



SLEEPY TIMES



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MESSAGE FROM THE CHAIRMAN:

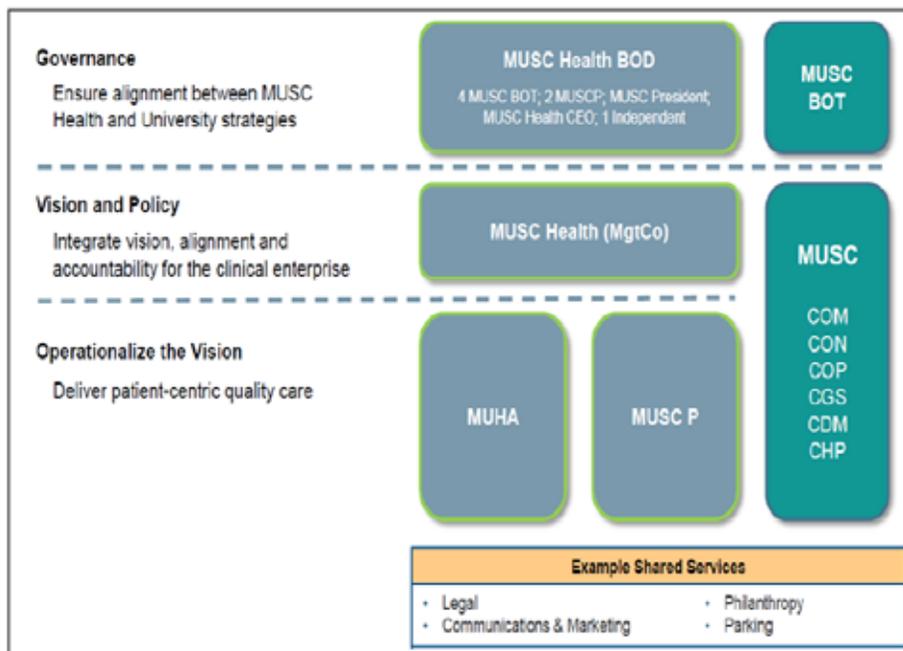
-SCOTT T. REEVES, MD, MBA

Creation of MUSC Health

Over the past eight months, leadership of the University, College of Medicine, Hospital (MUHA), and Faculty Practice Plan (MUSCP) have been meeting to discuss and develop a strategy that will better position MUSC in the changing healthcare marketplace. The outcome of this work is the creation of an integrated health system called MUSC Health. MUSC Health is a not for profit corporation whose purpose is to support the missions of MUSC, MUSC Physicians and their collaboration with MUHA. It will provide new opportunities for outreach and affiliations, allow us to further enhance the alignment of strategic initiatives, and will contract with MUSC, MUSCP, and MUHA to provide certain goods and services.



The structure of MUSC Health is outlined below.



MUSC Health will be governed by a nine-member board: four chosen from MUSC's Board of Trustees, MUSC President (David Cole), MUSC Health interim CEO (Pat Cawley), at-large member, and two from the faculty practice plan (MUSCP). MUSCP had a formal process of nominations and an election through its Board in early August. Donna Johnson, MD, chair of Ob/Gyn, and I were elected to be MUSCP's first representatives. There is significant work to be done, and I am honored to have been elected to help lead this process.

CREATION OF MUSC HEALTH CONTINUED . . .

As you can see in the diagram above, MUSC Health will integrate the functions of MUHA and MUSCP into a single entity. This will allow for more transparent and rapid decision-making across the clinical enterprise as well as improved funds flow for strategic initiatives. MUSC Health has a set of vision and guiding principles, which were developed through a campus wide retreat as outlined below.

MUSC Health

About

Vision

Leading Health Innovation for the lives we touch

As one of America's most preferred academic health systems, we will change what's possible with innovation that transforms expertise, learning and discovery into unrivaled patient-centered care. Our teamwork, coordination and accountability will provide the integrated breadth and depth to improve health and value for those we serve

We change what's Possible!

MUSC Health Strategic Goals

- 1 Partner to create South Carolina's preferred integrated health system.
- 2 Unify, align and integrate the Clinical Enterprise and Network to demonstrate superior value.
- 3 Ensure physician engagement in leadership and decision-making.
- 4 Pursue education, innovation and discovery focused to leading edge care.
- 5 Embrace Diversity and Inclusion



MUSC Health

About

Guiding Principles

Partnership / Collaboration	At its core, successful integrated healthcare leadership between MUSC, MUSC P and MUHA depends on a functional partnership between physicians and the hospital
Commitment to Quality & Value	Deliver transformational capabilities and processes that provide the capability to accept and manage health risks, improve quality, and reduce cost (Value = Quality / Cost)
Integrated Leadership	Ensure clinical and financial decisions are made across the clinical enterprise, providing accountability and a long-term orientation
Aligned Goals / Incentives	Align quality, operational, and financial incentives across all care teams
Flexibility	Provide entire clinical enterprise with capacity for quick and nimble decision-making
Drive Accountability	Improve transparency and standardize KPI measurement across the organization through information system infrastructure standardization
Health System Development	A structure and process that simplifies incorporation of other health care entities, with flexibility for entering into affiliation, joint venture's and other partnership agreements



CREATION OF MUSC HEALTH CONTINUED . . .

Many of you may be asking, why do all this? The hospital had a very good year. Why the hurry? Academic Healthcare Centers like MUSC are rapidly moving away from the inpatient centric fee for service mode of payment to one of ambulatory and personal health centric value driven payment models. The old model has resulted in MUSC having significant challenges such as:

- Revenue streams under significant pressure
- Lack of capital to do all the great things we want to do
- Lack of an appropriate structure for partnership and integration with others

MUSC Health will allow us to overcome these obstacles in the future. Over the next weeks and months I hope to further educate myself and you on this transformation. I look forward to your support and input.

MEET NEW FACULTY MEMBER, ALISON JEZIORSKI, MD

Alison Jeziorski is excited to join the pediatric group at MUSC. She is originally from Buffalo, New York and attended Binghamton University for her undergraduate schooling. She had the opportunity to return home for medical school at the University at Buffalo. Having grown tired of the long winters, Alison initially traveled to Virginia Commonwealth University in Richmond, Virginia to begin a neurosurgical residency. Alison found her interests in medicine had changed and she was offered an anesthesia position at the University of Virginia where she completed her residency training.

A brief return to the north allowed Alison to complete her pediatric anesthesia fellowship at the Children's Hospital of Pittsburgh of UPMC. She is happy to move closer to the ocean which also allows her family a cold weather escape in the winter. Outside of anesthesia, Alison enjoys running, good wine, and hopes to cultivate a new love of cycling.



CONGRATULATIONS TO DR. SYLVIA WILSON NAMED RUTLEDGE TOWER MEDICAL DIRECTOR



Dr. Sylvia Wilson was born and raised in Orlando, FL; amusement park central. She attended the University of Florida (GO GATORS!) for both her undergraduate and medical education, where she also met and married her husband, Joe. She completed her residency training at UNC in Chapel Hill, NC prior to her fellowship in Regional and Acute Pain Medicine at the University of Pittsburgh. Dr. Wilson joined the faculty at MUSC in 2010 and has served as the Regional Anesthesia Division Chief and Resident Rotation Director since. She has served as a junior editor for the ABA basic exam since 2013 and started a Regional Anesthesia Fellowship at MUSC in 2014.

Along the way, Dr. Wilson managed to have a couple of adorable boys, Liam (7) and Kyle ("I'm almost 5"), who can brighten any day. Her research interests include different modalities of regional anesthesia, the impact of regional anesthesia on patient care and outcomes, and non-opiate analgesics.

Dr. Wilson is incredibly excited about her new opportunity to work with a great group at Rutledge Tower; however, she would like to assure the CRNAs and residents in the main that she will still be around often enough to order ketamine for their patients. She would like to thank her mentor, Dr. Jerry Reves, for his administrative and research guidance and Dr. Scott Reeves for his constant support as her career grows. Additionally, she would like to thank Dr. Latha Hebbbar for incessant advice and strength.



CONGRATULATIONS TO DR. JAKE ABERNATHY FOR BECOMING THE SCA REPRESENTATIVE FOR THE STS TASK FORCE ON ACCESS AND PUBLICATIONS

In 2013 the Society of Cardiovascular Anesthesiologists (SCA) set out to create a database that will allow us to evaluate not only the quality of care we currently provide, but also ask and answer research questions about what best care looks like. To accomplish these goals, the SCA partnered with the Society of Thoracic Surgeons and their STS Database. Established in 1989, this database is one of the oldest in the country and has more than 5 million cardiac surgical procedures with over 3,000 participating surgeons. The Adult Cardiac Anesthesiology module is rapidly gaining data and members.

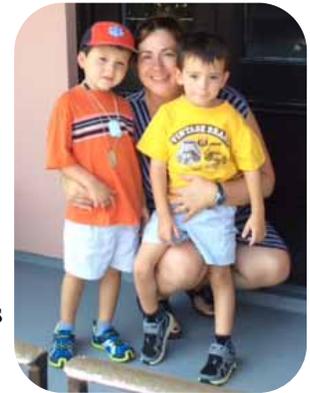
Our ability to link anesthesiology variables with surgical outcomes raises the opportunity to ask thoughtful research questions. The STS's Task Force on Access and Publications controls access to the data and assures the scientific rigor of database queries. Dr. Jake Abernathy has been chosen by the President of the Society of Cardiovascular Anesthesiologists to be the SCA's representative to this important committee. We look forward to the powerful and provocative research questions that no doubt will be brought to the committee by talented anesthesiologists.



CONGRATULATIONS TO DR. DAVID STOLL ON PROMOTION TO ASSOCIATE PROFESSOR, EFFECTIVE JANUARY 1, 2016



While Dr. David Stoll's family roots run deep in Charleston and Williamsburg Counties, he was raised in the small town of Whiteville, NC (although born in Conway, SC). He followed his older brother, John (MUSC School of Pharmacy Class of 1997) to Charleston to begin his undergraduate studies at the College of Charleston. Dr. Stoll made his most important accomplishment at College of Charleston when he met and married his wife, Mary. They moved to Columbia for medical school and then headed back to Charleston for his anesthesia training. In 2010, after 1 year of private practice in Murrells Inlet, SC, Dr. Stoll returned to MUSC as faculty. He found a niche in the world of Liver Transplant Anesthesia and has been serving as Division Chief in that field for



the past four years. His research interests are largely focused in the transplant world but involve OB, simulation, and goal-directed therapy. Dr. Stoll is indebted to many individuals including (but not limited to): Drs. Reeves, Hebbard, Hand, McEvoy, and Schaefer for these successful endeavors.

He is very grateful to be at MUSC and to be a part of an outstanding department and hospital system. He considers what he does to be a privilege, and hopes this is evident in his interactions with patients, residents, and CRNAs. Dr. Stoll has had a tremendous amount of support from both the home front and work in terms of patience, motivation, and mentoring. A big thanks to everyone for helping him achieve this promotion and to Mary and my boys, McLain (5) and Lexton (4) for putting up with me.



CONGRATULATIONS TO DR. WILLIAM HAND ON PROMOTION TO ASSOCIATE PROFESSOR, EFFECTIVE JANUARY 1, 2016

Dr. Will Hand is well known to everyone already. He completed residency at MUSC, serving as chief resident during his fourth year of training. He graduated from Saint Louis University School of Medicine in 2007 after completing his undergraduate degree in Applied Mathematics and a brief career working in the financial industry. Dr. Hand is an active researcher with three main areas of interest: abdominal transplantation, simulated crisis management, and goal-directed physiologic management. Outside of work Dr. Hand tries to keep up with his three children and is happily married to his beautiful bride Megan, a pediatric occupational therapist. He looks forward to new challenges and opportunities as MUSC and the department continue to grow and evolve.



CONGRATULATIONS TO DR. ERIC NELSON ON PROMOTION TO ASSOCIATE PROFESSOR, EFFECTIVE JANUARY 1, 2016

Dr. Nelson was born and raised in the southern suburbs of Chicago, the middle of four children (twin older sisters and a younger brother). When it came time for him to spread his wings and leave the nest, he ventured 200 miles west on I-80 to the University of Iowa where he earned a degree in Finance. Dr. Nelson returned to Chicago for medical school at the Chicago College of Osteopathic Medicine where he met and fell in love with his wife, Melissa, and graduated in 2005. He then went on to residency at Rush University and early on realized his future was in cardiac anesthesia, due to the influence of some great mentors there.

During residency, he and his wife had two children, Evan (8) and in 3rd grade and Alex (6) in 1st grade. Despite there only being two of them, at times the amount of energy the boys have makes it feel like more.

Dr. Nelson was fortunate enough to come to MUSC after residency for a CT Fellowship and he has remained here since. He feels it has been a blessing to take advantage of all the knowledge and tutelage those who've come before him and have shared and instilled in him to make his career what it has become.

Dr. Nelson and his family reside in Mt. Pleasant, and in their free time enjoy the beach, hiking in the mountains, and caring for all the animals they have accumulated in their home.



CONGRATULATIONS TO DR. JAKE ABERNATHY ON PROMOTION TO PROFESSOR, EFFECTIVE JANUARY 1, 2016

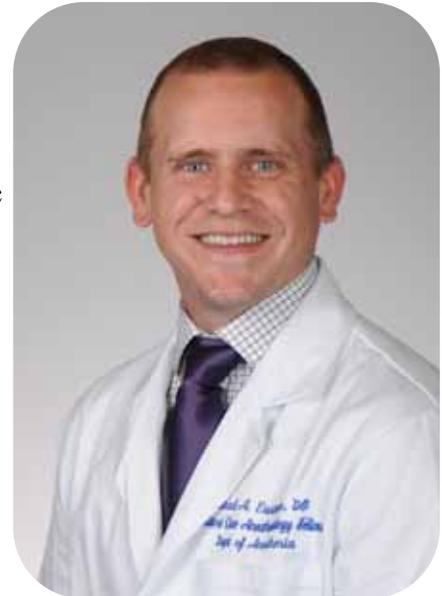


Jake joined MUSC in 2006 after completing a residency in Anesthesiology and a fellowship in Cardiothoracic Anesthesiology at Brigham and Women's Hospital in Boston, MA. Upon arrival, he joined an active and accomplished CT anesthesiology group at MUSC who he is proud to work with. Working with talented clinicians and human factors engineers, Jake has developed a research interest in how human error can be studied and reduced in the delivery of high-quality care.

Jake is proud to share life with his wife, Ally and their three children, Chandler Grace (10), Harry (7) and Rett (4).

MEET OUR NEW CRITICAL CARE FELLOW, DR. BRAD EASTMAN

Dr. Brad Eastman was born and raised in West 'By God' Virginia. He obtained his BS degree in Biology from West Virginia University in 2005 and his Doctor of Osteopathic Medicine from West Virginia School of Osteopathic Medicine in 2011. Dr. Eastman completed his internship at Charleston Area Medical Center in Charleston, WV and his residency at Allegheny General Hospital in Pittsburgh, PA. While in undergrad and medical school, he was a member of the WV Air National Guard where he had the opportunity to serve in Operation Enduring Freedom and Operation Iraqi Freedom. Dr. Eastman is joined at MUSC by his wife, Julie who is a CRNA at the University Hospital. He is excited to be joining MUSC's Department of Anesthesia. His current interests, aside from critical care medicine, include transplant and regional anesthesia. He and Julie enjoy spending time outdoors with friends and family.



MEET OUR NEW CARDIOTHORACIC FELLOW, DR. DOUG MCDONALD



After growing up in Columbia, SC, Dr. Doug McDonald obtained a mechanical engineering degree at Clemson University. He spent two years designing satellites as well as tactical and strategic lasers for Raytheon Space and Airborne Systems in El Segundo, California. Afterward he then moved to Charleston and spent two more years as an engineer before starting medical school at the University of South Carolina. Upon completion of school, Dr. McDonald started residency training at Mayo Clinic Florida in Jacksonville. Ultimately he decided cardiothoracic anesthesia was an extremely exciting career, which ended up bringing him back to Charleston to train. He and his wife Emily are blessed with a two year old and six month old. They love being back in Charleston so far, and look forward to the rest of the year!

MEET THE NEW ANESTHESIA TECH AT ART, ETHAN SYRACUSE

Ethan Syracuse, a native Charlestonian, has worked at MUSC for three and a half years and feels that MUSC provides the best health care in South Carolina -- and he does not hesitate to tell people. His hobbies include gardening, cooking, reading non-fiction, exercising, and anything that involves being outdoors (especially spring and fall) enjoying God's magnificent creations of nature (sports, however, not included). He likes to help people and practices the golden rule of doing unto others as you would have them do unto you. The strongest most influential people in his life, other than God, are his parents and grandfather. Southern comfort food is his favorite cuisine as evidenced by his favorite restaurant, School House BBQ in Scranton, SC.



MEET THE NEW ANESTHESIA TECH AT THE UNIVERSITY HOSPITAL, BRITTNEY WHALEY



Brittney Whaley was born and raised in Charleston, SC and graduate from Burke High School in 2005. She continued her education at Bluefield College for her bachelor's degree while on a basketball scholarship. Basketball is one of Brittney's favorite hobbies that she is very passionate about. She joined MUSC in 2014 working as a Patient Tech on 6 West and is very thankful for the opportunity to work in the Anesthesia Department to gain knowledge and experience that will help her in preparing for nursing school.

DR. ERIC NELSON TRAVELS TO BANGALORE, INDIA

This summer my family and I had the opportunity to travel to Bangalore, India on a mission trip to Bangalore Baptist Hospital. I was recruited for this trip by Dr. Rebekah Naylor, a missionary surgeon who worked there for 30 years and now teaches at UTSW. If you have time, google her; she's an amazing woman.

This trip would involve more teaching of residents than hands on work, which I was looking forward to as I figured it was a good way to leave more of a lasting impression on the people we worked with. While at the hospital, I was assigned to an operating theater (their term for OR) with a resident each day. When time allowed in afternoons, we did formal lectures. I lectured mostly on cardiac and vascular topics, but also went over some basic physiology with the younger residents.

Also, while at the hospital I was able to spend time with the chaplains and accompany them on rounds. It's amazing to see how grateful patients are to have someone, even a complete stranger, visit with them and talk to them, especially since many had been in the hospital for a long time and had little family visit.

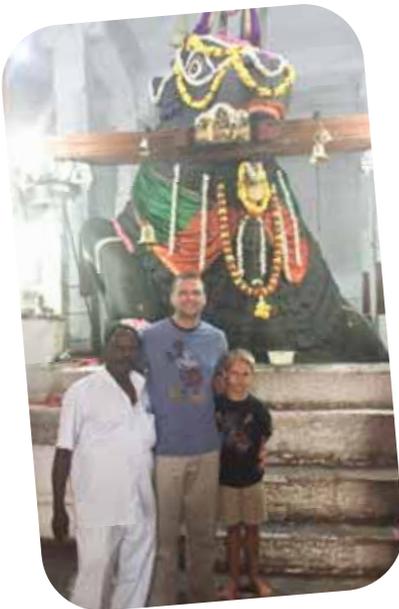
We were also blessed to connect with some missionaries while we were there. Melissa and the boys volunteered at a kind of day care for beggar children where the kids come and get a hot meal and help with homework, and the parents are given resources to help themselves as well.

We were able to do some site seeing in India as well. Melissa took the boys out every day to see a different part of the city with the help of our driver Mr. Mark, who'd worked at the hospital for nearly 40 years. We took in numerous palaces, temples, and gardens and also just got to see the every day life of a city with 14 million people. Evan and Alex were very popular on the streets and were constantly getting their pictures taken by people, I guess they aren't used to seeing blonde haired, blue eyed boys!

I hope to continue to build on the relationships that were made at the hospital on this trip and return every couple years or so. They also are very interested in regional anesthesia; so if anyone with more regional skills than me (which is almost anyone) ever wants to go, please let me know! As challenging and somewhat difficult as a trip like this is, it's very fulfilling and rewarding, and I'm always amazed at the impact it has on my own children.



DR. ERIC NELSON TRAVELS TO BANGALORE, INDIA CONTINUED . . .



RESEARCH CORNER

Chapter 41

HUMANITARIAN OPERATIONS AND
AID AGENCY ANESTHESIA

Dr. Laura Roberts

LAURA L. ROBERTS, MD^{*}; JEYASANKAR JEYANATHAN, MBBS[†]; JOHN H. CHILES, MD[‡]; AND PETER F. MAHONEY, FRCA[§]

INTRODUCTION

Humanitarian Assistance as an Additional Mission
Humanitarian Assistance as a Primary Mission
Humanitarian Assistance Supporting Disaster Relief

HUMANITARIAN ASSISTANCE MISSIONS: A GENERAL OVERVIEW

Hospital Ships
Mission Overview and Process
Disaster Relief
Host Nations and Nongovernmental Organizations
Medical Personnel
Surgical Services

PRACTICAL CONSIDERATIONS FOR THE ANESTHESIA PROVIDER

Preoperative Assessment
Intraoperative Anesthesia Management
Postoperative Care Considerations

AUSTERE AND RESOURCE-LIMITED ENVIRONMENTS

Anesthesia Techniques
Postoperative Care

CONCLUSION

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2015



Dr. Sylvia Wilson

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5 Essentials in Post-op Pain Management

Why you should ditch the opioids — and what to use instead.

Sylvia Wilson, wilsosh@musc.edu

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HISTORY OF ANESTHESIOLOGY AND MEDICINE: A BRIEF COLLECTION OF *RECOLLECTIONS* FROM DR. LAURIE BROWN

We continue our monthly series of Recollections learning about the introduction of volatile anesthetics and muscle relaxants into practice.

ANESTHETIC AGENTS AND TECHNIQUES

ETHYL ETHER was the most widely used anesthetic agent of the time. It could be and was administered in almost every way conceivable except orally, and I am not aware that it was used in the latter way. As it was used by the open drop method; a patient was anesthetized by dripping the ether onto a mask consisting of layers of gauze and held over the patient's face. Often VINETHENE (divinyl oxide) was used prior to the dripping of ether because it gave a more rapid induction of the patient. It could be used alone for brief procedures. Convulsions were not unusual with this method of anesthesia if the ether vaporized rapidly enough to exclude oxygen from underneath the mask or in other cases where the patient was too deeply anesthetized. It was used in a to and fro method where the patient breathed back and forth through a small soda lime canister. It was administered by the circle absorption method where it was vaporized with a wick in a glass jar. This was the common method of anesthesia for adult patients. Often, a more rapid acting inhalation agent such as cyclopropane was used for an induction agent prior to the use of the ether. Ether was administered by insufflation, commonly insufflated into the mouth through an "ether hook" into the pharynx through a catheter or an oral airway, during operations such as tonsillectomy. It was also insufflated through a catheter inserted into a tracheotomy tube or an endotracheal tube. It was also vaporized and administered in a non-breathing technique. We used ether rectally on occasion, mixed in olive oil, to treat status asthmaticus. On rare occasion it was used rectally as an analgesic. Ether was administered intravenously to measure the venous arm-to-lung circulation time. About five minims were mixed with five drops of saline and injected into an arm vein and when either the patient or the observer smelled the ether on the patient's breath, this was the circulation time. Ether was also injected on occasion into a catheter which could not be removed from the bladder because the bulb could not be deflated. Ether was injected into the bulb, the heat of the body expanded the ether and the bulb exploded. I can recall an instance in which a resident injected more than 2 cc ether into the catheter (equivalent to 440 cc of ether vapor) and the ensuing explosion could be heard all over the room. Fortunately, the patient had no ill effects other than being scared out of his wits. Administration of ether for induction of anesthesia always carried the risk of injury to the patient if he were not restrained properly by straps and/or personnel because there was almost always an excitement state through which the patient had no control of body movement, thoughts, or actions. Ether was both explosive and flammable, but I never knew of any problem in this area of the country. Although administered in the presence of both heating and all types of open electrical devices, there was never any fire or explosion to my knowledge.

CYCLOPROPANE was an agent utilized frequently, particularly by our professor of anesthesiology. This agent was also flammable and explosive. It was administered by the closed technique, in which only the patient's metabolic needs for oxygen were administered and the cyclopropane administered intermittently as the stage of anesthesia required. I was taught the technique of using cyclopropane by Dr. Brian Sword, a friend of Dr. John Brown's who had devised the circle absorber system of administering anesthesia and was the first to use, to the best of my knowledge, positive end expiratory pressure (PEEP) during anesthesia. We used cyclopropane in both closed and semi-closed methods for many years after our training. It could be used for analgesia only or for any desired depth of anesthesia desired. If the fire could be removed it would be an ideal agent.



HISTORY OF ANESTHESIOLOGY AND MEDICINE: A BRIEF COLLECTION OF *RECOLLECTIONS* FROM DR. LAURIE BROWN CONTINUED . . .

ETHYLENE was a weak anesthetic agent which as far as I was concerned had no use. Maybe this was because I never learned to use it properly for one reason and the other reason being that I couldn't stand the odor of the gas. It was also lighter than air so that it was all over the operating room when in use. Numerous Ethylene explosions were known in other parts of the country. Dr. Arthur Rivers who was the "Dean of Obstetrics" in the City always wanted us to use ethylene on his patients for Cesarean section due to the fact that he said that he had never had any real problems with babies delivered during this type of anesthesia. It is a small wonder because I don't believe that a patient was ever really asleep and anesthetized enough to depress the baby any whatsoever. To Dr. Ivester and to me this was sort of a nightmare. One day, Dr. Ivester confided in me that he had learned how to make this anesthetic a little more smoothly administered – by giving the patient a small amount of intravenous pentothal during induction. I had already caught on and had begun doing the same thing. The babies were always born of vigor, Dr. Rivers was pleased, and we were delighted that we could have an anesthetized patient, an awake baby, and a pleased surgeon all at the same time. To the best of my knowledge, Dr. Rivers never knew why our anesthesia became as smooth as it did.

NITROUS OXIDE was used essentially as it is today. I have seen a few patients anesthetized by the older nurse anesthetist staff by administering nothing but nitrous oxide until the patient began turning blue after having lost consciousness and then oxygen and the regular anesthetic agent added. This was not a technique which was pleasing to me, and I never used it. It faded rapidly from the scene.

TRICHLORETHYLENE (trilene) was an agent which came to be used as an analgesic during labor. A small vaporizer was utilized to administer the agent, the setting on the apparatus was locked into position so that the concentration could not be changed, and the patient would administer the agent to herself as dictated by her labor. This was virtually a safe analgesic because when the patient became somnolent the apparatus fell from the hand and was held to the arm by a strap in order to be available when she needed it again. Apparently, some well-meaning family members at times would hold the mask on patient's face from them and this could end in tragedy although it was never seen in our area.

FLUOTHANE (HALOTHANE) was developed in England as a non-flammable, non-explosive anesthetic agent is was introduced into the United States in 1956 and rapidly became popular. I cannot recall using this agent during my residency training which was completed on June 30, 1956, although I was soon assisting residents who followed me in its use.

THIOPENTOBARBITAL (pentothal) was one of the great advances in anesthesia and it came into use by Dr. John Lundy of the Mayo Clinic in Rochester, Minn. in the 1940's during World War II. Pentothal was used as I learned it essentially as it is still used in the 1990's. It is used for induction of anesthesia and prevents any stage of excitement. It was also utilized for anesthesia along with nitrous oxide. A 0.4 percent solution was used not only for the induction of anesthesia but throughout an extensive period of anesthesia along with nitrous oxide, particularly in operations which required no muscle relaxation. The solution was given as necessary and as the patient's respiration was assisted; otherwise, the depth of analgesia could not be maintained. A dilute solution of penthonal was often used as "truth serum" in psychiatric interviews, administering only enough to have the patient's cortex depressed to a minor degree.

Pentothal was used rectally, administered by the nurses on the pediatric ward, to have the patients asleep before they came to the operating room. It was also administered rectally during cardiac catheterization in order to transport the patients to the laboratory and have then amnesic at least during this time.

Pentothal was administered rectally to patients undergoing thyroidectomy under local novocaine anesthesia administered by the surgeon. Intermittent doses of the pentothal were given in order to keep the patient amnesic but not at the point beyond which the patient could always answer if necessary. To the best of my knowledge, this technique was developed by Dr. John Brown. It was not long then, before we began using dilute pentothal drip on these same patients, for amnesia only. It was also used as a sedative for patients undergoing long operations under regional anesthesia.

HISTORY OF ANESTHESIOLOGY AND MEDICINE: A BRIEF COLLECTION OF *RECOLLECTIONS* FROM DR. LAURIE BROWN CONTINUED . . .

EVIPAL was another ultra short-acting barbiturate which was sometimes used as an induction agent.

BREVITAL which was marketed in 1954 was seldom used by me except occasional during electroshock therapy. Pentothal was our first line barbiturate in anesthesia.

MUSCLE RELAXANTS

Curare was used during this period essentially as it is in the 1990's. One difference is that it was the muscle relaxant and was used for endotracheal intubation, as well as muscle relaxation.

Metubine (dimethyl tuburarine), syncurine (decamethonium bromide), and flaxedil were sometimes used, all acting similar to curare. Curare was the only muscle relaxant which causes a histamine like action occasionally. Syncurine had the advantage of not precipitating when added to barbiturate, thus evipal and syncurine were often mixed in the same syringe to use as an induction agent and to relax the patient for intubation also. This was infrequent in our training.

Anectine was introduced into Charleston during the last phases of our residency training. The first that I can recall was used by an anesthesiologist who came to Charleston for a very short time and his name was Albert Warshauer. Soon, this drug became common for use in anesthesia.

NOTE: Concerning the use of curare one day while I was in the laboratory working, Dr. Brown came in with a visitor and came over and said, "Laurie, I would like for your to meet Dr. Harold Griffith." What an honor to meet the man who had introduced curare (South American Indian arrow poison) into clinical anesthesia as the first muscle relaxant used in anesthesia in human patients. Dr. Griffith had been traveling through the area from Florida to Montreal and had stopped to visit on his way through. He appeared to be impressed with our laboratory work.

Narcotic Analgesia: Both Morphine and Demerol were utilized at time in conjunction with Nitrous oxide for operations requiring little or no muscle relaxation. Morphine was administered in small intermittent doses, whereas Demerol was used as a continuous drip, 100-300 mgm in 500 cc saline. This was satisfactory, but not ideal technique.

MEET MARSHA PORTER, RN ASSISTANT DIRECTOR OF PERIOPERATIVE SERVICES

Marsha comes to MUSC from Duke University Hospital, where she was Clinical Operations Director for the Duke Hospital Operating Rooms. She graduated in 1980 from Bluefield State College in Bluefield, WV with her nursing degree and the Duke University School of Nursing with a Master of Science in Nursing and with a focus in healthcare leadership. During her tenure as Director at Duke, Marsha created a Perioperative/ Transplant collaborative, expanded the OR Nurse Residency program to hire 40 new nurses a year, and led clinical teams in transition to 18 incremental state-of-the-art OR's, including iMRI and iCT. As a Certified OR Nurse with over 35 years in clinical and leadership positions and a strong background in an academic medical center, Marsha brings a wealth of knowledge and creativity to the organization. As the Assistant Director of Perioperative Services, Main OR, Marsha's focus is accountability and multidisciplinary collaboration, both areas that lead to outstanding patient care and MUSC Excellence.



On a personal note, she has been married to her husband, Jim, for 40 years and they have 2 sons; Eric who lives with his wife in Mt. Pleasant and Mike who lives in Asheville, NC, where they have a vacation home and visit regularly.

NEW MANAGEMENT COMPANY



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muscedu

August 18, 2015

To the MUSC Family:

We have an exciting development that will strengthen MUSC, and I'd like a few minutes of your time to explain why this is important for our future. I'm talking about the creation of a structured, integrated health system that will allow us to reduce redundancies and costs across the enterprise.

What does it mean to structure an "integrated health system?"

By implementing this new organizational model, we become more nimble and enhance our ability to decrease the cost of care and increase the level of convenience our patients expect and deserve. Additionally we vastly improve the alignment of our research innovations with our clinical expertise.

As you can imagine, this is a complex and evidence-based process, and it demonstrates how MUSC is embracing the changes in the health care industry. Academic medical centers currently operate with high costs per unit of service, and with low levels of convenience for our patients. This is unacceptable and those we serve deserve better from us.

Rest assured that we are looking nationally to health systems such as the Cleveland Clinic, Emory Healthcare, and other academic medical center peers for their best ideas and lessons learned. As guiding principles for developing this new integrated health system we are going to:

- embrace partnership/collaboration
- pursue education innovation and discovery as an integral part of our leading-edge care
- continue our commitment to quality and value
- develop integrated leadership,
- work to align common goals/incentives
- drive accountability

We have assembled a leadership team and work groups that are outlining our next steps, and as more information becomes available, it will be shared in upcoming months in a variety of channels.

What is the potential impact of this new way of doing things?

Operating as an integrated health system will enable our clinical providers to increase opportunities for outreach partnerships and affiliations, further enhance our strategic alignment and the reduction of siloes across the enterprise, and allow for integrated management of certain functions. This system doesn't "own" the hospital or existing

NEW MANAGEMENT COMPANY CONTINUED . . .

MUSC Physicians clinics, nor will it “provide” clinical services. In essence it is a legal structure that makes us more flexible in dealing with an ever-evolving health care delivery system.

In the interest of brevity, I encourage you to visit this new website, mcintranet.musc.edu/mgtco, where you can get more information about what this new system is, and is not.

Why does MUSC need to do this right now?

The vision is simple. We must change what’s possible through innovation and forward-thinking that transforms our expertise, learning and discovery into unrivaled, patient-centered care. I firmly believe that our collective dedication to teamwork, coordination and accountability through this new health system will provide the integrated breadth and depth we need to improve the health of those we serve.

Yours in service,



David J. Cole, MD, FACS
President
Medical University of South Carolina

SURVIVOR SUPPORT SACK PROJECT BY: ROBIN BUCHANAN, CRNA

Rutledge Tower CRNAs collected items for the Survivor Support Sack Project. This project was started three years ago by Dr. Cassandra Salgado. All the items she collects will be dispersed into bags to provide a special "pick me up" to patients receiving chemotherapy this summer At Hollings. This year she is promoting wellness. The three categories were snacks, health items, and fun activities. I am very proud of the staff at Rutledge Tower for the abundance of items they collected for this project!



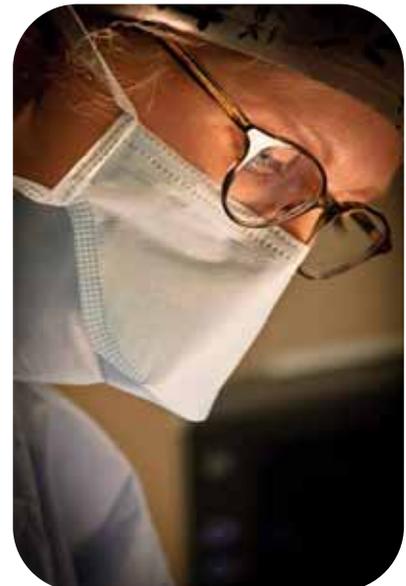
SUMMER CELEBRATIONS WITH THE PEDIATRIC TEAM



The pediatric anesthesia division celebrated twice in July. Our first was to send Dr. Ilka Theruvath off to her new life and career in Charlotte, NC.

Dr. Theruvath started as a resident at MUSC in 2008. She finished her residency here and followed with fellowship training at the Children’s Hospital of Philadelphia. Since that time Dr. Theruvath has been a highly valued member of the pediatric cardiac anesthesia section. Her work ethic, medical knowledge and procedural expertise are unrivaled. All good things must end and her tenure here ended when her husband accepted a position in Charlotte, NC. On July 30th the pediatric anesthesia division gathered for a reception honoring Dr. Theruvath. Held in the Pearlstein Garden at the Hollings Cancer Center, the reception included hors d’oeuvres from Fast and French and a selection of fine beverages. Dr. Charles Wallace (emeritus retired) surprised the pediatric anesthesia group by attending the reception. You can see from the pictures that everyone enjoyed the opportunity to

wish Dr. Theruvath well in her relocation. She will be practicing pediatric cardiac anesthesia at the Carolinas Medical Center. There are at least five MUSC anesthesiology alumni in practice with the anesthesia group there.



SUMMER CELEBRATIONS WITH THE PEDIATRIC TEAM CONTINUED . . .

The second social event of the summer for the pediatric anesthesia division was a Friday happy hour at Mynt. This happy hour included the pediatric OR nurses, pediatric surgeons, pediatric perfusionists, pediatric CRNA's and the pediatric anesthesiologists. Joe Sistino, program director for the perfusion school, played keyboard and sang for the event. A fabulous time was had by everyone who attended. This morale building event brought together more than 40 team members for fun, food, drink and conversation. The pictures show the pleasure everyone felt in meeting and celebrating happy hour as a group.



DR. LOREN FRANCIS' WEDDING FEATURED IN CHARLESTON MAGAZINE



CONGRATS TO ANGELA MUND, CRNA, DNP, ELECTED AS PRESIDENT OF THE MUSC FACULTY SENATE

Congrats to Angela Mund, CRNA, DNP, Division Director of the Anesthesia for Nurses Program in the College of Health Professions for her recent election as President of the MUSC Faculty Senate.



GRAND ROUNDS FOR THE MONTH OF SEPTEMBER

“Ambulatory/NORA Talk”

September 1, 2015

Catherine Tobin, MD

Assistant Professor

Medical University of South Carolina



“Pulmonary Hypertension”

September 8, 2015

Maria Yared, MD

Assistant Professor

Medical University of South Carolina

“Hyperbaric Oxygen in Anesthesia”

September 15, 2015

Klaus Torp, MD

Assistant Professor

Mayo Clinic Florida



September 22, 2015

“Morbidity & Mortality Conference”

Jeff McMurray, MD,

CA2 Anesthesia Resident



“Joint Commission Updates”

Carlee Clark, MD

Associate Professor

Medical University of South Carolina

**“Lung Development and Bronchopulmonary
Dysplasia”**

September 29, 2015

Tracy Wester, MD

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

10/Sept—Peripheral Vascular Disease,
Dr. Nelson

24/Sept—Preserving Renal Function,
Dr. Heinke

CA 1 Lecture Series

2/Sept—Inhalation Anesthetics, Drs. Guldan/
Hand

9/Sept—Nonvolatile Anesthetic Agents, Drs.
Guldan/Hand

23/Sept—Opioids and Benzodiazepines, Drs.
Guldan/Hand

30/Sept—Local Anesthetics and
Neuromuscular Blocking Agents,
Drs. Guldan/Hand

CA 2/3 Lecture Series

7/Sept—Labor Day, No Lecture

14/Sept—Pulmonary Hypertension in Patients
with Liver Disease, All Residents, Dr. Torp
(Mayo Clinic, FL)

21/Sept—Anesthesia for Thoracic Surgery,
Dr. Heinke, Moodle

28/Sept—Respiratory in Anesthesia PBL,
Dr. Tobin

Grand Rounds

1/Sept—Ambulatory/NORA Talk, Dr. Tobin

8/Sept—Pulmonary Hypertension, Dr. Yared

15/Sept—Hyperbaric Oxygen in Anesthesia,
Dr. Torp (Mayo Clinic, FL)

22/Sept—Morbidity & Mortality Conference/
Joint Commission Updates, Dr. McMurray/
Dr. Clark

29/Sept— Lung Development and
Bronchopulmonary Dysplasia, Dr. Wester



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 Crisp. Thanks so much!!

Marc McLawhorn, MD: Marc came down from ART call to lend a hand on a very busy MSICU night without even being asked. He had every right to sleep that night but he went the extra mile to help sick patients get the care they needed.

Molly Sekar, Anesthesia Tech: Picking up extra shifts and staying late. Thank you so much!

Treffe Beaupre, Anesthesia Tech: Working overtime to help out both main hospital and ART! Great team player!



**Department Holiday Party: December 4, 2015,
Carolina Yacht Club**

September 2015 Standard of the Month

Bring forward opportunities
for improvement and not wait
for an adverse event to happen.



We Would Love to Hear From You!

If you have ideas or would like to contribute to *Sleepy Times*, the deadline for the October edition will be September 21, 2015.