



SLEEPY TIMES

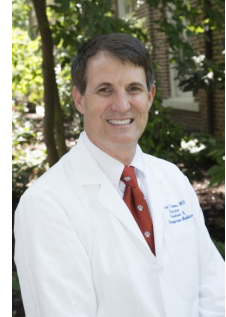
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MESSAGE FROM THE CHAIRMAN: VANDERBILT UNIVERSITY FAILS SYSTEM THINKING IN HEALTHCARE DELIVERY

-SCOTT T. REEVES, MD, MBA



Recently, RaDonda Vaught, a former nurse at Vanderbilt University Medical Center (VUMC), was sentenced to 3 years of supervised probation after being convicted of criminal negligent homicide for making a fatal medication error in 2017, which resulted in the death of a patient under her care.

She gave her 75 year old patient an injection of vecuronium instead of Versed for sedation while the patient was undergoing a radiologic procedure. VUMC, where Vaught worked as an intensive care unit, enabled the safety overrides that she employed in making the medication error. During her trial she stated, “I do not work in a vacuum. I work in a healthcare system.” Like her we all work in a very complex system.

The resulting manifestation of prosecuting nurses and others care team members for human errors made in the conduct of their jobs will have a chilling effect on sentinel/adverse event reporting and may exacerbate an already critical nursing shortage.

Fortunately, our department is a world leader in Human Factor Engineering and System Thinking through the research lead by Dr. Ken Catchpole. The teams’ recent correspondence in the British Journal of Anesthesia (below) is worth everyone reviewing as we continue to work for a zero harm patient care system and advocate for risk free system based reporting.



OPENING STATEMENT CONTINUED

Reconsidering the application of systems thinking in healthcare: the RaDonda Vaught case

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Keywords: human factors; medication errors; patient safety; systems engineering; systems safety

Editor—After being found guilty of criminally negligent homicide for a fatal medication accident, former Vanderbilt University Medical Center (VUMC) nurse RaDonda Vaught spoke out, ‘I do not work in a vacuum. I work in a healthcare system.’¹ Vaught incorrectly administered vecuronium, instead of Versed® (midazolam) as ordered, without patient monitoring, and immediately reported the error. VUMC fired her, negotiated a family settlement, failed to disclose the error, and reported natural cause of death. Years later, an anonymous tip prompted a criminal investigation and trial. The prosecution argued for Vaught’s negligence in issuing an override and failure to recognise different medications, whereas the defence argued that systemic factors contributed.

VUMC encouraged adherence to physician orders, even though they omitted patient monitoring in this case, which should be standard practice after midazolam administration. Overrides to the automatic dispensing cabinet (ADC) were encouraged to circumvent delays even though no effective systems were in place to prevent or detect the accidental selection, removal, and administration of medications obtained via override.² VUMC subsequently removed vecuronium from the medications capable of being obtained via override; implemented wristband barcoding and second nurse verification of medications in radiology; required entering ‘PARA’ in ADCs for paralytics; and implemented new patient monitoring policies for vecuronium. VUMC’s fixes were only for case-relevant medications and departments despite prevalent issues throughout the organisation. Despite evidence that administrators failed to implement safe medication practices, no administrators faced repercussions.

Criminalisation of medical accidents leaves clinicians scared to report systemic causes and contributors to bad outcomes, removing a foundational pillar of patient safety. Vaught’s conviction also demonstrates deep misperceptions amongst the public, legal, and medical communities that ignore more than 80 years of safety science, reflective of ongoing difficulty in acknowledging the complexity of safety in clinical work. Nurses across the USA, including those from our own hospital, have voiced their fear of being left unprotected and set up for failure by the US healthcare system.^{3,4} The conception of accidents as being easily avoided through greater attention, trying harder, or adherence to rules, is a naïve reductionist concept, serving only immediate purposes, and is still the dominant view of safety. There is not just a legal problem, but a wider systemic failure to understand and embrace what we know about safety within complex systems.

Since the recognition of the frequency and ubiquity of medical accidents,⁵ healthcare systems across the globe have sought to apply what has been termed a ‘systems approach’, based on the principle that accidents are not brought about by bad people, but by systems-of-work that have been poorly configured to support human activity. Work systems are constantly flexing in response to ever-changing productivity, financial, environmental, social, political, regulatory, and personal demands, and are dependent upon people working within them to adapt their behaviours, sometimes in violation of previous rules.⁶ This complex, adaptive view of safety is especially salient in healthcare, where patient-centred care requires constant adaptation, whereas the goals of health, longevity, and quality of life are ultimately unachievable given finite resources and the natural limitations of human existence.⁷

OPENING STATEMENT CONTINUED

e2 | Correspondence

Reinterpreting the events from this systems safety perspective, Vaught worked within a system that required trade-offs between safety and other aspects of system performance. This, ultimately, is what led her to administer the wrong medication inadvertently, killing Charlene Murphy. As the unit 'help all' nurse and preceptor, Vaught was responsible for the lives of several patients in coordination with uncommunicative staff while training an orientee.⁸⁻¹² Vaught administered the incorrect medication to Murphy in an unfamiliar environment without barcode or second nurse verification or access to electronic health records, and experienced technical difficulties and organisational pressures to circumvent delays by overriding the ADC rather than confirming with pharmacy, within a culture dependent on physician orders, even if they were incorrect in their omission of patient monitoring.^{2,8-12} There were many contributors to this incident; and thus, there are many ways it could have been avoided. To blame only one individual will perpetuate problems, rather than lead to any resolution.

There remains a vast systematic misapplication of systems safety approaches in healthcare. Safety is often viewed as 'common sense' with simplistic narratives around standardisation, strict protocol and checklist adherence, and team-work training based on cursory references to other industries. Despite interest in clinical decision making and support literature, how clinicians actually make decisions and where they seek trustworthy information to execute decisions, has rarely been explored. Clinicians can identify clinical failings, but do not always have the skills to acknowledge or identify the role played by bad design. Human-focused attributions such as 'cognitive bias' and 'situational awareness failure' can hide deeper systemic origins of these phenomena.¹³ Some clinicians state outright that they do not believe in systems thinking and it is completely unnecessary. This systemic lack of systems thinking sets up clinicians to fail at every level within healthcare systems, and ultimately made the Vaught conviction inevitable.

RaDonda Vaught did not come to work that day to deliberately contribute to Charlene Murphy's death, but was set up to fail by a system that allowed a fatal mistake to happen. Nurse Jarie Gamer responded thoughtfully to the Vaught case: 'There are two kinds of nurses. [Those] who assume they would never make a mistake ... because they don't realize they could. And ... the ones who know this could happen, any day, no matter how careful they are'.¹⁴ Simplistic views of 'error', where only bad people make mistakes, are still endemic across the global health system, yet must be challenged and changed. Although this case appears to be a miscarriage of justice, hopefully it will lead to better consideration and utilisation of systems thinking in healthcare and increased clinician and safety scientist collaboration. It is up to us to learn from this case and collaboratively redesign the healthcare system from inside out, with a systems perspective, especially in non-operating theatre environments as highlighted by this case.^{15,16}

Declarations of interest

The authors have no conflict of interest to declare.

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FACULTY PROMOTIONS



Carlee Clark, MD
Professor

I joined the department in July of 2009 and can't believe it has been 13 years already. My favorite thing about working at MUSC has always been the people. We have such great people in our department and our perioperative community. When I joined, I don't think I could have predicted what my path would have looked like, but I have been very thankful for and challenged by my various roles in the department over the years. I want to thank Dr. Reeves for the continued support to allow me to pursue leadership roles while staying committed to academics. Thank you to Drs. Hebbbar, Wilson and McSwain for collaboration and support in making the move from Associate Professor to Professor. Congratulations to Dr. Julie McSwain and Dr. Catherine Tobin on their promotion.

I was born in Pittsburgh, PA (go Penguins!) and spent my childhood years in New York, West Virginia, and North Carolina (go Canes!) before attending Duke University for college and University of North Carolina-Chapel Hill for both medical school and residency (and yes, I will only root for Duke during basketball season...sorry). After working for a year as an attending at UNC-CH, I moved even further south to Charleston and began employment at MUSC in 2009. I have been truly privileged to work with an amazing group of residents, CRNAs, anesthesia techs, and fellow faculty members over the past 13 years. I would also like to give a special thanks to Dr. Sylvia Wilson and Dr. Latha Hebbbar for guiding me through the past two promotions process. Outside of work, I currently spend my time running (well, more like "shuffling" in the summer heat), trying new recipes from NYT Cooking, reading, gardening, playing board games with my family, and fussing at my 11-year old daughter to get off her electronic device and read a book!



Julie McSwain, MD
Professor

I was born in Florence, South Carolina and attended college at the University of North Carolina in Chapel Hill. I then came to the Medical University of South Carolina in 2005 for medical school and have been here ever since. My how time flies, as I have been on the MUSC campus for 17 years, which includes my anesthesia residency and joining faculty in 2009. I seriously love our anesthesia department. What a wonderful group of residents, CRNA's, anesthesia techs, and fellow attending anesthesiologists I work with! I am thrilled to hear of my promotion to Professor. I also was recently named the new Medical Director of the MUSC Simulation Center and honored to become the Lewis Blackman Endowed Chair for Patient Safety and Simulation. Big changes are ahead as a new MUSC Simulation Center is under construction in the Colbert Library of the horseshoe. Stay tuned for this! I would like to thank Dr. Jerry Reves, Dr. Latha Hebbbar, and Dr. Sylvia Wilson for being my mentors and Dr. Scott Reeves for the support he has given me to pursue research and simulation education. A big congratulations to Dr. Julie McSwain and Dr. Carlee Clark on promotion to Professor as well. They serve as not only peer mentors to me, but as friends as well! When I am not on campus, I am enjoying a busy but amazing life with my husband, two children (son-age 10 and daughter-age 12), and our mini labradoodle!



Catherine Tobin, MD
Professor

PROMOTION TO ASSOCIATE PROFESSOR IN THE ACADEMIC TRACK



Michael Scofield, PhD
Associate Professor

Dr. Scofield and his team have been continuing the study of the cells and systems in the brain that establish persistent relapse vulnerability following exposure to drugs of abuse, including heroin and cocaine. Recent studies in the lab have extended to the use of live imaging, within rodent brains, while animals are actively taking and seeking drugs. Through the usage of viral vectors that engage activity-dependent emission of light, and computer-aided tracking and analysis, we are beginning to decode how activity patterns of cells within the mammalian cortex evolve during drug taking and withdrawal. Armed with this information, the lab is poised to begin to unravel how drug memories are encoded, and how formation and recall of these memories may be functionally abolished. It is our belief that acquiring these types of data will be required for a more complete understanding of the neural mechanisms of addiction and will aid in the future development of therapeutics for substance use disorder in humans.

RIVERDOGS WELCOME PARTY



RIVERDOGS WELCOME PARTY



WELCOME TO THE DEPARTMENT

Jules Harper
Research Assistant

Last May, I graduated from Clemson University with my Bachelor of Science degree. During my four years at Clemson, I was a Biological Sciences major and Psychology minor. My goal is to attend medical school in the near future, but in the meantime, I am so excited to be working as a Program Assistant in the Department of Anesthesia & Perioperative Medicine at MUSC. I grew up in Charleston for the majority of my life and feel very fortunate to be back in this wonderful city I call home!

MEET OUR NEW FELLOW

I grew up in Charleston, SC and attended Clemson University where I majored in Biological Sciences. I completed medical school and residency here at MUSC. I married my husband, John Nix, in April. We recently bought a house in Mount Pleasant where we live with our 2 year old golden retriever, Mac!



Kendall Headden, MD
Regional Fellow

RESIDENT/FELLOW GRADUATION DATE SET—JUNE 16, 2023

All residents, fellows and faculty, please mark June 16, 2023 as our graduation date. It will be held at 6:00pm at Founders Hall. Should be a great event!

UNIVERSITY HOSPITAL WELCOMES NEW CRNAs



Melanie Schutt,
DNAP, CRNA

Dr. Melanie Schutt recently transferred her practice to the anesthesia department at MUSC. Previously she worked at the University of Maryland Medical Center for two years. Melanie earned her doctorate in nursing anesthesia from the University of Buffalo. Her project, Improving Anesthesia Non-Technical Skills in Nurse Anesthetists Through an Online Workshop, examines the impact of education on anesthesia non-technical skills of New York State nurse anesthetists with the project goal of decreasing the critical errors in anesthesia.



Mike Martz,
DNAP, CRNA

Dr. Michael "Mike" Martz is a CRNA here at MUSC. Mike was born in Chapel Hill, NC but grew up in Dallas, Texas. Mike attended TCU to earn his BSN, he subsequently worked at Parkland hospital in the Burn ICU for 4 years before moving to Charleston, SC for CRNA school. Mike attended the DNAP program here at MUSC before accepting a job at Main hospital. He still has a large interest in burns and the anesthetic care involved. In his free time, Mike likes to play/watch any sporting event available. He played soccer in college and is a fan of any Dallas area sports team.



Megan Pattavina,
MSN, CRNA

I attended Duke University's nurse anesthesia program and worked at Massachusetts General Hospital in Boston, MA for 8 years. I worked in all clinical areas with a focus on joint arthroplasty and spinal anesthesia. I was also the SRNA clinical coordinator for the past three years growing the program to three clinical sites and three nurse anesthesia programs. I enjoy process improvement projects and simulation training for SRNAs and CRNAs. Look forward to working with everyone!

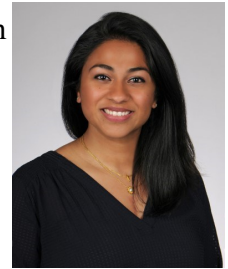
CONGRATULATIONS DR. JENNIFER HALE



Jennifer Hale, DNAP, CRNA was awarded the Researcher of the Year from the South Carolina Association of Nurse Anesthetists. This occurred at the annual meeting in Kiawah on August 26. Dr. Hale's research is in clinical preceptorship and learning. Jennifer was recently the Clinical Coordinator for the Anesthesia for Nurses Program, MUSC.

CULTURAL AWARENESS AND EDUCATION

Drs. Reeves, Hebbar, Clark, Whitener, Selassie, Guldan and George have recently been in discussions regarding the importance of Diversity, Equity and Inclusion (DEI) and all agree that one of the first steps is to form a committee in the department that has representation from all facets - faculty, CRNAs, residents, techs, admin and research staff.



Renuka George, MD

In forming this committee, we aim to integrate DEI initiatives within the department's mission, operations and strategies while fostering a work environment that values, develops and advances diversity and inclusivity. There would be multiple opportunities within the committee to focus on different areas: recruitment and retention, departmental education and training, institutional collaboration as well as community outreach and engagement. Please note, you do not have to have any experience to volunteer; curiosity and an open mind are all that's required!

This is volunteer based and we will be meeting once a month. If you are interested, please email Stephanie Whitener and we will email out the date of the first meeting (TBD). Thank you in advance for your interest, effort and enthusiasm.

CONGRATULATIONS TO NICOLE MCCOY AND THE PEDIATRIC DIVISION FOR THEIR NATIONALLY RECOGNIZED RESEARCH SHOWING SIGNIFICANT PAIN REDUCTION IN CHILDREN UNDERGOING BONE MARROW TRANSPLANTATION.

EurekaAlert! | AAAS

SEARCH ARCHIVE

ADVANCED SEARCH

HOME NEWS RELEASES MULTIMEDIA MEETINGS LOGIN REGISTER

NEWS RELEASE 18-JUL-2022

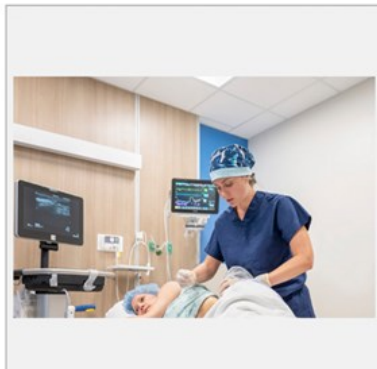
With radically improved pain control, bone marrow donors can gift stem cells without worry of undue side effects or opioid use

Peer-Reviewed Publication

MEDICAL UNIVERSITY OF SOUTH CAROLINA



Sharing gifts is a favorite way to sustain connection across peoples and cultures worldwide, but with bone marrow donation the gift-giving act is accompanied by uncomfortable side effects to the donor, making it a truly selfless expression of kindness. Recognizing this good will and wanting to improve the donor experience, [Nicole McCoy, M.D.](#), an anesthesiologist at MUSC, started looking for a new way to manage pain during and after the harvest procedure.



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More on this News Release

With radically improved pain control, bone marrow donors can gift stem cells without worry of undue side effects or opioid use

MEDICAL UNIVERSITY OF SOUTH CAROLINA

JOURNAL
Frontiers in Medicine

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RESEARCH CORNER



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PMCID: PMC9086676

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PMID: [35559351](https://pubmed.ncbi.nlm.nih.gov/35559351/)

Decreased Opioid Consumption in Bone Marrow Harvest Patients Using Quadratus Lumborum Blocks in a Standardized Protocol

[Nicole C. McCoy](#),^{1,*} [Ellen L. Hay](#),¹ [Deborah A. Romeo](#),¹ [J. Wesley Doty](#),¹ [Bethany J. Wolf](#),² and [Michelle P. Hudspeth](#)³



Nicole McCoy, MD



Ellen Hay, MD



Deborah Romeo, MD



Wes Doty, MD



Bethany Wolf, PhD

Preoperative Quadratus Lumborum Block Reduces Initial Postoperative Opioid Consumption Following Hip Arthroscopy: A Retrospective Analysis

[Sylvia H. Wilson](#), MD¹; [Renuka M. George](#), MD¹; [Dulaney A. Wilson](#), PhD²; [Caitlyn Risley](#), BS¹; and [Shane K. Woolf](#), MD³

Compare postoperative opioid consumption following hip arthroscopy in patients who received a preoperative, lateral quadratus lumborum block versus those who did not. Patients were retrospectively identified. The primary outcome was postoperative opioid consumption (IV morphine milligram equivalents) in patients with and without a block. Comparisons between groups were conducted with Chi-square tests and Fisher Exact Tests where appropriate. Continuous data were compared with two-sided t-tests and Wilcoxon rank-sum tests. Data were collected on 100 patients. Mean (95% confidence interval) postoperative opioid consumption was reduced in patients with a quadratus lumborum block compared to those without a block (6.6 [5.2 – 8.1] vs 11.8 [10.2 – 13.4]; $p < 0.0001$; respectively). Eleven percent of patients with a preoperative quadratus lumborum block did not consume any opioids in the post anesthesia care unit. Opioid consumption in the immediate postoperative period was significantly reduced in patients that received a preoperative quadratus lumborum block. Level of Evidence: Level III – Retrospective Cohort Study. (Journal of Surgical Orthopaedic Advances 31(1):017–021, 2022)



Sylvia Wilson, MD



Renuka George, MD



Dulaney Wilson, PhD

RESEARCH CORNER

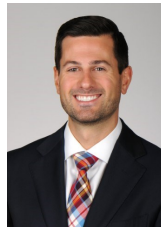
DOI: 10.1111/ctr.14667


 Clinical TRANSPLANTATION
 The Journal of Clinical and Translational Research
 

REVIEW ARTICLE

Perioperative management of adult living donor liver transplantation: Part 1 – recipients

Tetsuro Sakai^{1,2,3}  | Justin Sangwook Ko⁴ | Cara E. Crouch⁵  | Sathish Kumar⁶ | Michael B. Little⁷ | Min Suk Chae^{8,†}  | Armando Ganoza^{9,†} | Luis Gómez-Salinas^{10,†} | Abhi Humar^{9,†} | Sang Hyun Kim^{11,†} | Bon-Nyeo Koo^{12,†} | Gonzalo Rodriguez^{13,†}  | Joel Sirianni^{14,†} | Natalie K. Smith^{15,†}  | Jun-Gol Song^{16,†} | Aisha Ullah^{1,†} | Adrian Hendrickse⁵



Joel Sirianni, MD





Applied Ergonomics

Volume 104, October 2022, 103831



Improving safety in the operating room: Medication icon labels increase visibility and discrimination

Connor Lusk^a  , Ken Catchpole^a, David M. Neyens^b, Swati Goel^c, Riley Graham^d, Nicolas Elrod^d, Amanjot Paintlia^d, Myrte de Alfred^e, Anjali Joseph^c, Candace Jaruzel^f, Catherine Tobin^a, Timothy Heinke^a, James H. Abernathy III^g



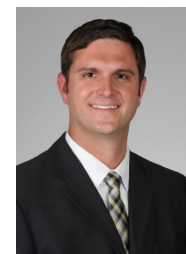
Connor Lusk, PhD



Ken Catchpole, PhD



Catherine Tobin, MD



Tim Heinke, MD

Catching Up with Dr. Joseph ‘Jerry’ Reves, MD

The ASA Monitor sat down with Dr. Joseph “Jerry” Reves – Distinguished Professor and Emeritus Dean of the College of Medicine Medical at the University of South Carolina and a former innovator and leader in anesthesiology – for his insights on the specialty now. His areas of focus throughout his career include intravenous anesthetics and novel ways of administering them and studying the effects of cardiac surgery on the brain to reduce stroke and neurocognitive dysfunction after surgery. He also fostered interdisciplinary programs and was founding Director of the Duke Heart Center. More recently, Dr. Reves has focused on innovation in medical education, including the importance of medical simulation and methods to improve research in anesthesiology education.



Joseph “Jerry” Reves, MD

You have a reputation as a visionary: an early adopter of science and technology to improve patient care. You were among the first to 1) use benzodiazepine-opioid combinations for cardiac surgery, 2) try to capture the massive amount of information generated in routine perioperative care, 3) directly integrate cardiac physiology into cardiac anesthesia, and 4) harness the power of computers to deliver intravenous anesthetic drugs. However, how does the reality of anesthesia practice in 2021 differ from your vision of the future while you were actively engaged in clinical practice and research?

Dr. Reves: Today’s practice, as I understand it, is as exciting as it was when we were doing so many “new” things. Clinicians, today as yesterday, turn over in their minds every day the same questions: can we do things any differently, any better? For our field to remain vibrant and for patient care to be improved, anesthesiologists must continue to ask these questions. My greatest concern about today, as compared to my time in practice, is that anesthesiologists, particularly those in academia, do not have the time and, in many cases, the resources, to test new ideas and test hypotheses using the scientific method. We have to figure out ways to let inquiring minds find answers to their important clinical questions about the practice of anesthesia. This will ensure that the field progresses as it has since I first entered it in 1969.

As the Research Division Chief at the University of Alabama, then Chair of the Department of Anesthesiology at Duke, and eventually as Dean of the Medical University of South Carolina, you have had ample opportunity to develop academic careers. Many of your mentees have gone on to help shape the future of the specialty. Looking at those whom you have trained and mentored, could you share some of the contributions you’re most proud of?

Dr. Reves: The absolute greatest satisfaction of my career was seeing others accomplish so much – many, far more than I did. My count is probably off, but I know of at least 11 former colleagues I have mentored who have gone on to chair academic departments of anesthesiology and six who have become deans and or vice presidents of medical affairs around the country. One, for example, is Debra Schwinn, MD, who did her cardiac anesthesia fellowship with us at Duke, chaired the department at the University of Washington, served as dean at the University of Iowa and president of Palm Beach Atlantic University, is a member of the National Academy of Sciences, and has never lost her zest for discovery and enthusiasm for fostering investigation among her many mentees. Joseph Mathew, MD, current chair at Duke, was recently told in my presence by a colleague that he embodied the spirit of academic excellence we tried to establish at Duke. To see this philosophy live on through mentees is all the legacy that one could ever hope to have.

You are now dean emeritus, and one of the senior statesmen in anesthesiology. Has this been a time to reflect on those who helped you? If you could have a gathering to celebrate those who helped you accomplish so much during your career, who would you invite? What would you say to them?

Dr. Reves: This is a fascinating question. When I retired as Dean and Vice President of Clinical Affairs here at MUSC, I was asked to give the “last lecture,” and I named significant professional mentors in a chronological order. At MUSC, Robert Walton, MD, PhD, was an inventor and tireless investigator in cardiovascular pharmacology. Guenter Corsen, MD, my chair during residency at UAB, taught me that you could deliver all anesthesia with intravenous or locally injected anesthetics, and he had a boundless

enthusiasm for new anesthetic drugs and techniques. The surgeon John Kirklín, MD, and my colleagues in cardiac anesthesia at UAB, Bill Lell, MD, and Paul Samuelson, MD, all stood for excellence in clinical care that was uncompromising and inspirational. During my 17-year tenure at Duke there were so many people with whom I collaborated and from whom I learned so much that it is impossible to list them all. I hope they know who they are – they subsequently became chairs and leaders in their own right. I would like to mention Drs. David Sabiston and Joe Greenfield, chairs of surgery and medicine at Duke, respectively, who were friends and mentors. From Dr. Sabiston I learned the value of incorporating all academic pursuits in a department, and from Dr. Greenfield I learned how to take advantage of new and exciting opportunities in cardiovascular medicine. Philippa Newfield, MD, neuroanesthesiologist in San Francisco, inspired me to look at the brain while doing cardiac cases, and this led to a fruitful line of investigation. Of course, in the field of anesthesiology around the globe, I have had the privilege of learning from many people who were doing exciting new things that in some cases we tried to replicate and improve. My heroes in academic anesthesia away from Duke were Nick Greene, MD, of New Haven, Arthur Keats, MD, in Houston, and friend Ed Lowenstein, MD, of Boston. To each and every one of these important people in my career, I would simply say thanks for the encouragement, support, ideas, and most of all the enthusiasm for pushing onward and upward. What I would say to this collection of mentors: we wouldn’t and couldn’t have done whatever we did without you. Thank you.

Now, let’s think about a different party: one for the next generation. These are the young recruits into anesthesiology, the next generation of clinicians, leaders, educators, and researchers. You are giving them a final pep talk before they venture into the future of anesthesiology – to create a future that we can barely perceive today. They want your counsel, insight, and encouragement. What would you say to them?

Dr. Reves: This is the most important group of all. They represent and will create the future. Everything new and better depends on them. I do not know them, but I am already proud of them. My advice to them is never quit

asking questions. Always think of how things can be done better to ultimately improve patient care. Never forget that the whole reason to be in medicine is to serve your fellow citizens and for those in academics, to improve the field through rigorous scientific discovery. There have always been impediments to advancing the field; those who persevere can succeed. Consider the disappointments, failures, and frustrations as merely scenery along the path to success. And, finally, be sure you share your passion for discovery with the next generation.

Now that you are dean emeritus, do you have more time for your pursuits, or are you still as bound to the deliverables of academic scholarship as you were when you were chair or dean? If you have time for pursuits and hobbies, what engages you?

Dr. Reves: Administration was time consuming. Someone has to do it, but too much time is spent dealing with challenging personnel issues because people can be problematic. Moving out of administration with retirement 12 years ago did allow me to do some things I never had time to do before, like cruise 7,000 miles around North American on our trawler boat “Sweetgrass,” personally undergo coronary bypass surgery, and get to know our grandchildren a bit better. However, the main thing retirement has brought is the ability to focus on things that continue to bring great enjoyment, like faculty career development, clinical research, and helping those who want it. My tennis game is confined to doubles now and continues to decline from its pinnacle when I was 14 years old. Aside from the occasional cruise on our boat, weekly tennis, visiting with family, fighting the rising tides from global warming, creating an arboretum campus at MUSC, and trying to help our church get through COVID, I still love being in the office to help faculty design research, edit papers, and write the occasional one. I completed my final grant November 30, 2021, so that part of the career is now over, too.

And one final question from Dr. Shafer: Rumor has it that you pilot Sweetgrass by pushing buttons. Is that true?

Yes, that is true – the automatic pilot requires pushing buttons only, and even Dr. Shafer mastered it. It is almost as easy as target-controlled anesthesia, something we both hope to see approved some time. ■

DARTMOUTH HEALTH CEO AND PRESIDENT, JOANNE CONROY, MD, NAMED TO MODERN HEALTHCARE'S 50 MOST INFLUENTIAL CLINICAL EXECUTIVES CLASS OF 2022

This is a great honor for Dr. Conroy who did her anesthesiology residency at MUSC and was the department's chair from 1996-2001. Dr. G.J. Guldan holds the Joanne Conroy endowed chair for Education and Leadership development.



Joanne M. Conroy, MD, CEO and president of Dartmouth Health, has been named to the 2022 class of Modern Healthcare's 50 Most Influential Clinical Executives. The 50 Most Influential Clinical Executives award honors individuals in healthcare who, according to their peers and the senior editors of Modern Healthcare magazine, are paving the way to better health through their executive responsibility, leadership qualities, innovation, community service and achievements inside and outside of their respective organizations.

"I'm incredibly honored to be included in Modern Healthcare's 2022 class of 50 Most Influential Clinical Executives—not only to be among peers I know and respect but also to be selected by peers I know and respect," Conroy said. "We are living in arguably the most transformative period of this century, especially in healthcare. This year's class of top clinical executives is a true 'who's who' of healthcare leaders. These individuals have led and adapted through this period of intense change by relying on and listening to the people who staff their organizations. I'm truly humbled to be among this group."

In addition to Conroy, the Class of 2022 includes notable honorees, including the U.S. Surgeon General and leaders of Mayo Clinic, Dana Farber, Cleveland Clinic, and others.

"Clinician leaders have shouldered a heavy load for healthcare organizations and the country at large throughout the past few years. We are proud to recognize those leaders who have risen to the occasion and then some," says Fawn Lopez, publisher of Modern Healthcare. "These 50 honorees have demonstrated leadership and innovation in a time of crisis and made a vital impact on the success of their organizations, the well-being of the healthcare workforce and the health of their patients and communities. We congratulate and thank them for their dedication to the advancement of healthcare."

Since joining Dartmouth Health in 2017, Conroy's leadership and commitment to improving access to and quality of healthcare in New Hampshire and northern New England and improving patient experience while saving the system money, has transformed the health system, resulting in improvements in all areas of operation. She has overseen significant positive changes across the health system, including the undertaking of two major expansion projects—the Ambulatory Surgery Center Manchester and the Patient Pavilion in Lebanon—and a strategic planning process that will guide the organization into the future. As part of this strategic plan, the system initiated a strategic effort to update its Dartmouth-Hitchcock Health brand identity in 2019, and on April 12, 2022, the system officially announced its new brand and name, Dartmouth Health.

Leading the state's largest academic health system through the COVID-19 pandemic has been a monumental and complex challenge. Throughout the pandemic, Conroy has led Dartmouth Health with integrity, authenticity and compassion. She considered the impact of decisions made by the health system on the broader community and worked collaboratively with individuals and organizations at the local, state and federal levels to ensure the safety and well-being of patients, staff and all residents of New Hampshire.

In 2013, Conroy co-founded Women of Impact (WOI) with a small group of executive-level women from diverse sectors of the healthcare industry. Since then, WOI has grown to more than 100 members who work to advance the role of women in healthcare leadership and to realign the healthcare system to meet the needs of all Americans, recognizing that the people who need care come from all walks of life. Conroy continues to be actively involved in WOI, and other initiatives to improve access to healthcare and encourage more women to pursue leadership roles.

Conroy earned her undergraduate degree in chemistry from Dartmouth. She received her medical degree from the Medical University of South Carolina, where she completed her residency in anesthesiology.

Conroy is board certified with the American Board of Anesthesiologists, attained a Certificate of Added Qualifications in Pain Management and is a diplomat with the American Academy of Pain Management. Prior to joining Dartmouth Health, Conroy served as CEO of Lahey Hospital and Medical Center in Burlington, Mass.

JOANNE CONROY, MD NAMED CHAIR ELECT OF THE AMERICAN HOSPITAL ASSOCIATION—CONGRATULATIONS ON YET ANOTHER MARVELOUS ACCOMPLISHMENT



Dartmouth Hitchcock
Medical Center and Clinics

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American Hospital Association board names Joanne M. Conroy, MD, as Chair-elect Designate

The American Hospital Association (AHA) Board of Trustees has elected Joanne M. Conroy, MD, CEO and President of Dartmouth Health, as its Chair-elect Designate. Conroy will be Chair-elect in 2023 and become the 2024 Chair of the AHA, the top-elected official of the national organization that represents America's hospitals and health systems and works to advance health in America.

“The American Hospital Association is a powerful force in leading and advocating for hospitals and health systems around our country and, by extension, the patients and communities we serve,” said Conroy. “I’m deeply honored that my colleagues on the Board have elected me to serve as Chair, and I look forward to continuing to work with Rick Pollack and AHA team in achieving our vision of a just society of healthy communities, where all individuals reach their highest potential for health.”



Since joining Dartmouth Health in 2017, Conroy's leadership and commitment to improving access to, and the quality of, health care in New Hampshire and Vermont, and improving patient experience while saving the system money, has transformed the academic health system, resulting in an improvement in all areas of operation at the nation's most rural academic health system.

Conroy has overseen significant changes across Dartmouth Health, including the undertaking of two major expansion projects, guiding the system through the challenges of the COVID-19 pandemic, and a strategic planning process that will guide the organization into the future and build upon its partnership with the world-class Geisel School of Medicine at Dartmouth.

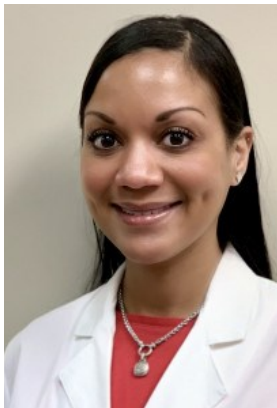
Conroy is a co-founder of “Women of Impact,” a nonpartisan group of 85 female healthcare leaders. She led Dartmouth Health in becoming an early signatory of the TIME'S UP Healthcare initiative to increase safety and gender equity in the health sector. In June 2022, Modern Healthcare named Conroy as one of its “50 Most Influential Clinical Executives,” and the magazine has named her among “100 Most Influential People in Healthcare” in 2018 and 2020.

The Dartmouth Health system includes 396-bed flagship Dartmouth Hitchcock Medical Center; four other system member hospitals and a home health agency; Dartmouth Cancer Center; Dartmouth Health Children's, including New Hampshire's only children's hospital; a multispecialty group practice employing more than 2,000 providers; and 24 ambulatory care clinics around New Hampshire and Vermont. Conroy is a member of the AHA Executive Committee, Operations Committee and chair of the Health Forum. She chaired the AHA Task Force on Primary Care in 2021.

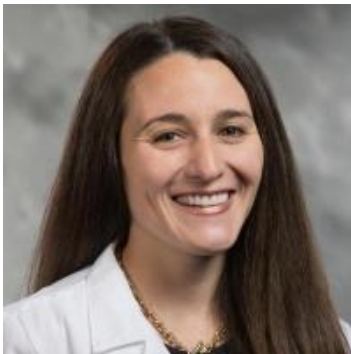
GRAND ROUNDS- SEPTEMBER 2022



“TBD”
September 6, 2022
Matt Finneran, MD
Assistant Professor
Obstetrics and Gynecology
Medical University of South Carolina



“Healthcare Disparities in Maternal Mortality and Morbidity”
September 13, 2022
Shelly Norris, MD
Assistant Professor
Department of Anesthesiology
Emory University Hospital Midtown



“Maternal Cardiac Disease: Peripartum Planning”
September 20, 2022
Mary-Louise Meng, MD
Assistant Professor
Department of Anesthesiology
Duke University Hospital



“Maternal Mortality”
September 27, 2022
Michael Marotta, MD
Assistant Professor
Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina

DEPARTMENT OF ANESTHESIA AND PERIOPERATIVE MEDICINE

Email: hameedi@musc.edu
Phone: 843-792-9369
Fax: 843-792-9314



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

[CHECK OUT OUR WEBSITE](#)

Future Events/Lectures

Intern Lecture Series

9/1—Ischemic & Valvular Heart Disease—GJ Guldan

9/15—Preserving Renal Function—Joseph Abro, MD

9/29—Peripheral Vascular Disease—Chris Heine, MD

CA 1 Lecture Series

9/7—Neuromuscular Blocking Agents—Jenny Matos, MD

9/14—Anticholinergic Drugs; Cholinesterase Inhibitors—Carey Brewbaker, MD

9/21—Adrenergic Agonists & Antagonists; Hypotensive Agents—Jackson Condrey, MD

9/28—Peripheral Nerve Blocks; Anesthesia for Orthopedic Surgery—William Barrett, DO

CA 2/3 Lecture Series

Per Rotations



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<https://www.instagram.com/musc.anesthesiology/>



Holiday Party
Saturday, December 3rd, 2022
Carolina Yacht Club

Graduation
Friday, June 16th, 2023 6:00pm
Founders Hall

[ONE MUSC 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 October edition will be September 20, 2022.