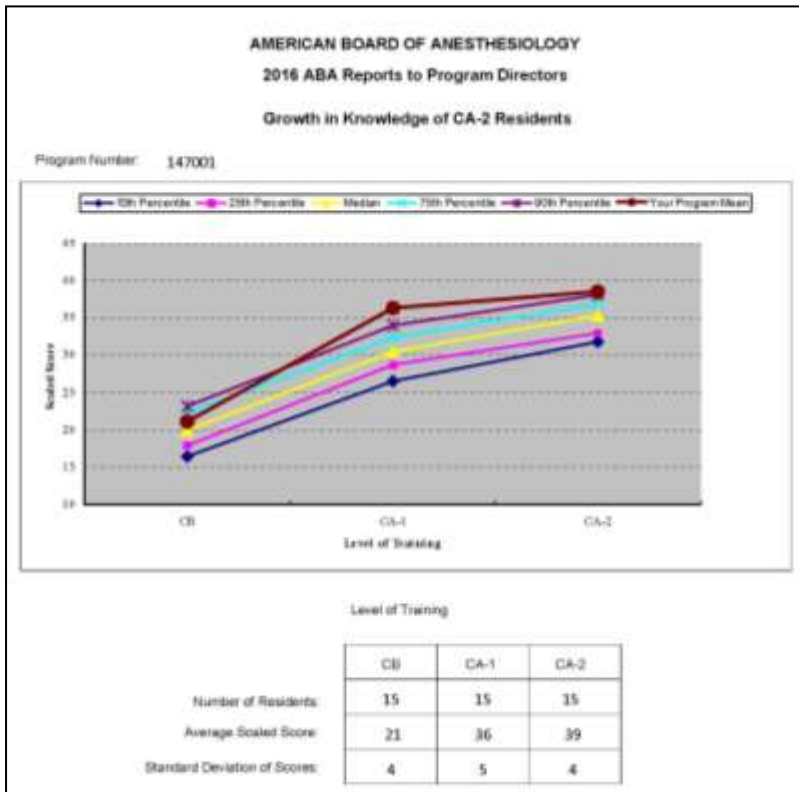
8:00 - 11:00AM

Morning Workshops

Workshop 9: Fellow Transesophageal Echocardiography Review Session

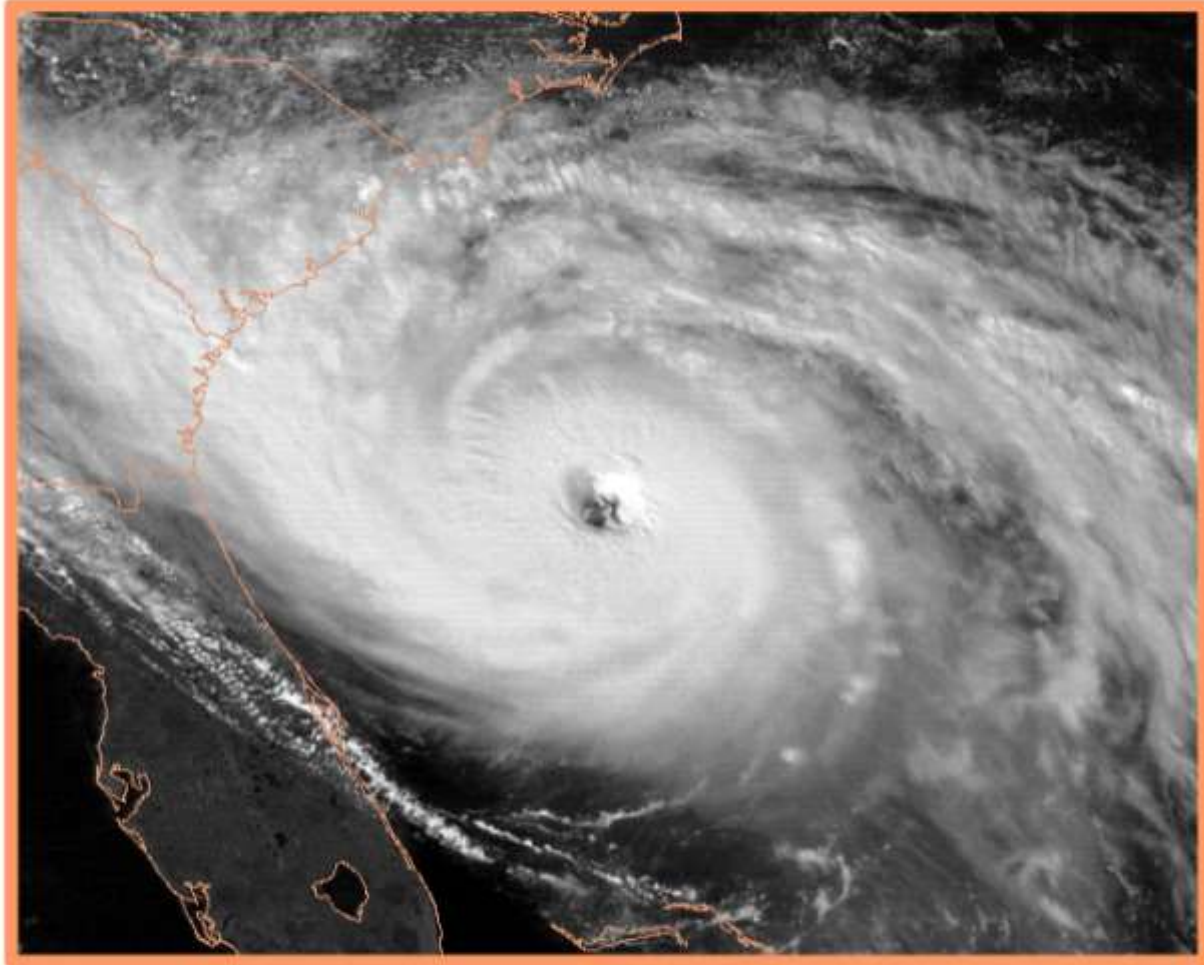
38th Annual SCA Meeting & Workshops
 April 2 - April 6, 2016
 Manchester Grand Hyatt
 1 Market Place
 Front Desk: (619) 232-1234
 (888) 423-1442

Resident in training exam results



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

Department of Anesthesia and Perioperative Medicine



Hurricane Plan

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

Page 1 of 32

Last saved by:MEK
Revised: May 19, 2015

EPIC'S BLOOD PRODUCT ADMINISTRATION MODULE IS COMING TO MUSC BY: MUSC'S PERFORMANCE IMPROVEMENT NEWSLETTER

Blood transfusions can be life-sustaining and life-saving treatments, but they aren't without risk. Safe transfusion practice starts with accurate collection of a patient's pre-transfusion blood sample for typing and cross matching after a physician has determined the need for a transfusion. It continues with matching the ordered blood product to the correct patient before administration, and monitoring the patient for adverse reactions after the transfusion begins.

BPAM, short for Blood Product Administration Module, is an electronic medical record technology that is used by hospitals to add another layer of patient safety when a transfusion is needed. BPAM uses barcode technology to help the clinician match the blood product dispensed from the blood bank with the blood order a physician has placed for a patient. Using system-controlled logic, it requires a positive match between a patient's blood product order, the patient's identification information (the barcode on the patient's identification wristband), and product identification information (the barcode on the blood product). BPAM can also check the expiration date identified on the blood product for appropriateness.

Prior to the decision to implement BPAM at MUSC, a multidisciplinary team had already recognized the opportunity to standardize and streamline many of the workflow steps involved with blood product transfusion for our patients across our organization. Front line staff were involved from the beginning helping to identify current workflow challenges, developing sustainable workflows and long-term optimization in order to meet clinical quality and patient safety objectives. The team was able to incorporate the BPAM workflow into the larger blood utilization project.



BPAM Picture Above

Fire safety response plan, main or suite: react

If you discover a fire in the OR Suite alert team: "fire" + location, (example) PT airway, ON patient right side, ON neck drape, blanket warmer machine, etc.

Staff Roles during a fire in the OR Suite (This reaction process will happen simultaneously):

- *Anesthesia Provider: Turn off O2, Assess & manage airway, remove ET tube if source of fire, maintain airway, re-intubate, remove injured patient if required, concur with surgeon to relocate/evacuate
- *Surgeon: Lead team at field, halt procedure, remove fire source from pt, extinguish fire, apply saline/H2O/ wet towels, determine need to close or cover surgical site, determine need to relocate/ evacuate
- *Circulator: Call 2-3333, state fire (where) 4th floor CH Main, OR # & phone extension, send extra staff to pull fire alarm, or activate fire pull, assist in fighting fire, communicate with front desk, evacuate if needed
- *Extra Staff: Activate fire alarm pull, obtain proper fire extinguisher, assist in fighting the fire, assist in relocation/evacuation
- *Scrub: Provide sterile saline or H2O to extinguish fire, supply wet towels or laps, assist in wound closure or cover, maintain sterile field if possible, prepare to relocate if required
- *Anesthesia Tech: Assist airway recovery, determine with anesthesia provider to turn off main O2 supply to the OR Suite, prepare relocation supplies: O2 tank, ambu
- *Environmental Services: Ensure doors are closed, clear halls, obtain stretcher for relocation or if the OR table is on fire
- *PCA: Assist circulator and scrub in assigned ORs, obtain needed supplies, get fire extinguisher if needed, move equipment out of the way in the OR

Front Desk Staff Action

- *DOD/CRNA: Manage response at desk, plan for patient relocations if needed, communicate plans to all anesthesia staff
- *Charge Nurse: Hold all surgery, assess situation, stop cases that have not made incision in the OR suite, identify available ORs for relocation needs, plan OR patient relocation to 20,21,22 and PACU
- *Unit Secretary and other Front Desk Personnel: Alert all periop staff of the fire location, page surgical services administration, OR management staff and any assistance staff needed, alert Pre-Op holding and PACU of an "OR fire hold" alert and notify PACU if/of possible transfers from OR

Egress destination for surgical patients is horizontal to the next fire/smoke compartment, which is the PACU. Main OR rooms 20, 21, and 22 are located in separate fire/smoke compartment from other Main OR Suites and may be used as an egress destination for patients. Take inventory of patient and staff at evacuation destination location.

MUSC - "BEST OF CHARLESTON" ONCE AGAIN!

BY: PAT CAWLEY, M.D.

Dear MUSC Health Medical Staff,

For 2016, the Charleston City Paper voting has ended and MUSC has come out on top in 4 categories!



- Best Hospital**
- Best Place to Work**
- Best Health Club**
- Best Weight Loss Center**

Even though we are South Carolina's #1 hospital as noted by US News & World Report, it is just as important to be considered the best right here at home.

Each of you makes these awards possible by providing advance, coordinated health care while pioneering ways to treat and heal patients. We are going to celebrate these awards by marketing them to the public and here is a preview of those efforts:

The Medical University of South Carolina is the 2016 City Paper Reader's Poll Best Place to Work.

Thank you, Charleston, for making the Medical University of South Carolina the Best Place to Work in 2016. Excellent employee benefits as well as MUSC's wide selection of diverse health care services and services are what make us the Best Place to Work in the City Paper Reader's Poll. Through the best care, the best education and the best staff we are the best hospital and health system in the South.

Thank you, Charleston, for making the Medical University of South Carolina the Best Place to Work in 2016.

MUSC Health | 843-792-5100

MUSC Health
The Medical University of South Carolina
Charleston, South Carolina

The Medical University of South Carolina is the 2016 City Paper Reader's Poll Best Hospital.

It's no surprise that MUSC is the Best Hospital in South Carolina, and among the Best Hospitals in the U.S., according to U.S. News & World Report. It's not just our reputation for excellent care, it's our commitment to our community and our patients. The Medical University of South Carolina is the only hospital in the state to be ranked as a top 10 hospital in the U.S. by U.S. News & World Report. We are proud to be the best hospital in the South, and we are proud to be the best hospital in the U.S. We are proud to be the best hospital in the South, and we are proud to be the best hospital in the U.S.

MUSC Health | 843-792-5100

MUSC Health
The Medical University of South Carolina
Charleston, South Carolina

Weight Management Center

Thanks for tipping the scales in our favor! May we do the same for you?

One of the reasons you're the Best Weight Loss Center in the South is because of our staff. Our staff is the best in the business, and we're proud to have the best staff in the business. Our staff is the best in the business, and we're proud to have the best staff in the business. Our staff is the best in the business, and we're proud to have the best staff in the business.

MUSC Health | 843-792-5100

MUSC Health
The Medical University of South Carolina
Charleston, South Carolina

The Medical University of South Carolina is the 2016 City Paper Reader's Poll Best Health Club.

Anyone can join!

With state-of-the-art facilities, the weight loss center is a perfect fit for anyone looking to lose weight. Our staff is the best in the business, and we're proud to have the best staff in the business. Our staff is the best in the business, and we're proud to have the best staff in the business.

MUSC Health | 843-792-5100

MUSC Health
The Medical University of South Carolina
Charleston, South Carolina

BEST ANESTHESIOLOGY DEPARTMENT “MUSC”

BY: KINSEY GIDICK FOR THE *CHARLESTON CITY PAPER*



You know what’s fun? Experiencing a contraction while a doctor places a three-inch needle into your back. So fun in fact, moments later you may even puke all over the hospital floor. If this should happen to you, we pray you’re at MUSC because their anesthesiologists are the original Dr. Feelgoods. Last spring, when I was in the throes of delivery hell my epidural initially left my right abdomen cramping in pain. A quick ring to my anesthesiologist and I learned the single best word you can hear in a delivery room “booster.” A booster is a bump of additional pain meds and

I was allowed to deliver mine via my own button. Suffice to say, I treated that like an Atari joystick and blew that pain away like it was so many saucers in the game Asteroids.

EBONY HILTON, M.D. RECEIVES ExCEL AWARD FROM COLLEGE OF CHARLESTON



Dr. Ebony Hilton was the recent recipient of the Eddie Ganaway Distinguished Alumni of the Year Award for the College of Charleston.

Eddie Ganaway was the first African American to graduate from the College of Charleston in 1971. This alumnus chose to take the initial steps to break the racial barriers at the College of Charleston. This award honors alumni who have distinguished themselves as leaders in their career field. In addition, the recipients of this award exemplify the spirit of selfless dedication to the public, continued leaders in community service, and loyal supporters of the College.

WELCOME NEW MAIN ANESTHESIA TECH, DARRELL JENKINS

Darrell has relocated back to South Carolina from New Jersey. His previous employer was Kessler Institute for Rehabilitation in West Orange, New Jersey where he worked in outpatient therapy with SCI patients.

WELCOME NEW MAIN ANESTHESIA TECH, MARCUS BERRY

Marcus was born in Goose Creek, South Carolina. He has spent his whole life living in South Carolina. Growing up, he always enjoyed helping others and learning new things. After graduating from Stratford High School, Marcus wanted to pursue a career where he could help others on a daily basis. Last year, he took EMT courses with the intent of seeking a career as a Paramedic. Throughout his classes, he quickly realized that he had an interest in working in the hospital. After completing his courses, Marcus decided to pursue a job at MUSC. He is very excited to be working as an Anesthesia Technician. He knows that this is where he is meant to be.

WELCOME NEW MAIN ANESTHESIA TECH, MARGARET YOUNG

Margaret Young is a native of Charleston, SC. She is a graduate of Bethune Cookman University where she earned her Bachelor of Science in Gerontology! She has two beautiful children, Payton and Paisley, who she adores. Margaret has been employed at MUSC for eight years and is very excited about joining our Anesthesia team. She looks forward to furthering her career and one day becoming a CRNA! She enjoys singing, dancing, and spending time with her children.

CONGRATULATIONS TO DR. JOE WHITELEY ON PROMOTION TO ASSOCIATE PROFESSOR



Dr. Joe Whiteley was raised in the Midwest and completed his undergraduate degree at the University of Michigan, and graduate school at SUNY Buffalo. He escaped the cold weather to attend medical school at Nova Southeastern University in Fort Lauderdale, and completed residency at Virginia Commonwealth University in Richmond, VA. In 2008, Dr. Whiteley joined the faculty at MUSC on the liver transplant team. His clinical and research interests are primarily in organ transplantation and neuroanesthesia. Dr. Whiteley keeps busy at home with his three young boys (Matthew, Jason, Ryan) and his loving wife Mari. Dr. Whiteley feels fortunate to be working with such a great group of anesthesiologists, residents, and CRNAs here at MUSC. He would like to thank his colleagues and family for their support in helping him achieve this promotion.

CONGRATULATIONS TO DR. TOM EPPERSON ON PROMOTION TO ASSOCIATE PROFESSOR



Dr. Epperson joined MUSC in 2008 after completing his residency at VCU School of Medicine, where he served as Chief Resident for the department. His clinical and research interests are in regional and neuro-anesthesia, but he soon found that his previous experience as a used car salesman would help him in the world of administration. In 2012, he became the Medical Director of Rutledge Tower Ambulatory Surgery Center. Those three years of experience would prepare him for his current responsibilities as Medical Director of the UH OR. Dr. Epperson resides in Mt Pleasant with his beautiful wife Kimberly, his sons Tyler and Baylor, and two pugs, Ruby and Miss Kay. In the fall he spends free time chasing elusive Redfish and Tarpon; in fact, some here refer to him as "Fishing Jesus" due to his ability to locate fish in difficult conditions. Dr. Epperson looks forward to new challenges and opportunities as MUSC continues to grow, and is proud to be part of an outstanding department.

History of Anesthesiology and medicine: A Brief Collection of *Recollections* from dr. Laurie Brown

What is a Recovery Room?

“The Post-Anesthesia Room is primarily a unit in which the patient is closely observed in the immediate postoperative period until the possibility of asphyxia, shock, and other complications requiring ventilator and circulatory resuscitation is over. The patient remains in the recovery room a matter of hours-until consciousness has been fully regained and reflexes have returned.”

From “The Recovery Room” by Adriani and Parmley, 1958.

Florence Nightingale in 1863 said, “It is not uncommon, in small country hospitals to have a recess or small room leading from the operating theatre in which the patients remain until they have recovered, or at least recovered from the immediate effects of the operation.”

Dr. W.E. Dandy in 1923 opened a three bed unit Johns Hopkins Hospital for post-operative neurosurgical patients. Dr. Kirschner was Director of the Clinic at the University of Tuebingen’s Surgical Hospital in Germany in which was constructed combined RR-ICU in 1930. He proposed having the most skilled nurses in one area with an experienced physician director to coordinate patient care.

World War II, with all the American casualties in North Africa and Italy from December 1942 until June 1944, brought the need and gave birth to the idea of “shock wards” which were established in 1943 to prepare battle casualties for surgery.

That war also caused a severe nursing shortage in the U.S. and provided much of the impetus for opening recovery rooms. Mayo Clinic and Strong Memorial Hospital in 1942 opened recovery rooms in unused operating rooms and New York Hospital in 1944. Ochsner Clinic in New Orleans in 1947 opened a large recovery room for patients undergoing the large and new operations-such as pneumonectomy. Dr. Alton Ochsner stressed the need for specially trained recovery room nurses who had to understand complications and therapy.

Millard Fillmore Hospital in Buffalo opened an obstetrical recovery room in 1945, with a 50-75% decrease in maternal mortality due chiefly to detection of early post-partum hemorrhage.

Lowenthal and Russell in a paper presented at the 1950 meeting of the Southern Society of Anesthesiologists at St. Louis, entitled “Recovery Room; Life Saving and Economics.” It was stated that, “Until recently little has been said on the importance of a recovery room in preventing morbidity and death during the post anesthesia period.” They referred to the findings of the Philadelphia Anesthesia Study Commission in which, Ruth, Hawgen and Grove reported 307 deaths related to anesthesia with half of them being preventable and 63% of the total occurring as a result of inadequate nursing care and respiratory obstruction, all in the immediate post anesthesia period. Dr. Lowenthal said that the establishment of recovery rooms at emergency hospitals in 1942 and at Doctor’s Hospital in 1947 had practically eliminated these needless deaths. He went on to point out the requisites for operation of a successful recovery unit and these are much the same today.

Unrecognized Lifesaving Potential

It is rather sad that, like too many great advances in medicine, some of the most eminent surgeons and anesthesiologists either did not recognize-or if they did, they ignored-the potential for saving lives that recovery rooms offered. Minds were focused on other important aspects of development of anesthesia and surgery, and recovery rooms for the most part were ignored. The reports on recovery rooms were found mostly in hospital and nursing journals.

However, one must remember that at this time, soon after World War II, anesthesiologists were relatively scarce (the first one came to Charleston in 1949), nurse anesthesiologists were few and anesthesia was frequently passed down to the lowest ranking member of the operating team.

History of Anesthesiology and medicine: A Brief Collection of *Recollections* from Dr. Laurie Brown

Unrecognized Lifesaving Potential Continued . . .

Only a select few understood even the simple maneuvers necessary to maintain a patient airway, and anesthesia often consisted of bubbling, gurgling, retching, regurgitating, hypercapnic, hypoxic and cyanotic patients who were indeed fortunate to survive the surgical onslaught during bouts of asphyxia. (Unfortunately, this is not unheard of in some areas of the country today!), and if this went on in the operating rooms, just think of the needless and unnecessary deaths that occurred in the immediate post-operative period.

Monitoring

As a student working with Dr. John Brown on anesthesia, and during my early residency I observed numerous cases of what one might call "primitive monitoring." In other words, when the patient began turning blue the anesthetist attempted to do something about increasing the oxygen. When the patient stopped breathing or the respirations became very shallow, one waited for the normal breathing pattern to return. Usually, the outcome was satisfactory. But as mentioned earlier, the outcome was not always desirable and many patients suffered unnecessary and undesirable consequences of this situation. Perhaps even I was guilty at one time or another while anesthetizing patients with open drop ether for brief procedures of not monitoring as well as I could have. In fact, often when we would tape a precordial stethoscope to the chest as we were taught, if the patient were undergoing a tonsillectomy and adenoidectomy (T&A), it is doubtful that heard much for that the noise of the electric motorized combination vaporizer and suction apparatus in addition to the gurgling respiration and the surgeon telling us from moment to moment what we should and should not do.

We were taught to monitor every patient with a blood pressure cuff for adults and precordial stethoscope for children. There was always a frequent or continuous finger on the pulse of the patient. A roving little finger of the hand holding a mask on the face could usually locate either a maxillary or carotid artery pulse without having to change position of the mask.

The five senses have always played a significant role in the field of anesthesiology, as well as in the field of general medicine. Touch, sight, sound and smell can give one a vast amount of information concerning a patient before, during and after an operative procedure. It is not the amount and type and quality of knowledge obtained by today's electronic and automatic monitoring systems, but it could and did result in safe and quality anesthesia for those who paid meticulous attention to detail. (Some of the residents who I instruct in the operating room in the 1990s seem to fear that they will contract some dread disease if they even so much as touch a patient to check the temperature or the pulse.) "Taste" is the only one of the five senses which I have never found useful in medicine. In the early days when Novocaine, distilled water, and saline were all dispensed in the same type of Erlenmeyer flask an occasional member of the house staff would squirt a little of the liquid on the tongue to see whether or not it had the distinctive taste of saline or Novocaine. This probably saved a few patients the pain of injection of fluids other than Novocaine, but this type of testing never appealed to me. In fact, the only reason that I did really find taste useful was when an occasional patient would bring me a nice homemade cake or batch of cookies.

The electrocardiogram was a luxury which was not available to us in the operating rooms. Roper Hospital had one portable machine and this was used by the internist on special occasions. Dr. Ivester and I borrowed this a few times to run an EKG on Dr. Brown's mother-in-law in Hardeeville, S.C. The strip was returned to Charleston where it was interpreted by Dr. Vince Moseley. Neither Ray nor I knew what we were looking at when we obtained the tracing. We could tell whether or not the heart rhythm was regular, but this was no more than we could with a finger on the pulse or by listening with a stethoscope.

The first EKG machine to which we were exposed was one which was owned by Dr. Joseph Cannon and he utilized this in a little room on the first floor of Old Roper Hospital. This was a strong galvanometer which operated on the principle of light on a mirror and it was printed on photographic paper.

History of Anesthesiology and medicine: A Brief Collection of *Recollections* from Dr. Laurie Brown

Monitoring Continued . . .

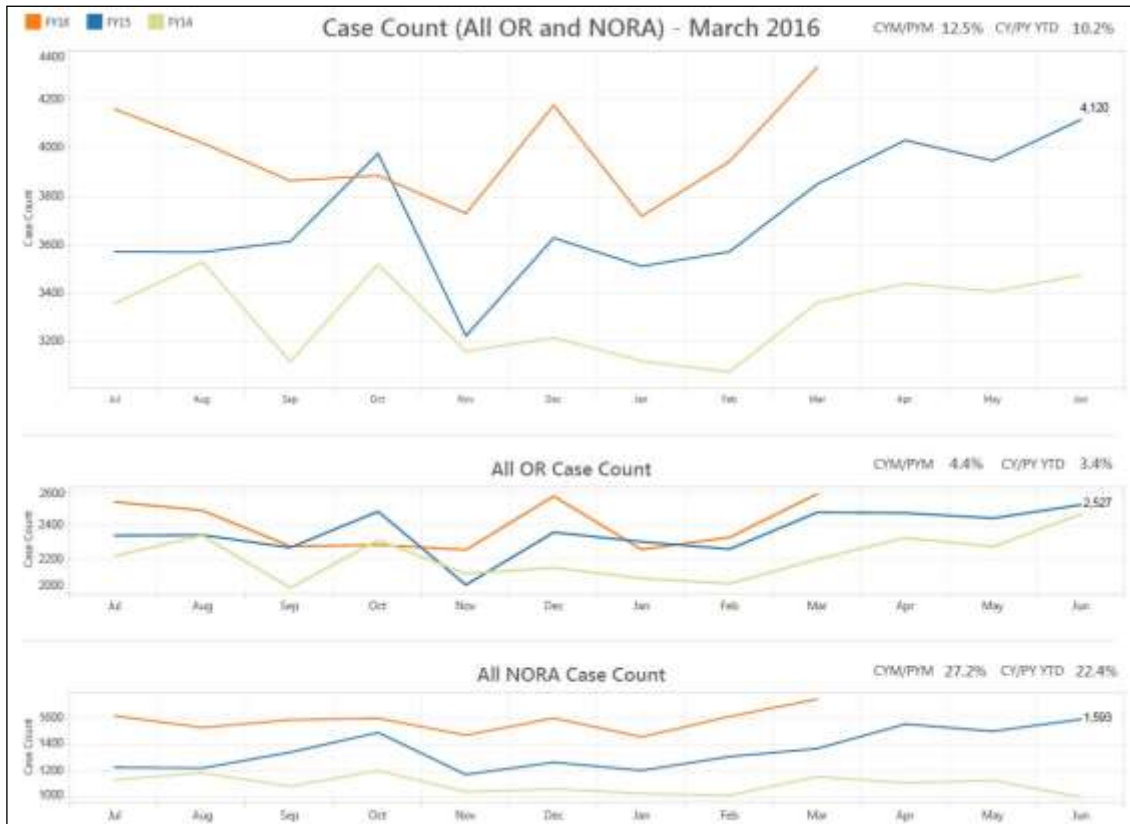
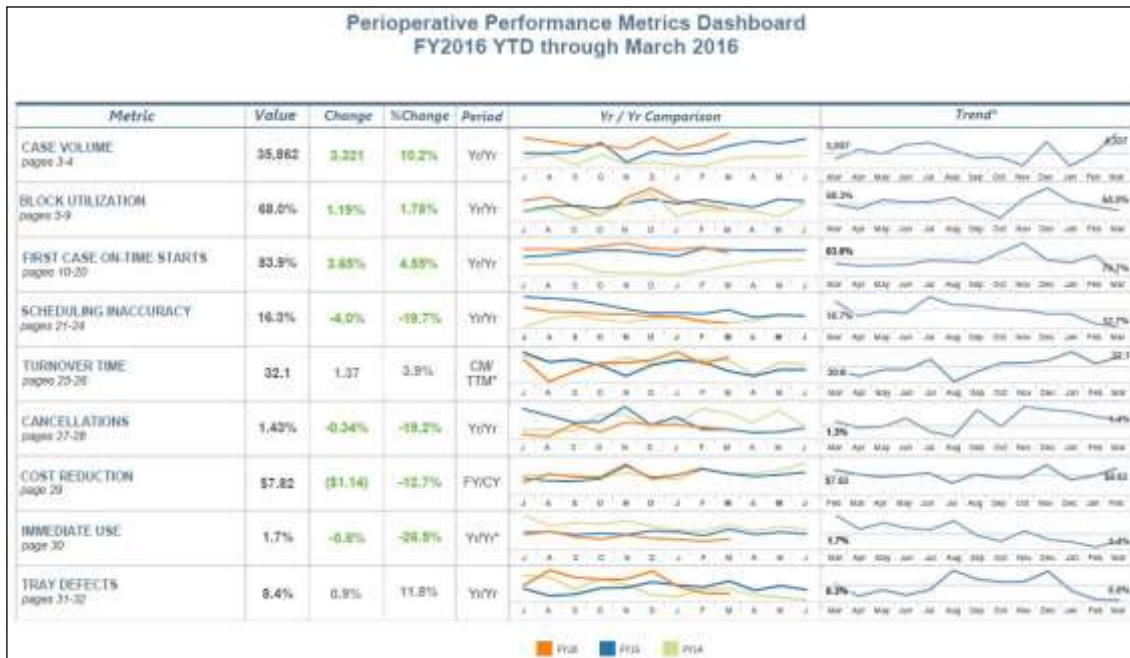
What we saw was a negative, consisting of 3 leads and sometimes one augmented lead. Nobody ever knew what the EKG showed until the whole roll of paper was developed in the EKG darkroom. In fact, Dr. Cannon's EKG machine was the first in South Carolina to the best of my knowledge. Next came the Model 50 Sanborn EKG machine and it had a heated stylus which would inscribe the tracing onto the EKG paper. This was the first direct writer which we had and it was used mainly for rhythm changes. The red-hot stylus of course was incompatible with the explosive gases which we used in the operating room. I cannot recall utilizing an EKG during my early days of open heart operations under hypothermia anesthesia. But soon, this was overcome by a technician who was hired by the Medical College, Mr. Wofford W. Francis, the brother-in-law of Dr. Ivester. Mr. Francis constructed longer leads for the EKG machine and fashioned them by utilizing the tip from a Luer-Lok syringe onto which was fitted a flattened needle which could be utilized either taped to the skin or under the skin itself. This allowed the EKG machine to remain outside of the operating room while the patient was monitored during heart operations. Sixty-cycle interference from the electrical systems was always a problem with the early EKG units, and this sometimes made the cardiogram almost impossible to interpret.

In the 1950s the major equipment of the college consisted of a Geiger counter, a flame photometer and a portable EKG machine. Mr. Francis came to the Medical College in 1955. He had been a radar technician on a small Navy ship during WWII when radar was in its infancy. How did he get to the Medical College? Dr. Ivester's wife, Mary, was working as a lab technician in the biochemistry's laboratory of Dr. William M. McCord, Professor and Chairman of Biochemistry and Dr. John C. Aull, Jr., a Professor of Biochemistry. Dr. McCord had acquired one of the very early Geiger counters which were used for monitoring radioactive isotopes. Of course, the monitor would get out of action and it would take several months to repair at the factory. Mr. Francis was being showed through the lab when he was visiting in Charleston one day and the Geiger counter was mentioned to him. He took one look at it and repaired it on the spot. From that time forward, and until this day in October 1991, Mr. Francis has been a technician at and for the Medical University and the Roper Hospital. He kept up with and always seemed to be a little ahead of any of the electronic monitoring devices in use in the hospitals during that entire time. Among other things that he designed and which were utilized during my residency years was an internal alternating-current heart defibrillator which was utilized when necessary by any hospital within the city. He designed and constructed what I believe were the first, and if not the first one of the earliest, pulse monitoring devices to be utilized. He made one for me and one for Dr. Ivester. It was a little metal box about 6"x 3"x 3" which utilized a WWII B-17 pilot throat microphone taped to the finger and each pulse beat would give an audible beep or a flashing light. I thought that Mr. Francis might be able to construct some of these and sell them to anesthesiologists within the State to use in the operating rooms, but the President of the South Carolina Society of Anesthesiologists let me know that it would be foolish to bring a device such as this into the operating room and it would do nothing but distract from the observation of the patient. The monitor which was used by Dr. Ivester is now in the Waring Historical Library of the Medical University and the one utilized by me is in the Anesthesia Museum in the Anesthesiology Department at the Medical University. My monitor, unfortunately, was "updated" to a certain extent by a fellow anesthesiologist a few years ago, but it remains essentially the same. (Mr. Wofford W. Francis was truly the "Father of Electronic Monitoring" at the Medical College of South Carolina and the hospitals in Charleston.) Another innovation by Mr. Francis, in collaboration with Dr. Dale Groom who was a cardiologist, was the remote recording of electrocardiograms; I believe the first in this country. They taped electrodes to Citadel football players and monitored their heart rates and electrocardiograms from the sidelines.

According to 1991 standards, and ASA "Standards of Care," monitoring was primitive in those days. But are all of our patients now a lot safer during anesthesia? I sometimes wonder.

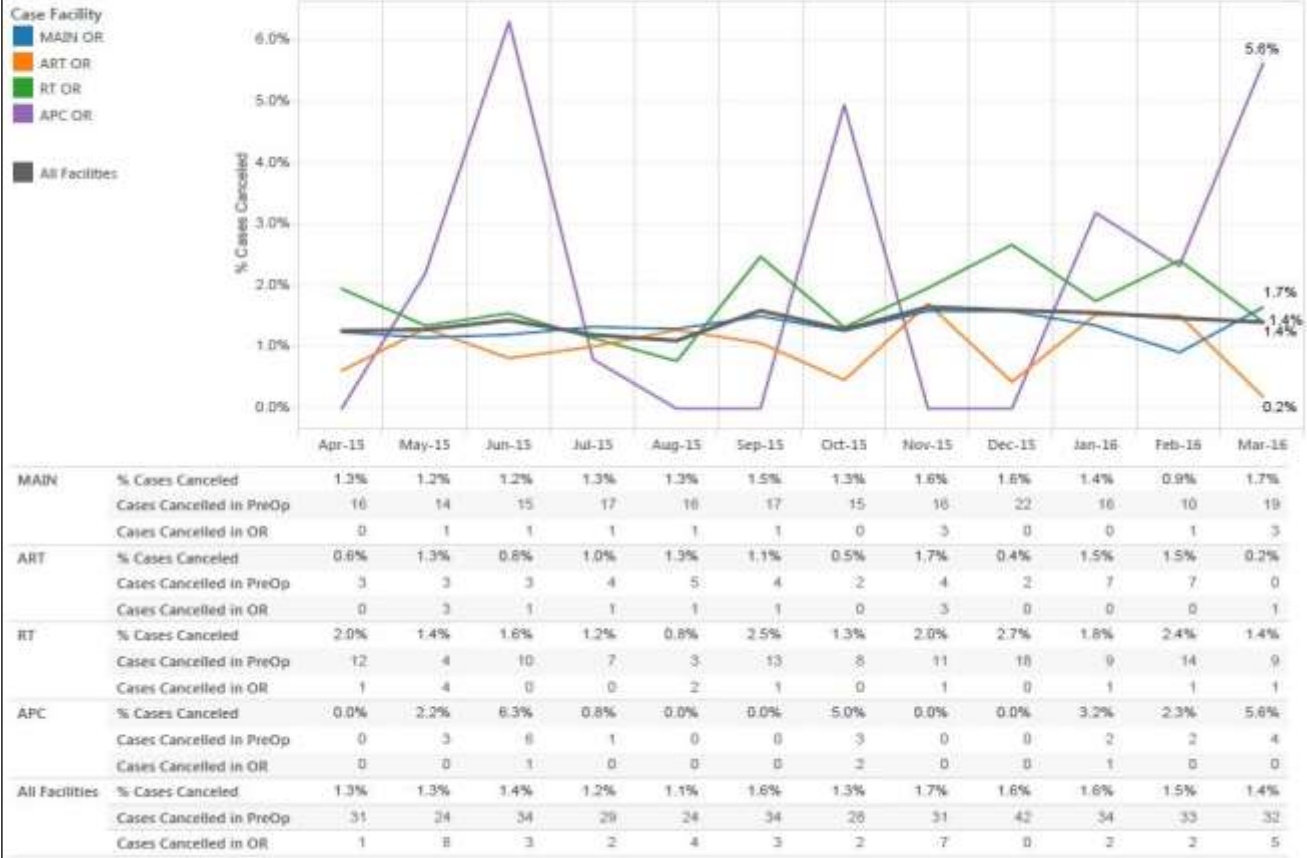
PERIOPERATIVE METRICS UPDATE

Intermittently, it is important to highlight where the department and institution stands regarding our OR performance metrics. Please review the data below. We are doing well overall, but there are areas in which we can improve.

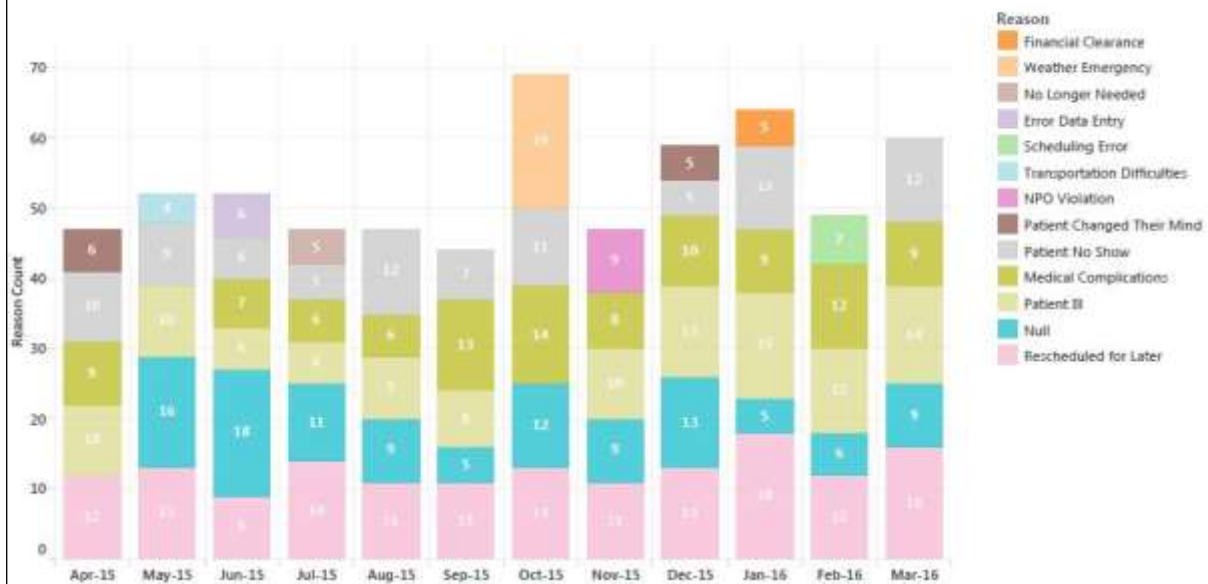


PERIOPERATIVE METRICS UPDATE CONTINUED . . .

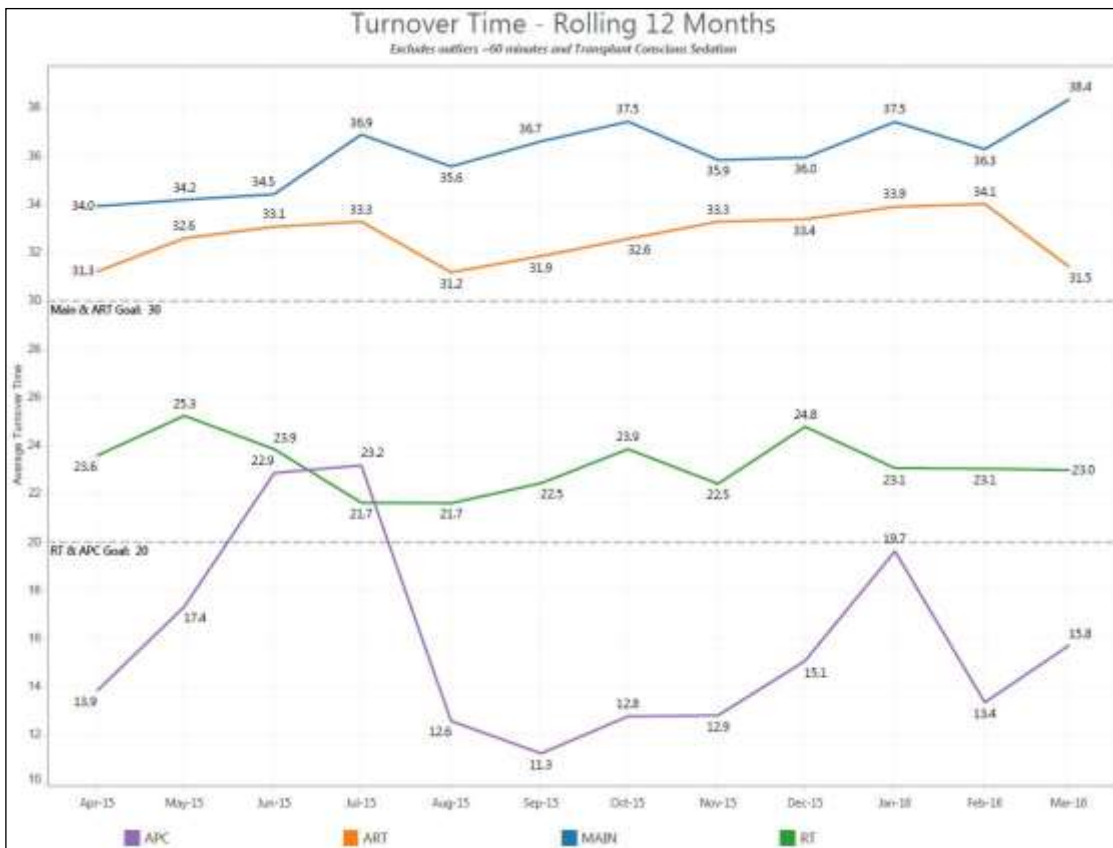
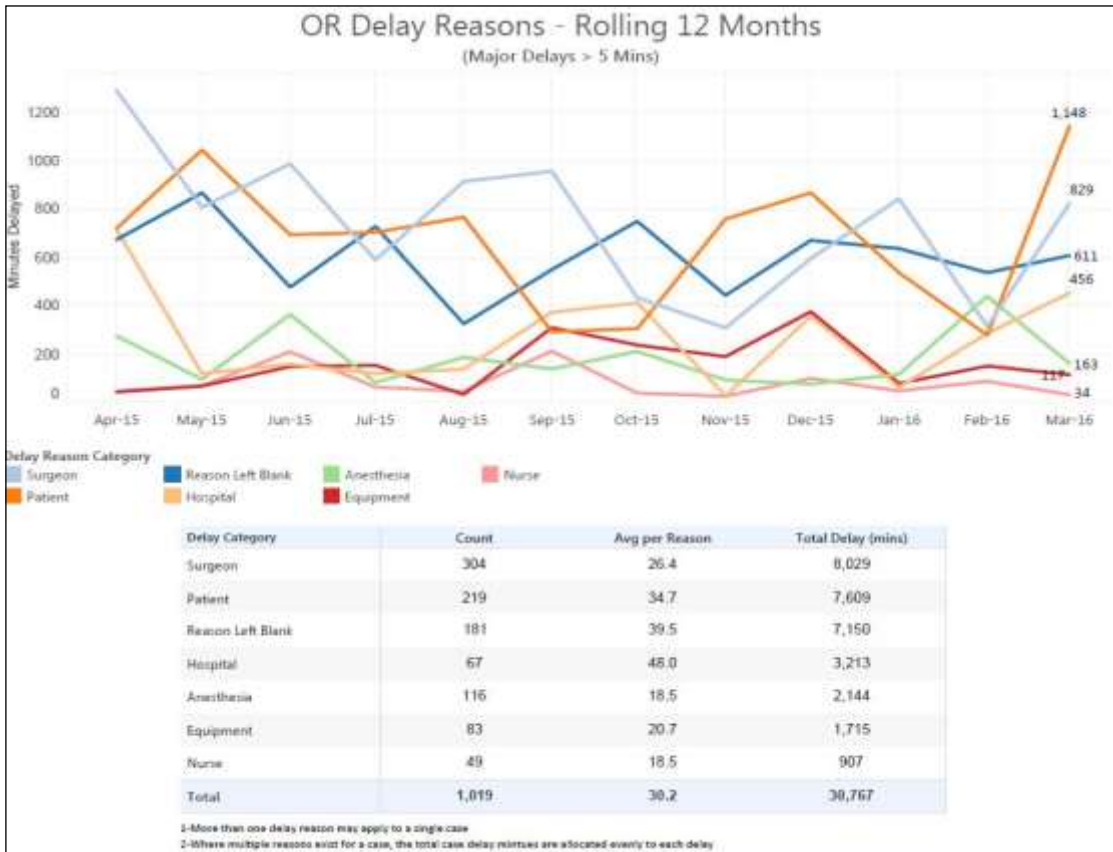
Day-of-Surgery Cancellation Rate - Rolling 12 Months



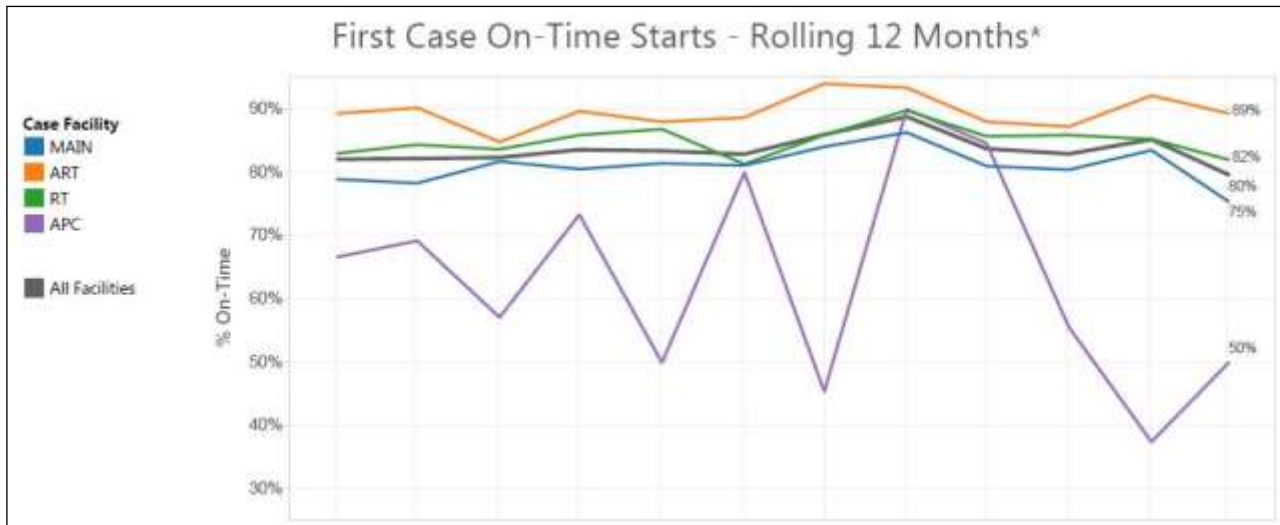
Top 5 Day-of-Surgery Cancellation Reasons - Rolling 12 Months



PERIOPERATIVE METRICS UPDATE CONTINUED ...



PERIOPERATIVE METRICS UPDATE CONTINUED . . .



American Board of Anesthesiology OSCE Set Up
 By: George Guldan, M.D.

Last month I attended the program directors’ meeting at the ABA’s facilities in Raleigh N.C. We discussed many upcoming changes to the ABA training database, but the highlight of the meeting was the update on the OSCE (Objective Structured Clinical Examination) portion of the Part 3 exam (previously oral exam). Currently, the plan is for all residents who graduate after June 2016 to take the full step system, including the OSCE/Oral part three exam. Our current CA-3 class will be the last to take the traditional Oral exam in 2017. Below are pictures of the various OSCE rooms that show the scope of the situations tested, from pre-op, to clinic, to simulated OR (beware the otoscope). Content is still being developed and validated by the ABA, and we should soon have more information on exam content. An example of a clinical test would be, while using a patient actor, show the proctor multiple structures by ultrasound. I am certain our residents will be up for the challenge, but we will be integrating this into our Mock Orals when a content outline is published.



National Anesthesia Tech Day 2016



Rutledge Tower



University Hospital



Ashley River Tower

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 Dawn Leberknight
leberkni@musc.edu or (843) 792-2437*



New Babies in the department



Congratulations to Jay Chan and his family

Riley Chan

Born March 29, 2016

6 lbs, 11 oz, 19.25 inches



Congratulations to Lisa and Robert Crusenberry

Eleanor McKay Crusenberry

Born March 26, 2016

7 lbs, 8 oz, 21 inches

GRAND ROUNDS FOR THE MONTH OF MAY



“Problems of Critical Thinking”
May 3, 2016
Horst Rieke, M.D.
Professor
Medical University of South Carolina

“Principles & Practice: Strategies of Mechanical Ventilation for Brain Injured Patients ”
May 10, 2016
M. Dustin Boone, M.D.
Division Director, Neuroanesthesia
Harvard Medical School



“Department Research Symposium/Presentations”
May 17, 2016
Will Hand, M.D., Associate Professor
Ryan Gunselman, M.D., Assistant Professor
Medical University of South Carolina

“Morbidity and Mortality Conference”
May 24, 2016
George Guldan, M.D., Assistant Professor
Ryan Gunselman, M.D., Assistant Professor
Medical University of South Carolina



“The Cost of Being Black: The Influence of Race on Health Disparities”
May 31, 2016
Ebony Hilton, M.D.
Assistant Professor
Medical University of South Carolina



DEPARTMENT OF ANESTHESIA AND
PERIOPERATIVE MEDICINE

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CHECK OUT OUR WEBSITE AT:
[HTTP://WWW.MUSC.EDU/ANESTHESIA](http://www.musc.edu/anesthesia)

Future Events/Lectures

Intern Lecture Series

May 12th — Pulmonary Disease, Dr. Heine

CA 1 Lecture Series

May 4th — Anesthesia for the Trauma Patient,
Dr. Skorke

May 11th — Pediatric Anesthesia PBL, Dr.
Redding

May 18th — Anesthesia for Patients with
Endocrine Disease & Neuromuscular Disease, Dr.
Stephanie Whitener

May 25th — Basic Statistics for the Boards and
Board Question Review

CA 2/3 Lecture Series

May 2nd — Managing Sepsis PBLD (Barash Ch.
56), Dr. Clark, Moodle

May 9th — A Time to Chill, Dr. Boone (Harvard
Medical School)

May 16th — Minimizing Complications in ICU
PBLD, (Barash Ch. 56), Dr. Field, Moodle

May 23rd — Hemodynamics in Critical Care
PBLD (Barash Ch. 56), Dr. Rieke, Moodle

Grand Rounds

May 3rd — Problems of Critical Thinking, Dr.
Rieke

May 10th — Principles & Practice: Strategies of
Mechanical Ventilation for Brain Injured Patients,
Dr. Boone (Harvard Medical School)

May 17th — Departmental Research
Symposium/Presentations, Drs. Hand and
Gunselman

May 24th — Morbidity & Mortality Conference,
Drs. Guldán and Gunselman

May 31st — The Cost of Being Black: The
Influence of Race on Health Disparities, Dr.
Hilton



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!

Chris Skorke, M.D. — Helping Dr. Catherine Tobin when she was sick. He rescued her from the APC. Thank you, thank you!

Amy Smith, CRNA — Staying in MRI to help me finish and transport to the PICU. Thank you!

Laura Uebelhoer, CRNA — Helping me with emergency wake up and transfer. Thank you!

Tori Flynn, Anesthesia Tech — Always being awesome, but specifically helping with getting a 1B settled, huge help! Thank you!

**Resident Graduation, June 17th
Founders Hall**

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

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



May 2016

Standard of the Month

**Seek to resolve differences
by communicating in a direct
and respectful manner.**

We Would Love to Hear From You!

If you have ideas or would like to contribute
to *Sleepy Times*, the deadline for the June edition will be
May 23, 2016.