Department of Anesthesia And Perioperative Medicine

# Sleepy Times

Volume 9, Issue 2 February 2015


**Special Points of Interest**

- *National CRNA Week*
- *History of Anesthesiology and Medicine*
- *CRNA and Anesthesia Tech Strategic Plan*

**Inside this issue:**



## Message from the Chairman:

-Scott T. Reeves, MD, MBA

### Rediscovering Our History:

Over the past several years, I have had the opportunity to remind us of the robust history we have in the department. We started out by learning about our early years under Dr. John Mahaffey. We then looked through the eyes of Drs. Charlie Wallace and Fred Guidry as they wrote about *Leaving a Legacy*. Most recently, *Sleepy Times* has included a *History of Anesthesiology and Medicine* section. Each month, I attempt to discover a historic manuscript or piece to include in that section.

As time has progressed, many of you are starting to send me pieces to consider. January was a very special month, as I received new information about two deceased members of our department, Doctors Joseph Redding and Laurie Brown. Fred Guidry has included a summary and attached the early manuscript highlighting the substantial contributions that Dr. Redding had in the early days of cardiac resuscitation and the use of vasopressin.

Dr. Raymond Roy (MUSC Chairman 1992-1996) sent me an abstract of a history paper he is presenting at the Anesthesia History Association Spring Meeting entitled *Non-anesthetic Uses of Ether during the Anesthesia Residency of Dr. Laurie Brown 1955-57.* He was prompted to send this to me by one of our medical students, Katherine Margaret Rose, who was interviewing for an anesthesia residency position at Wake Forest. As I read the abstract, I was caught by the phrase "Recollections." There is more to the story, I asked? Many of you may not know but Dr. Brown was the Chief of Anesthesiology at the VA from 1966-1992. He was the department historian from 1992-1998. I did not know that he wrote *Recollections of the Medical College of South Carolina Anesthesiology Residency Years 1955-1957* which was completed on April 15, 1992. Fortunately, Katie Rose asked Dr. Roy to email me, and we now have the 80-plus pages of *Recollections* as part of our history again. In the months ahead, I hope to share parts of this story with you.

**Dr. Laurie Brown**

**Dr. Joseph Redding**

# NATIONAL CRNA WEEK
## BY: DR. CARLEE CLARK

The 16th annual National CRNA week was January 25-31, 2015, and is a celebration of anesthesia patient safety and the contribution of the nation's Certified Registered Nurse Anesthetists and Student Nurse Anesthetists to the anesthesia care team. CRNAs are nationally recognized as leaders in patient safety. MUSC has employed CRNAs since 1963 and the MUSC CRNA training program started in 1967 as a hospital based certificate one-year program under Everard Hicks, CRNA. The Program moved to the College of Allied Health in 1971 when it became a Master's degree program. US News and World Report has ranked the program in the top 25 percentile of all nurse anesthesia programs. Thank you for helping us celebrate our MUSC CRNAs and SRNAs!

# HISTORY OF ANESTHESIOLOGY AND MEDICINE: THE ROLE OF EPINEPHRINE IN CARDIAC RESUSCITATION

## BY: FRED GUIDRY, MD

When I joined the Department I learned of Joseph Redding because of the critical care lecture that bears his name but did not give it any further thought.

Recently, I wanted some quick facts about vasopressin and went the easy route – Google/Wikipedia. In the entry for vasopressin, I found the following intriguing section: "Injection of vasopressors for the treatment of cardiac arrest was first suggested in the literature in 1896 when Austrian scientist Dr. R. Gottlieb described the vasopressor epinephrine as an "infusion of a solution of suprarenal extract [that] would restore circulation when the blood pressure had been lowered to unrecordable levels by chloral hydrate."[30] Modern interest in vasopressors as a treatment for cardiac arrest stem mostly from canine studies performed in the 1960s by anesthesiologists Dr. John W. Pearson and Dr. Joseph Stafford Redding in which they demonstrated improved outcomes with the use of adjunct intracardiac epinephrine injection during resuscitation attempts after induced cardiac arrest."

The article referenced is titled "The Role of Epinephrine in Cardiac Resuscitation" published in *Anesthesia and Analgesia* in 1963. It is an interesting article because it reviews the acceptance of closed massage as an effective method of managing cardiac arrest and the confusion about the effectiveness of epinephrine. It is a seminal article because it established epinephrine as the cornerstone of pharmacologic resuscitation. The article is copied at the end of this page.

Dr. Redding is described on our departmental website as "internationally known as a pioneer in critical care research which led to modern day concepts of cardiopulmonary resuscitation," but frankly I did not fully appreciate his contributions to modern medicine.

It is hard now to remember how relatively recently that modern CPR was developed. When I was a Boy Scout we were taught the Holger Nielson technique of artificial respiration, described in the first edition of the Boy Scout Handbook in the United States in 1911. The patient was laid on their front, with their head to the side, resting on the palms of both hands. Upward pressure applied at the patient's elbows raised the upper body while pressure on their back forced air into the lungs. We practiced at summer camp, but it obviously was not very effective!

Before coming to MUSC, Dr. Redding was at the University of Maryland where he worked with Dr. Peter Safar, who was truly the founder of modern resuscitation along with a group that developed all the elements of modern ACLS.

He was one of the founders of the Society of Critical Care Medicine and published articles in the early 60's on the role of anesthesiologists in critical care and the institution of an ICU at Baltimore City Hospital in 1958. The now defunct Southern Society of Anesthesiologists established the Joseph S. Redding Critical Care Research Award.

The leaders in resuscitation research initiated a series of Wolf Creek Conferences with the first being in 1975. The conferences brought together the leaders in CPR research in order to improve the clinical practices of cardiopulmonary resuscitation by stimulating laboratory and clinical research. Dr. Redding chaired the second conference, and its proceedings were published in *Critical Care Medicine* in 1981

Dr. Redding died in 1984 and his contributions are discussed in a memorial article in the journal *Critical Care Medicine*. Dr. Redding was stricken with polio at age 5 (an almost unheard of disease now) and conquered the resultant disabilities to become a superb person and physician. We should be proud of his association with MUSC and emulate his example.

Click Here for Full Article

THE ROLE OF
EPINEPHRINE IN
CARDIAC RESUSCITATION

JOHN W. PEARSON, B.M.
JOSEPH S. REDDING, M.D.
Baltimore, Maryland*

*"Of those who recover from a state approaching to dissolution a greater number will owe their recovery to unassisted nature, than to the most judicious treatment. But let us not on this account undervalue the knowledge which physiological investigations throw on this interesting subject."*
*Sir Benjamin Brodie, 1846*

SINCE 1960, closed-chest cardiac massage has been accepted as an effective means of treating cardiac arrest. It would now seem appropriate to re-evaluate some of the other measures which might be used with this technic. Much of our knowledge of closed-chest cardiac massage is based on clinical reports, although it is well known that this is a poor basis for the evaluation of any resuscitation method. However, we know experimentally that the combination of closed-chest cardiac massage and intermittent positive pressure ventilation will reoxygenate arterial blood even when profound asphyxia is present.[1] At the same time, this artificial circulation is only about 10 to 20 per cent of normal.[2]

It seems reasonable, therefore, to suppose that in cardiac arrest, spontaneous circulation should be restored as soon as possible.

One of the measures advocated to restore spontaneous circulation in cardiac arrest is the injection of epinephrine. The use of epinephrine in the treatment of cardiac arrest dates from 1896, a year after the excellent original description of the effects of suprarenal extract by Oliver and Schäfer.[3] In 1896, Gottlieb[4] showed that the infusion of a solution of suprarenal extract would restore circulation when the blood pressure had been lowered to unrecordable levels by chloral hydrate. Since this time, there have been both fervid advocates of epinephrine and equally fervid opponents.

In the last 15 years or so, there have been many suggestions that epinephrine has some use in the treatment of both asystole[5-10] and ventricular fibrillation.[11-14] However, these suggestions are far from being enthusiastic testimonials; furthermore, the doses vary widely. Beecher and Linton[5] warn

*Department of Anesthesiology, Baltimore City Hospitals, Baltimore, Maryland.

This investigation was supported by Research Grant H-6459 from the National Heart Institute, Public Health Service.

Read at the 37th Congress of the International Anesthesia Research Society, March 24-28, 1963, Bal Harbour, Florida.

# HISTORY OF ANESTHESIOLOGY AND MEDICINE: NON-ANESTHETIC USES OF ETHER DURING THE ANESTHESIA RESIDENCY OF DR. LAURIE BROWN 1955-1957

Raymond C. Roy, M.D., Ph.D., Wake Forest School of Medicine, Winston-Salem, North Carolina, USA

**Background**: In 1992 L. Laurie Brown, M.D., Professor Emeritus and historian at the Medical University of South Carolina (MUSC), wrote "Recollections" of his anesthesia residency at MUSC 1955-1957 (1). He described 4 non-anesthetic applications for ether. The aim of this study was to determine whether these now defunct practices were idiosyncratic to MUSC or supported by the literature prior to his residency.

**Methods**: Pubmed was queried with the following search terms; ether analgesia, ether asthma, circulation time, and retained urinary catheter. The table of contents of *Anesthesiology* and *Anesthesia & Analgesia* were reviewed from 1935-1955 for titles mentioning these applications.

**Results**: Quotations (italicized) from Brown's "Recollections" (pages 28-29) are followed by quotations from literature references supporting these applications.

"*We used ether rectally on occasion, mixed in olive oil, to treat status asthmaticus*." "The adult dosage…was from five to seven ounces of equal parts of ether and olive oil thoroughly mixed, and twenty minutes' time was allotted for each administration. The narcosis following was usually deep, lasting several hours (2)."

"*On rare occasion it was used rectally as an analgesic*." "The results of the medication vary from a sedative effect to analgesia with unconsciousness and complete amnesia… In 98 percent of 540 analgesized cases pain was greatly alleviated – of these 67 percent had practically no pain, while 31 percent obtained very considerable relief but not to be graded perfect (3)."

"*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*." "The intravenous injection of ether, saccharin or sodium dehydrocholate carry with them not only disadvantages but even dangers (4)." "The normal circulation time is seriously prolonged in patients suffering from myocardial failure (5)."

"*Ether was injected on occasion into a catheter which could not be removed from the bladder because the bulb could not be deflated*." "…the balloon sometimes becomes exasperatingly difficult to deflate… The injection of ½ to 1 cc. of ether, xylene, or chloroform produces rupture of the balloon (6)."

**Conclusions**: The applications described by Brown were not unique to his institution because they were described in the literature prior to his tenure as an anesthesia resident.

**References**:

(1) Brown LL. "Recollections" Medical College of South Carolina. Anesthesiology Residency Years 1955-1957. April 15, 1992. Typed copy presented to me when I was department chair 1992-1996;

(2) Kahn IS. Anesth Analg 1938; 17:39-41;

(3) Stevens WJ. Can Med Assoc J 1932; 26:178-81;

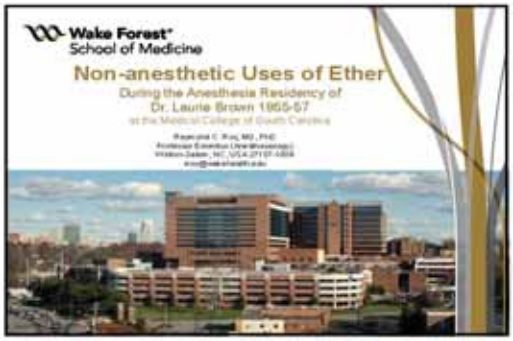
(4) Jablonis B. Science 1943; 97(2527):515-6;

(5) Hunter AR. Br Med J 1947; 1(4487):16;

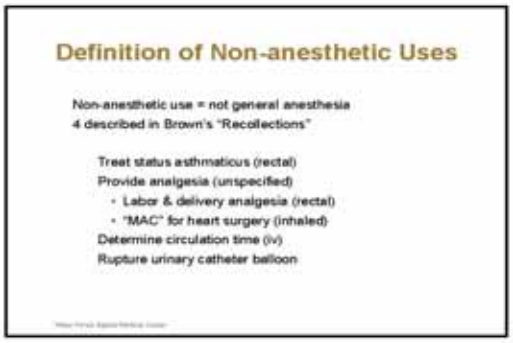
(6) Bodner H, Howard AH, Kaplan JH. JAMA 1954; 154:833

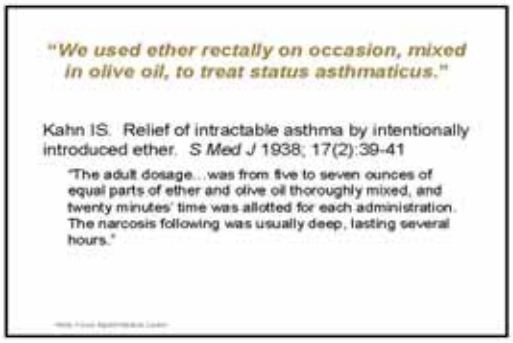
# HISTORY OF ANESTHESIOLOGY AND MEDICINE: NON-ANESTHETIC USES OF ETHER DURING THE ANESTHESIA RESIDENCY OF DR. LAURIE BROWN 1955-1957 CONTINUED . . .

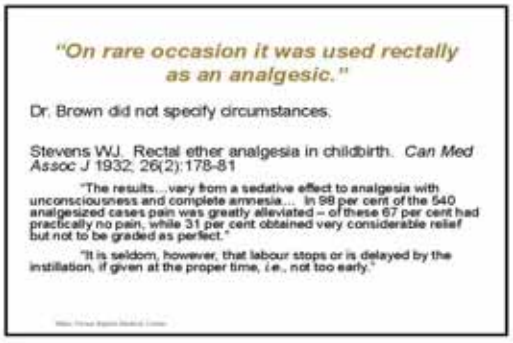
01/27/2015

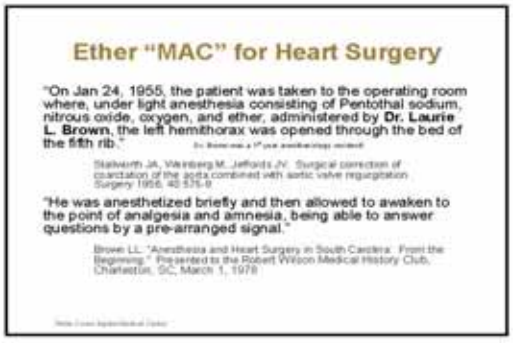






# HISTORY OF ANESTHESIOLOGY AND MEDICINE: NON-ANESTHETIC USES OF ETHER DURING THE ANESTHESIA RESIDENCY OF DR. LAURIE BROWN 1955-1957 CONTINUED . . .

01/28/2015

## Ether "MAC" for Heart Surgery

"Two patients not included in this series [Hufnagel valve in descending aorta to treat aortic insufficiency] were offered operation and died during induction of anesthesia before the operation had begun. A technique has been developed† for induction and maintenance of these patients on an extremely light anesthesia, which has been most encouraging, and which represents a major achievement in the control of these patients."

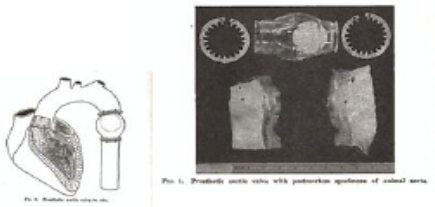
†By Thomas McDermott, professor of anesthesiology, Georgetown University Medical Center"

Hufnagel CA, Harvey WP, Rabil PJ, McDermott TF. Surgical correction of aortic insufficiency. *Surgery* 1954; 35:673-83

Wake Forest Baptist Medical Center

## Hufnagel Valve

O'Donnell JA, McDermott TF. Anesthetic problems of surgical correction of aortic insufficiency. *Anesthesiology* 1955; 16:343-54.



Wake Forest Baptist Medical Center

## Ether "MAC" for Heart Surgery

O'Donnell JA, McDermott TF. Anesthetic problems of surgical correction of aortic insufficiency. *Anesthesiology* 1955; 16:343-54.

Preop prep: 2 weeks in house to treat CHF; "...determine circulatory time"

Premed: barbiturate 1.5 hr preop, morphine + scopolamine 1.0 hr preop

Intubation: topical – 1% pontocaine translaryngeal, 10% cocaine pharynx

Induction: minimum amount of pentothal until just lose consciousness, $N_2O$, $O_2$

Maintenance: small amount of ether (stage 1), $O_2$

Brown LL. "Recollections" p 28

"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." Did not mention copper kettle (1952).

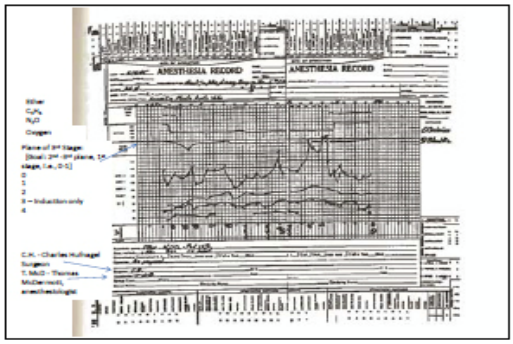
Wake Forest Baptist Medical Center

## Stages of Ether Anesthesia with Subdivisions of Stage 1

Artusio JF. Ether analgesia during major surgery. *JAMA* 1955; 157(1):33-6

Artusio JF. Ether analgesia for the patient in shock. *Clin Anesth* 1965; 2:103-18

Wake Forest Baptist Medical Center




## Ether "MAC" for Heart Surgery

Dripps RD, Eckenhoff JE, Vandam LD. Introduction to Anesthesia

2nd Edition 1961

"Analgesia rather than surgical anesthesia with ether has been assayed for certain operations in very ill patients. With peripheral venous blood levels as low as 10 to 15 mg. per cent, pain relief has been provided together with adequate operative conditions for the surgery during major operations on the heart. The patient can respond to questions during the procedure, obey commands, recognize colors, and even distinguish differences in the sensation of taste." p 79

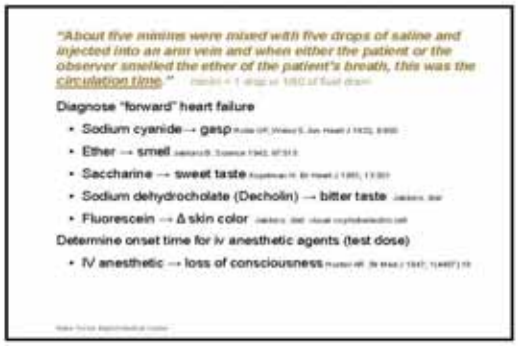
3rd Edition 1967

"Clinical experience suggests that the analgesic state is best reached by first deepening anesthesia beyond this level for a brief period." p 119

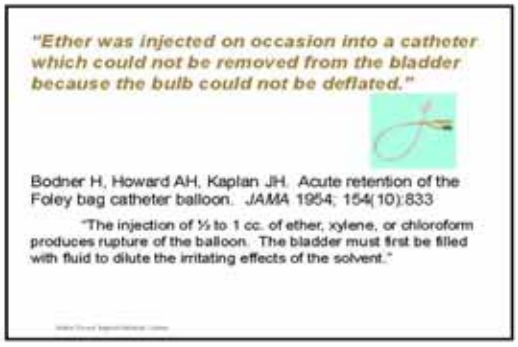
Wake Forest Baptist Medical Center

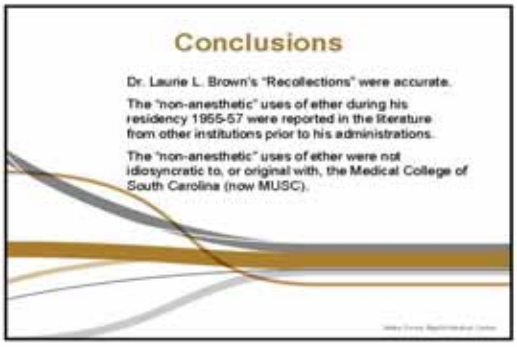
# HISTORY OF ANESTHESIOLOGY AND MEDICINE: NON-ANESTHETIC USES OF ETHER DURING THE ANESTHESIA RESIDENCY OF DR. LAURIE BROWN 1955-1957 CONTINUED . . .

01/27/2015








## CRNA and Anesthesia Techs Strategic Plan
### By: Carlee Clark, MD

In October 2014, Dr. Handel, CMO, asked that the recently reorganized Anesthesia Services, which encompasses all of the CRNAs and Anesthesia Technicians, create a three year Strategic Plan. This group had never had the opportunity to think about where they wanted to be in three years and how they were going to get there, so they welcomed the opportunity. Over several sessions led by facilitators from the Hospital's Performance Improvement department, the CRNAs and Anesthesia Techs generated Mission and Vision statements. From the larger group, a smaller task force was generated, and the work of that group led to the creation of specific goals and strategies for the Anesthesia Services Strategic Plan. The process was a great success, and we look forward to working with the Anesthesia Department to move toward accomplishing these goals.

**Mission Statement**: -Provide patient centered, high quality care in a safe and efficient manner. Our care will continue to be collaborative, innovative and driven by education and research.

**Vision Statement**: -Advancing the specialty through its clinical, educational and research endeavors.

**Goals Summary:**

-MUSC education and career development program for Anesthesia Technicians

-Improve education for CRNAs and SRNAs by combining resources and formation of an education committee

-Improve and increase the use of simulation training in education

-Teamwork – Work toward improving relationships and teamwork throughout the anesthesia department and more incorporation of Anesthesia Techs, CRNAs and SRNAs in anesthesia care plan.

-Promotion of Anesthesia Services – Improve the recognition of the services and accomplishments of the CRNAs, anesthesia technicians, faculty and residents.

## CME for Prescribing and Monitoring Controlled Substances

**A new requirement for education to maintain state license has been passed by the legislative. Please complete the required free training as outlined below as it is**
***Mandatory for All South Carolina Licensed Physicians***

As you are aware, the South Carolina Prescription Monitoring Program (PMP), also known as Senate Bill 840, was signed into law on June 6, 2014. Through this statute, **South Carolina licensed physicians are required to obtain two continuing medical education credit hours related to the approved procedures of prescribing and monitoring controlled substances listed in Schedules II, III, and IV.**

As outlined by the legislature, the two hour **requirement must be met** before the end of the current license renewal cycle which is **June 30, 2015.** The SCMA is approved by statute to offer this course.

The SCMA recognizes the critical need for more education on prescription abuse and monitoring in our state. Because the SCMA leadership knows it is important for physicians to be at the forefront of understanding the complexities of this law, immediately after understanding this new requirement, the SCMA developed an approved CME course designed specifically for SC licensed physicians.

## CME FOR PRESCRIBING AND MONITORING CONTROLLED SUBSTANCES

**You need not be an SCMA member to take the CME course free of charge.**

To make adherence to this requirement easier for our physician community, the SCMA is offering an approved course on prescribing and monitoring controlled substances **for free** to all SC licensed physicians.

To receive your two CME credit hours prior to June 30, please visit: ***www.scmedical.org/content/mycmehome*.**

Click *Take a CME Course,* follow the prompts to register, complete the course, and print a CME certificate for your records.

**SCMA members** should login using their SCMA account number.

**Non-SCMA members** should register for SCMA CME by clicking the link provided above and set up a account. Add the required course to your shopping cart. Enter the **coupon code SCMD6207** at check out to get the course free of charge.

For questions about this course, please contact the SCMA Director of Education, Sharron Kelley, at *s.kelly@scmedical.org* or 1-800-327-1027, extension 173 or directly at 803-612-4104.

## ANNUAL FACULTY/RESIDENT BOWLING COMPETITION

This year's annual competition was held on Wednesday, January 21 at The Alley. It may have been our largest attended bowling competition yet. The residents took the win for a second year in a row behind the hot arm of Tony Lawson who bowled a 194. GJ Guldan led the faculty with a 132. I challenge all faculty to practice weekly between now and next year. Congratulations again to the residents!

# BLACKS AND MEDICINE: HOW HISTORY SHAPES THE PRESENT

## BY: EBONY HILTON, MD

When reviewing the past medical history of blacks in medicine, it can relay a story of great triumph and one of unsettling tragedy. Unfortunately, many of the stories are not commonly spoke of during our medical training although the tales are shared and live on in the African American Community. These incidences have shaped the way we interact with our patients and the way they view us.

There is no secret that slave life was a tough life. It has been said that "slaves provided antebellum doctors with their own personal guinea pigs."[1] Take John Brown, a slave purchased by Dr. Hamilton in the 1820's whose body was burned to blisters by hot pokers on a daily basis to "see how deep his black skin went."[2] Then there is Dr. James Marion Sims (1813-1883), born in Lancasterville, SC, who is considered the father of modern gynecology. It is well documented that he perfected his technique of vesicovaginal fistula repair on enslaved African-American women. He reportedly performed over 30 procedures on one slave in particular, Anarcha. Sadly, he did these procedures without the use of anesthesia for it was commonly accepted that African Americans had a higher pain threshold than their Caucasian counterparts.[3] Unfortunately, these exploitations were more common than not and serve as "a prime example of progress in the medical profession made at the expense of a vulnerable population."[4] Now if these tales stopped at slavery, then maybe there could be hope or some twisted way to justify that this was just the ways of a sick era, but they do not.

Take the story of an African-American man, Dr. Charles Drew (1904-1950). Born to a carpenter and teacher, Dr. Drew went on to be a prominent surgeon and researcher. He is credited with pioneering the technique of blood storage and became the leading authority on massive transfusion and processing methods. He later became director for the American Red Cross blood bank after a successful campaign coined "Blood for Britain." Here he supplied over 5,000 ampules of dried plasma for transfusions during WWII. He soon resigned after being insulted when the military ordered the segregation of donated blood by race. He went on to become the first black surgeon to serve as an examiner for the American Board of Surgery in 1943. On April 1, 1950 he was involved in a major car accident. He was taken to Alamance General Hospital in Burlington, NC, which during this rigidly segregated time was considered a "White" hospital. It is rumored that in his critical state he was denied a lifesaving blood transfusion, the very technique he invented. Whether or not this intervention could have saved him is questionable, but the cloud of doubt still lingers within the black community.[5]

Then there is the infamous Tuskegee syphilis experiment conducted by the U.S. Public Health Service from 1932-1972. Here a total of 399 African American men were enrolled in a study to evaluate the natural progression of syphilis. Although penicillin was known to cure the disease by the 1940's, this study was allowed to continue. The results are alarming. By the end of the experiment, 28 of the men had died directly of syphilis, 100 were dead of related complications, 40 of their wives had been infected, and 19 of their children had been born with congenital syphilis.[6,7] It is scary to think this was brought to an end only 10 years before I was born and that the very government that I pledge allegiance to was behind it all.

All the stories collectively influence health disparities and shape the interactions we have with our patients- for who do we learn trust from if not from those who came before. And how can they trust a system that treated them so unkindly. It is this barrier that we must aim to repair in order to open the lines of communication for a better, healthier tomorrow and to right the wrongs of history.

**John Brown**

# BLACKS AND MEDICINE: HOW HISTORY SHAPES THE PRESENT CONTINUED . . .

**BY: EBONY HILTON, MD**

Dr. Charles Drew

Tuskegee Case of ulcerated cutaneous syphilis on the left leg.
(Center for Disease Control, Atlanta, GA)


References

1. http://breakingbrown.com/2014/03/white-torture-of-black-bodies-6-medical-experiments-on-african-americans-you-never-knew-about/
2. Brown J. Slave Life in Georgia: A Narrative of the Life, Sufferings, and Escape of John Brown, A Fugitive Slave, Now in England London. W. M. Watts, 1855. Pg 48.
3. Ojanuga D. The medical ethics of the "father of gynaecology", Dr J Marion Sims. J Med Ethics 1993. 1928–31.31
4. S. Spettel, M.D.White, "The Portrayal of J. Marion Sims' Controversial Surgical Legacy", The Journal of Urology, Vol. 185, 2424-2427, June 2011, accessed 4 November 2013
5. Hoover E. Dr. Charles R. Drew:facts, fiction, and legend. J Natl Med Assoc. Jun 2005; 97(6): 837–838.
6. http://www.cdc.gov/tuskegee/timeline.htm
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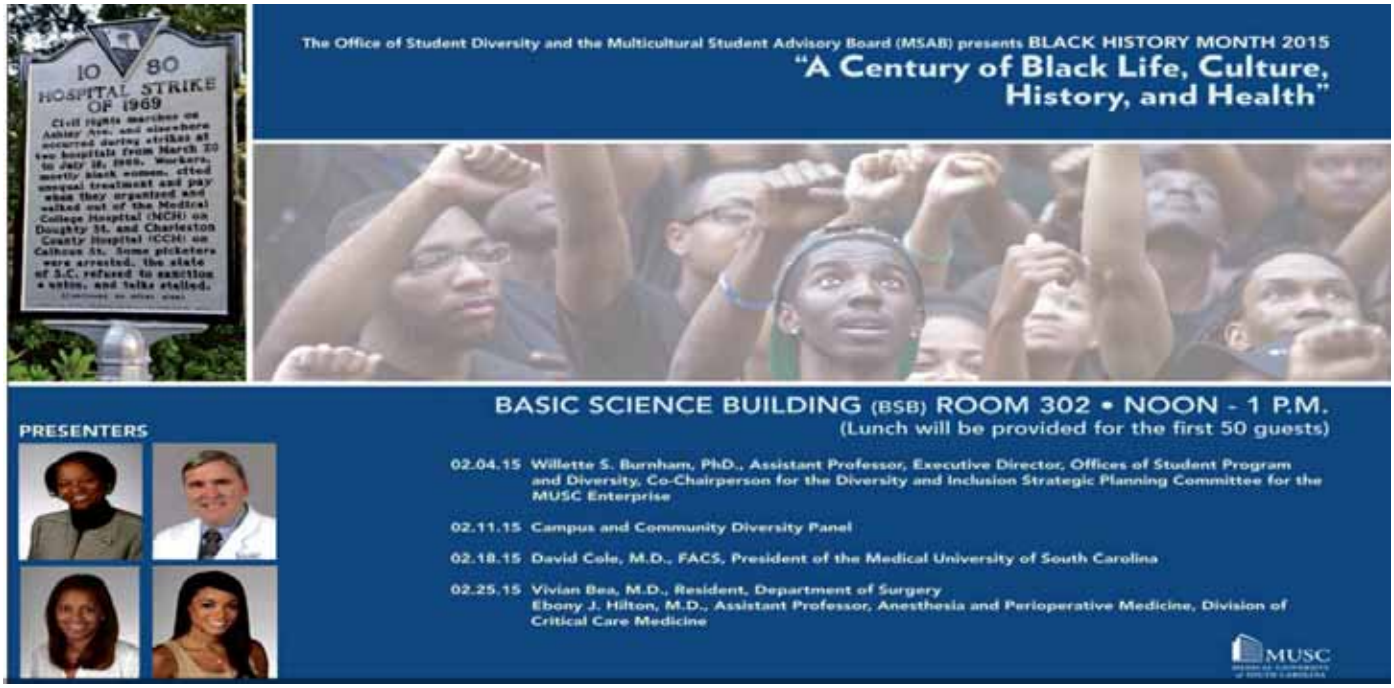


## CENTERS FOR ECONOMIC EXCELLENCE (COEE) HAS NAMED ANJALI JOSEPH, PHD AS THE ENDOWED CHAIR OF HEALTHCARE ARCHITECTURE AND DESIGN

The joint Clemson/MUSC Endowed Chair of Healthcare Architecture and Design is a complement to the CoEE in Patient Safety and Medical Simulation held by John Schaefer, MD. It is my desire now for the department to work along with MUHA and the College of Nursing to recruit and fill the CoEE in Human Factors. Once these three strong leaders are together, MUSC and Clemson will be leaders in hospital design and patient safety research.

**From Left to Right:**
**David Allison, Alumni Distinguished Professor and Director Graduate Studies in Architecture and Health, Clemson University**

**Anjali Joseph, PhD Endowed Chair of Healthcare Architecture and Design, Clemson University**

**Gail Stuart, PhD, Dean College of Nursing MUSC**

**Scott T. Reeves, MD, Chairman of Anesthesia, MUSC**

## CONGRATULATIONS TO DR. SCHAEFER FOR BEING AWARDED PRESIDENTIAL CITATION

HealthCare Simulation SOUTH CAROLINA

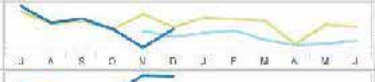
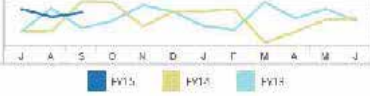
Dr. John J. Schaefer, III, MD was awarded the Presidential Citation for his lifetime commitment to advancing simulation globally through innovations, collaborations and leadership.

This award was presented to Dr. Schaefer at the 15th Annual International Meeting on Simulation in Healthcare earlier this month in New Orleans, LA by the Society for Simulation in Healthcare.

# PERFORMANCE INDICATORS

EPIC has just recently been able to start giving the OR leadership team data on how well the operating rooms are running. These Performance metrics are important for us to track and improve. A few of the most important ones are included below.

## Perioperative Performance Metrics Dashboard
## FY2014 YTD through December 2014

| Metric | Value | Change | %Change | Period | Yr / Yr Comparison | Trend* |
|---|---|---|---|---|---|---|
| CASE VOLUME *pages 3-4* | 21,548 | 1,634 | 8.2% | Yr/Yr |  |  |
| BLOCK UTILIZATION *pages 5-9* | 66.1% | 1.64% | 2.54% | Yr/Yr |  |  |
| FIRST CASE ON-TIME STARTS *pages 16-20* | 67.0% | -0.47% | -0.69% | Yr/Yr |  |  |
| SCHEDULING INACCURACY *pages 21-24* | 21.8% | 7.9% | 57.1% | Yr/Yr |  |  |
| TURNOVER TIME *pages 25-26* | 31.0 | -0.25 | -0.8% | CM/ TTM* |  |  |
| CANCELLATIONS *pages 27-28* | 2.46% | 0.88% | 55.2% | Yr/Yr |  |  |
| COST REDUCTION *page 29 - FY15 Not Yet Available* | $7.31 | ($1.19) | -14.0% | FY/CY |  |  |
| SCIP MEASURES *page 30* | 98.9% | -0.33% | -0.33% | Yr/Yr* |  |  |
| IMMEDIATE USE *page 31* | 2.2% | -1.3% | -37.6% | Yr/Yr |  |  |
| TRAY DEFECTS *pages 32-33* | 7.3% | -0.9% | -11.1% | Yr/Yr |  |  |
| PATIENT SATISFACTION-Inpatient *page 34* | 93.57 | 0.13 | 0.14% | Yr/Yr* |  |  |
| PATIENT SATISFACTION-Outpatient *pages 35* | 94.68 | 1.81 | 1.95% | Yr/Yr* |  |  |

Periods
Yr/Yr - Current Fiscal Year-to-Date compared to the prior year Fiscal Year-to-Date
CM/TTM - Current Month compared to the Trailing Twelve Months average
FY/CY - Current Fiscal Year-to-Date compared to the prior Calendar Year average

Data Availability:
Turnover Time: Standardized data not available until November 2012
Patient Satisifcation: Data is not final until after 90 days. Only finalized data shown
SCIP: Data is not final until after 90 days. Only finalized data shown.

FY15 FY14 FY13

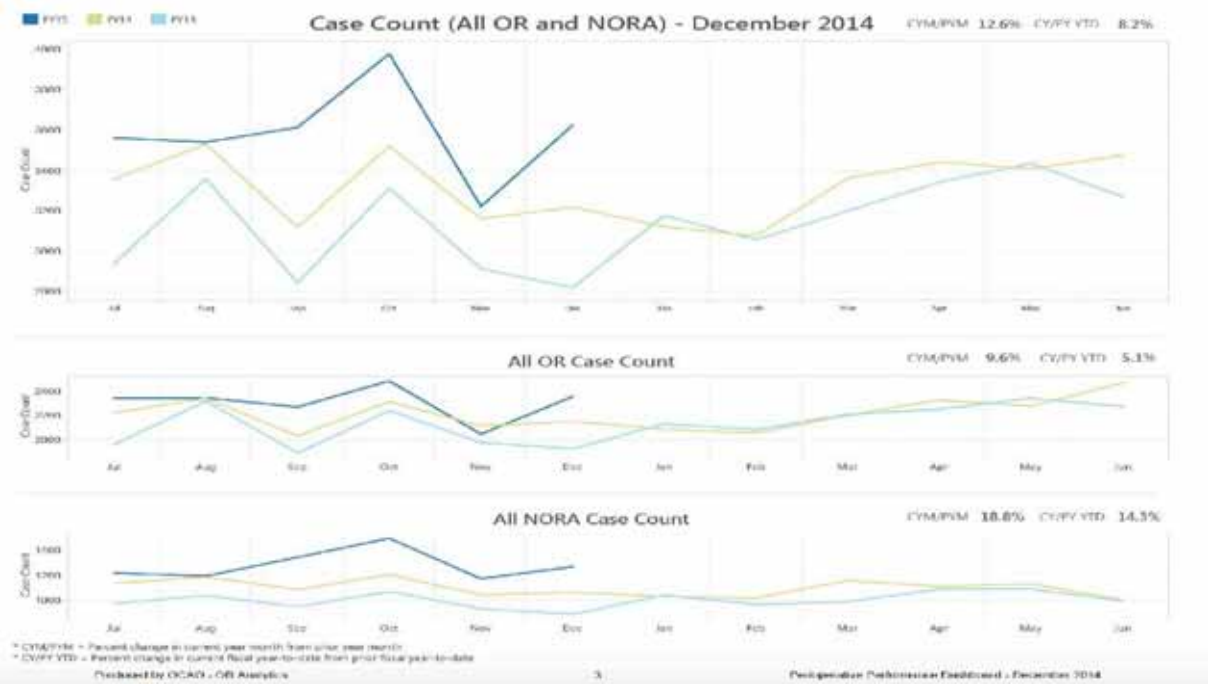
Trend
Current Month compared to Trailing Twelve Month Average

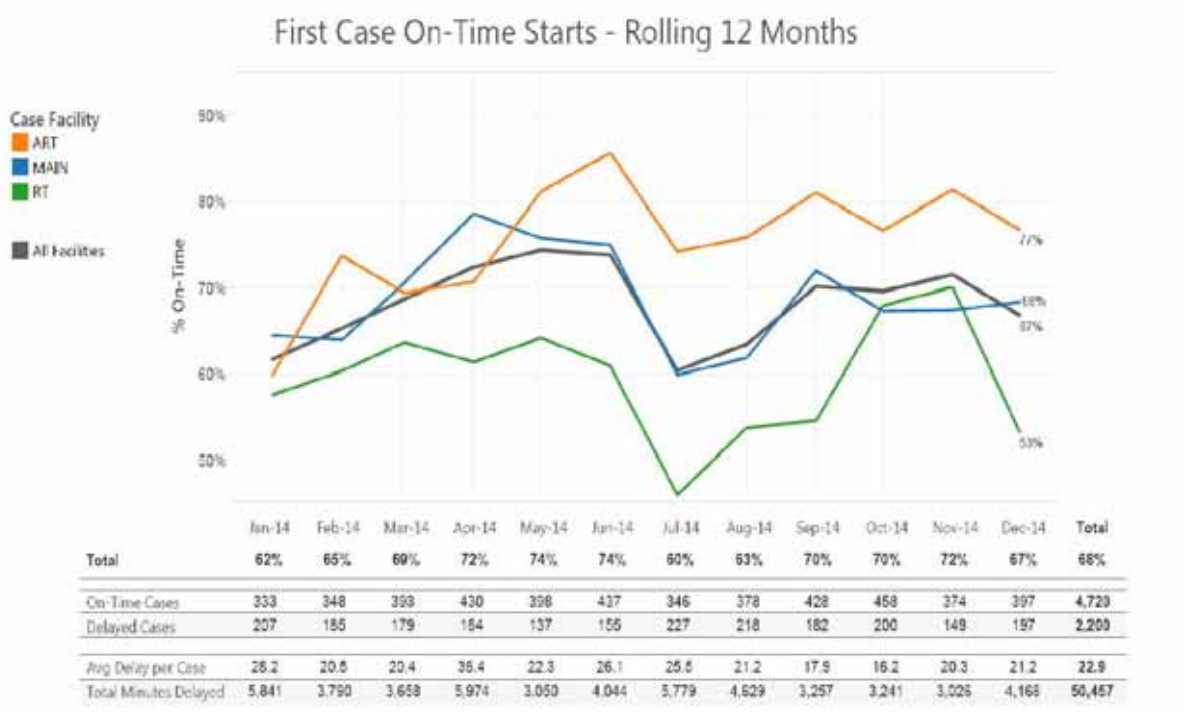
Change Colors: Better / Worse

Value: YTD finalized data for all measures except Turnover Time which show Current Month.

Produced by OCAO - OR Analytics 2 Perioperative Performance Dashboard - December 2014

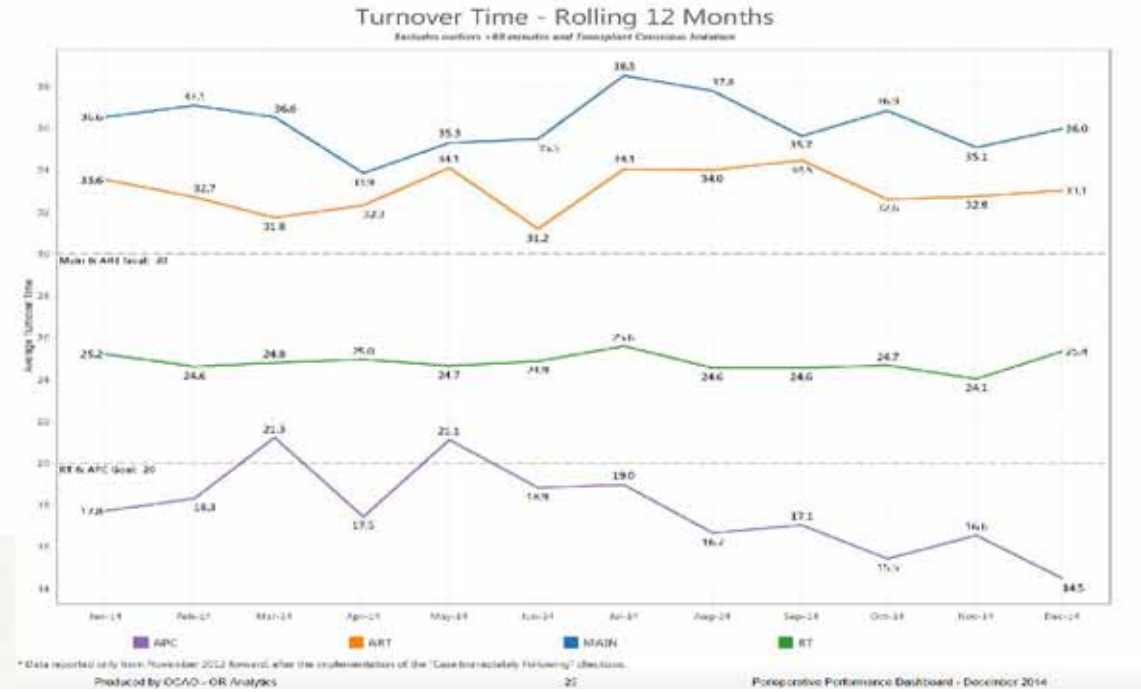
# PERFORMANCE INDICATORS CONTINUED . . .

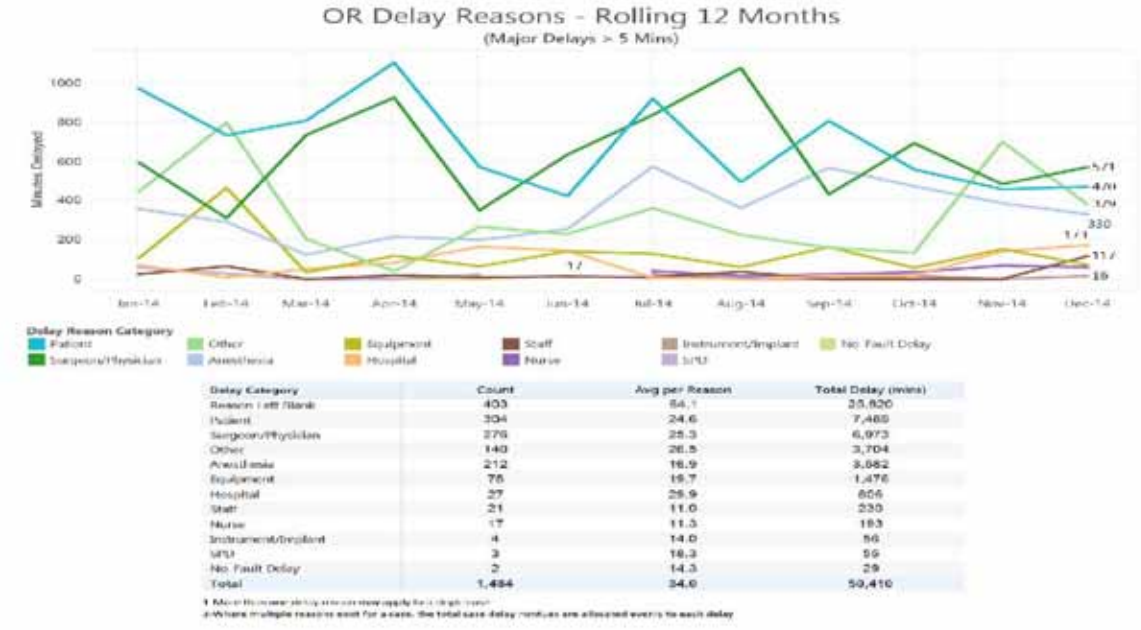



| | Jan-14 | Feb-14 | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **62%** | **65%** | **69%** | **72%** | **74%** | **74%** | **60%** | **63%** | **70%** | **70%** | **72%** | **67%** | **68%** |
| On-Time Cases | 333 | 348 | 393 | 430 | 398 | 437 | 346 | 378 | 428 | 458 | 374 | 397 | 4,729 |
| Delayed Cases | 207 | 185 | 179 | 164 | 137 | 156 | 227 | 218 | 182 | 200 | 149 | 197 | 2,209 |
| Avg Delay per Case | 28.2 | 20.6 | 20.4 | 35.4 | 22.3 | 26.1 | 25.6 | 21.2 | 17.9 | 16.2 | 20.3 | 21.2 | 22.9 |
| Total Minutes Delayed | 5,841 | 3,790 | 3,658 | 5,974 | 3,050 | 4,044 | 5,779 | 4,629 | 3,257 | 3,241 | 3,026 | 4,168 | 50,457 |

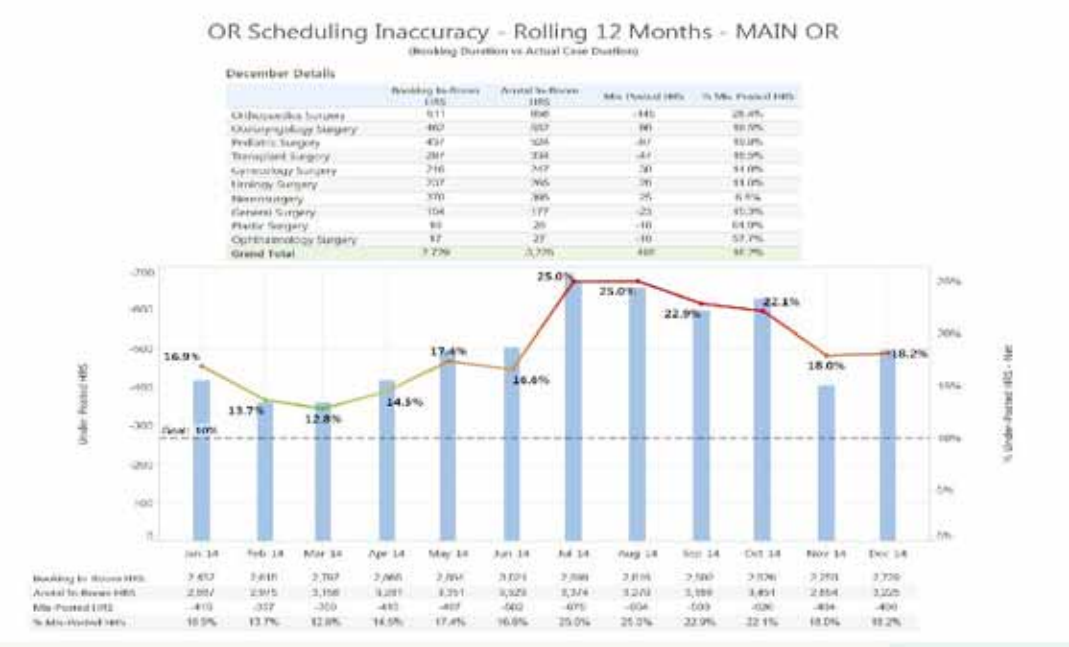
# PERFORMANCE INDICATORS CONTINUED . . .




| Delay Category | Count | Avg per Reason | Total Delay (mins) |
|---|---|---|---|
| Reason Left Blank | 403 | 64.1 | 25,820 |
| Patient | 304 | 24.6 | 7,465 |
| Surgeon/Physician | 276 | 25.3 | 6,973 |
| Other | 140 | 26.5 | 3,704 |
| Anesthesia | 212 | 16.9 | 3,582 |
| Equipment | 76 | 19.7 | 1,476 |
| Hospital | 27 | 25.9 | 606 |
| Staff | 21 | 11.0 | 230 |
| Nurse | 17 | 11.3 | 193 |
| Instrument/Implant | 4 | 14.0 | 56 |
| SPU | 3 | 19.3 | 59 |
| No Fault Delay | 2 | 14.3 | 29 |
| Total | 1,484 | 34.0 | 50,410 |

## PERFORMANCE INDICATORS CONTINUED . . .




## MUSC CLINICAL INSTRUCTORS AWARD

Anesthesia for Nurses Class of 2014 Recognizes Top Clinical Instructors

Nurse Anesthesia Programs could not exist without excellent clinical sites that allow our students to obtain the clinical skills that make them outstanding clinical CRNAs. These clinical sites would not be able to educate students for their clinical roles without the presence of CRNAs who are not only expert practitioners, but also amazing educators. Upon graduation, students get the opportunity to recognize a CRNA clinician at each clinical site for their excellence in clinical instruction.

The students recognize a CRNA from each of the MUSC Clinical Areas. This year's award winner were recognized at the AFN Graduation on December 5, 2014.

**Rutledge Tower: Kate Wendorf, CRNA**

**Ashley River Tower: Lester Kitten, CRNA**

**Main Operating Room: Shelley Richardson, CRNA**

## Grand Rounds for the month of February

**"Mentoring: A Professional Legacy to Posterity"**
**February 3, 2015**
**Latha Hebbar, MDM FRCA, FFARCS (I)**
**Professor**
**Medical University of South Carolina**

**"Anesthesia Medically Challenging Case Conference"**
**February 10, 2015**
**Paul Anderson and Ashley LeFevre, MDs**
**CA3 Residents**
**Medical University of South Carolina**

**"Update on Liposomal Bupivacaine & Regional Anesthesia for Total Joint Surgery "**
**February 17, 2015**
**Eric Bolin, MD**
**Assistant Professor**
**Medical University of South Carolina**

**"Preop Care of Chronic Pain Patients"**
**February 24, 2015**
**Jennifer Matos, MD**
**Clinical Instructor**
**Medical University of South Carolina**

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Department of Anesthesia and Perioperative Medicine

Medical University of South Carolina

167 Ashley Avenue

Email: kinmic@musc.edu
Phone: 843-792-7503
Fax: 843-792-9314

Check out our website at:
http://www.musc.edu/anesthesia

## Future Events/Lectures

**Intern Lecture Series**

5/Feb—Endocrinology, Dr. Tobin
19/Feb—Bleeding and Transfusion, Dr. Roberts

**CA 1 Lecture Series**

4/Feb—Anesthetic Complications, Dr. Freely
11/Feb—Postanesthesia Care, Dr. Roberts
25/Feb—Geriatric Anesthesia, Dr. Skorke

**CA 2/3 Lecture Series**

2/Feb—Post Anesthesia Recovery/(Barash Ch. 55) (Moodle), Dr. Stoll
2/Feb—ITE Review– Critical Care/ Cardiothoracic, Drs. Clark/Guldan
9/Feb—ITE Review– Regional/Pain Management/Neuro, Drs. Gunselman/ Nobles/Whiteley
16/Feb—ITE Review-Obstetrics/Pediatrics, Drs. Hebbar/Heine
23/Feb—Financial Planning, Carolina Capital Management

**Grand Rounds**

3/Feb—Mentoring: A Professional Legacy to Posterity, Dr. Hebbar
10/Feb—Anesthesia Medically Challenging Case Conference, Drs. Anderson/LeFevre
17/Feb—Update on Liposomal Bupivacaine & Regional Anesthesia for Total Joint Surgery, Dr. Bolin
24/Feb—Preop Care of Chronic Pain Patients, Dr. Matos



**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!!**

**Rachelle Singleton, Anesthesia Tech–** "Amazing teamwork during an emergency. Very organized and efficient!"

**Christopher Ravenell, Anesthesia Tech-** "Being such a great team player! Many, many compliments!"

**Deb Feller, Alice Michaux, and Phil Ridgely, CRNAs; Sheryl Champagne, Anesthesia Tech; and Wes Doty, MD-** "Being available to help with a difficult emergency at the end of the day. Team work at its finest!"

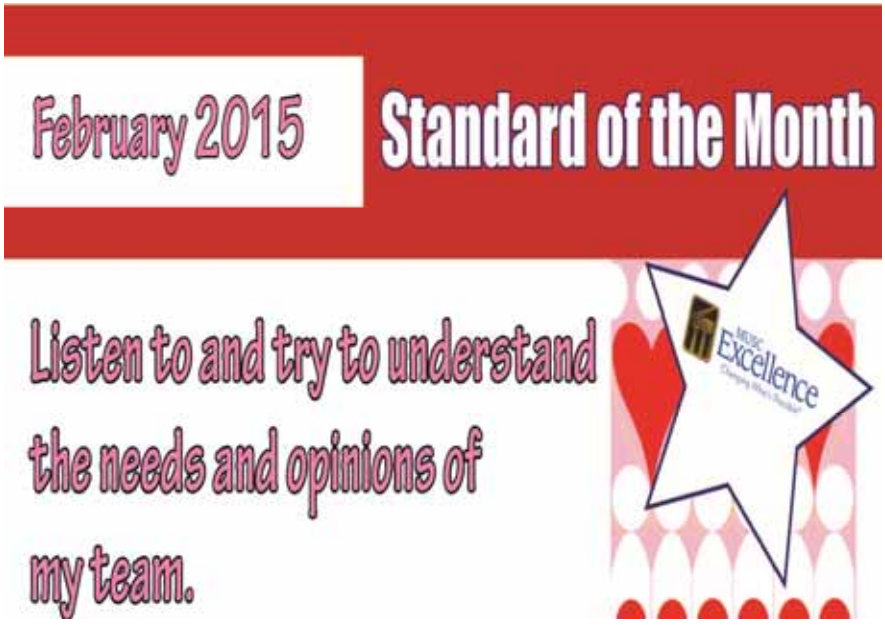
**Lucy Cofran, Anesthesia Tech**- "Being a great team player! Compliments from all of techs!"

**DJ Beckman and Lisa Crusenberry, Anesthesia Techs-** "Helping out with the liver. Such great team players and great leaders who taught me a lot today!"

**Loren Francis, MD-** "Hard work during regional rotation. She's always on top of things, taking care of paperwork, always prepared and ready to go first thing in the morning."


**Resident Graduation: June 19, 2015, Founders Hall**

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




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

If you have ideas or would like to contribute to *Sleepy Times,* the deadline for the March edition will be February 23, 2015.