MESSAGE FROM THE CHAIR
- SCOTT REEVES, MD, MBA

This month I took a much anticipated fishing vacation with my father to Panama. We went to a small fishing resort 100 miles from the nearest road with no internet, phone or TV service. For six days we fished nine hours a day for bill fish. Between the two of us we caught 5 marlin and 4 sailfish plus countless dorado and tuna. What a trip! It was very relaxing and allowed me to reenergize as we begin 2009.

While away, the residents were busy completing a new resident satisfaction survey. The MUSC Excellence campaigned has helped me understand the importance of asking specific questions to our “shareholders” whether faculty, staff or residents. Only by being willing to ask then adapt based upon the specific responses can we continue to grow and improve. On initial glance, what exactly did we learn from this year’s survey?

First of all, 93% of the CA1-CA3 residents responded. 96% felt the rapport between the faculty and residents was good. Eighty eight percent felt the program was designed to optimize their training and education. Several specific questions were asked regarding our educational offerings.

The percentage of residents with a favorable impression of our educational efforts included:
- Grand Rounds 84%
- Simulation training 96%
- Resident workshops (wet lab, regional anesthesia) 96%
- Didactic lectures 60%

The residents also held favorable clinical expectations:
- Clinical rotations offered a wide range of exposure 96%
- Appropriate faculty supervision 88%
- Satisfied with number of inpatients 96%
- Satisfied with call schedule 75%

The residents were asked specifically to comment regarding “what does the residency program do poorly?” A few responses included:

- Structured basic clinical science education. This is not entirely program dependent in that a physician should invest in their own education as well. However, a structured and consistent program of basic teaching outside of the OR would be beneficial.

- As a CA-1, I believe that the lecture series could be better. Most of the time our lectures are combined with CA-2,3’s but I think it would be helpful to have more lectures geared at CA-1 basic knowledge

- Would appreciate more regional anesthesia experience

Survey results continued on next page...
RESIDENT SURVEY RESULTS CONTINUED...

The residents were asked specifically to comment regarding “what does the residency program do well?” A few responses included:

- This residency program gives us a wide range of clinical cases. When I ask the residents that have graduated, they state that they are prepared and above average when compared to other recent grads

- Residents are given freedom to explore multiple modes of anesthesia and over a large range of cases. The attendings… care a great deal and are excellent at making us think our case through thoroughly.

- Great residents; Great department-wide functions; Grand Rounds Series; Schedule/call; Clinical experiences; Trying to improve at responding to residents needs

- Residents are treated fairly.

- Wide breadth of cases. Exposure to the sickest of patients and most involved cases

- Clinical teaching. Building confidence in resident skills. Ensuring time to study. Offering alternative methods to achieve goals.

- The cases we are exposed to are great. The acuity of care, variety, and case load all help provide a solid clinical fund of knowledge

Overall we are doing a great job, but certain themes became apparent. We must not become complacent. There is room for further improvement in our educational offerings specifically the weekly didactic series. This will be a high priority as Rebecca Cain, Tommy Burch and the Education committee with input from the chief residents modify and revise our lecture schedule for the upcoming academic year. Regional anesthesia has seen significant growth since the creation of the Regional Anesthesia Pain Service (RAPS). With the addition of new orthopedic surgeons there should be opportunities to capture additional patients and new techniques. In the months ahead, the whole survey will be shared with the faculty and residents. Additional improvements will come from it. We must always be willing to self reflect and try new ideas. The next big area will be our future Surgeon Satisfaction Survey.

UPDATE FROM THE SOCIETY OF SIMULATION IN HEALTHCARE ANNUAL MEETING

Dr. Schaefer, Dr. McEvoy, and Matt Crumpler (4th year medical student) presented research in January at the Society for Simulation in Healthcare Annual Meeting in Orlando. They presented four research abstracts. One of their particular interests is the effects of cognitive aids/reference cards on adherence to ACLS protocols during the management of cardiac arrest. Matt Crumpler is pictured presenting one of the abstracts, while Dr. McEvoy is shown giving a “plenary lecture” to an excited group of future leaders in healthcare (while at Disney World).

-Matt McEvoy, MD
MESSAGE FROM THE DEPARTMENT ADMINISTRATOR

-BRENDA DORMAN, MBA

There has been much bad news in the press lately with the world-wide economic downturn, state budget cuts, hospital financial woes, furloughs, RIFs and the list goes on. All this makes it difficult to see the positive things that are going on around us everyday. Departmentally, as Dr. Reeves reported earlier, we have received our first NIH grant, our finances remain strong, we continue to recruit young energetic faculty, and expand our “family” within our own ranks (welcoming Gracie Hankes, Ruth Looper, Luella Hudson, and Lucy Cassidy). At an institutional level, everyone is pulling together to cut costs and gain efficiencies while at the same time trying hard to preserve jobs. The generosity of the people at MUSC has not wavered during these difficult times. President Greenberg reported that “we exceeded our goal of $230,000” for the Trident United Way campaign and raised $130,000 for the Employee Furlough Relief Fund to help those employees affected most by the budget constraints. Nationally, we have just seated a new president who has energized our people and brings hope and inspiration to our country.

In a time when the only thing up is the sale of Prozac and Zoloft, it is easy to dwell on the negative. We, however, are stronger than that. Let’s look beyond the clouds that hang low overhead and remember life is short so we need to embrace every minute of it, and remember to count our blessings everyday.

MESSAGE FROM THE CRNAs AT UNIVERSITY HOSPITAL

January 2009 seemed to come and go very quickly, but not without a very significant event taking place. We, the people, inaugurated our first African American president of the United States. Laurie Uebelhoer and her family traveled all the way to Washington, D.C., and braved the cold, to witness this very historic event. We are all hoping for positive change this next four years.

The CRNAs welcomed three new graduates to the department. Rhiannan Davis and Emily Munday came to us from the MUSC anesthesia program. Micki Ballister came all the way from Villanova in Pennsylvania to join us. Congratulations to all three on passing their boards. Please help us welcome them to MUSC.

Thanks to Jane Swing and Lester Kitten, almost all the CRNAs in the Main OR have completed the DAM course in the simulator lab. We have all enjoyed it and appreciate all their time and effort.

February will bring more challenges to the anesthesia department, as we start training for computer charting. I am confident we will be fine with help from the super users, and our friends at ART and Rutledge Tower, who went before us. Please don’t change your phone numbers!

MESSAGE FROM THE DESK OF YOUR COMPLIANCE MANAGER

Greetings and Congratulations to the physicians and CRNAs on a great audit month. In an effort to continue striving for 100% accuracy in medical record documentation I offer this tip; Per the Medicare Carriers Manual, Anesthesia time “starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care.” Typically, CMS recognizes the threshold time for “preparation” before the case begins and after the case ends as up to 30 minutes. Anything longer than this must have accompanying documentation to support the extra time (ex. Difficult intubation, surgeon arrived late). CMS POLICY 140.3.3

Remember, my door swings on welcome hinges, and I am always available if you have any questions.

Jennifer Simmons, CPC, MA

Far and away the best prize that life has to offer is the chance to work hard at work worth doing.

- Theodore Roosevelt
MESSAGE FROM THE PAIN CLINIC

To strengthen communication and collaboration between physicians and nurses, Pain Management started 2009 by addressing clinic concerns and improving nurse/physician satisfaction. The Joint Commission recognizes strained relationships between healthcare workers can compromise patient safety and quality of care. The Ambulatory Care setting can produce daily tensions: technical issues that involve accessibility of supplies, inability to locate patient information that is not available in electronic record, lack of communication, and at times, addressed with lack of courtesy and respect.

Trust your instincts
Be direct and consistent in your communications
Learn to listen
Don’t hold grudges
Celebrate everyday…..Taken from Cesar Millan, The Dog Whisperer

A continuous process improvement in Ambulatory Care is Educate not only patients but the staff. Education of staff will include improvement of collaborative relationships by building a culture without blame.

THE DEPARTMENT WELCOMES FOUR BEAUTIFUL GIRLS!

Lucy Cassidy (shown below) is the daughter of Dr. Amy Cassidy

Luella Hudson (shown to the left) is the daughter of Dr. Wes Hudson

Gracie Hankes (shown to the right) is the daughter of Dr. Diane Hankes

“Giggles, curls, ribbons, and bows, she is adorable from head to toe”
-Author Unknown

Ruth Looper (shown above) is the daughter of Dr. Mike Looper
Intimidation, verbal outbursts and physical threats are considered unacceptable in nearly all professional arenas. That’s especially the case in health care settings, where unruly actions can jeopardize patient safety and quality of care.

AMA policy specifically addresses the conduct of individual physicians. Earlier this year, the Joint Commission issued an alert about disruptive behavior that can undermine patient safety. And beginning in January, a new leadership standard from the Joint Commission will require hospital administrators to define such behavior and develop procedures to discipline inappropriate conduct by individuals working at all levels of an organization, including management, clinical and administrative staff members, licensed independent practitioners and governing body members.

The hope is that this will foster the free flow of communication between all members of a treatment team, which AMA member Robert Wise, MD, called essential to establishing a culture of safety. “Anything that impedes that communication potentially produces a barrier to safety,” said Dr. Wise, vice president of standards and survey methods at the Joint Commission.

Disruptive conduct could be described as anything from a physician speaking in an angry tone with other medical staff members to making sensitive comments within earshot of patients and their families.

AMA member Gamini Soori, MD, past chief of staff and medical director at Alegent Bergan Mercy Cancer Center in Omaha, Neb., noted the importance of physicians—the leaders of any treatment team—to be professional and approachable at all times.

“That health care workers need to be able to communicate with physicians without having reservations about being treated in a condescending manner or being yelled at for disturbing them,” Dr. Soori said.

Physicians also must be cognizant of who might be nearby when making comments, Dr. Soori said. Whether or not physicians’ remarks are inappropriate, they could be construed as such. “It’s not just what you say, it’s where you say it,” Dr. Soori said.

The Joint Commission’s new standard directs hospitals to establish policies that address inappropriate behavior before a safety issue ever arises. Dr. Wise stressed that it is in no way meant to serve as a vehicle for hospitals to shut down criticism by physicians or to remove doctors who speak out about quality and safety concerns.

“That is so far away from the spirit of the standard,” said Dr. Wise, who served as a panelist at an AMA Organized Medical Staff Section educational session on this subject prior to the 2008 Interim Meeting of the AMA House of Delegates. “It focuses on where care is delivered, and that’s where the need for ongoing communication needs to occur.”

Consistent with national trends, MUSC has now adopted a program of zero tolerance for bad professional behavior.

### MUSC Adoption of a Universal Pre-Procedural Checklist

Recently the World Health Organization developed a pre-surgical checklist and is advocating its use throughout the world with a program called “Safer Surgery Saves Lives.”

The checklist was developed by an expert group of surgeons, nurses, anesthesiologists, and patient safety experts from around the world. It identifies key safety steps during perioperative care that should be accomplished during every operation. The guiding principles that the group considered when adding a safety check to the list were simplicity, wide applicability, and measurability. In addition, the safety steps had to reduce the likelihood of serious, avoidable surgical harm and be unlikely to introduce unmanageable costs or additional risks to patient safety.

The checklist involves the coordination of the operating team – the surgeons, anesthesia providers, and nurses – to discuss key safety checks prior to specific phases of perioperative care: 1) “Sign In” prior to induction of anesthesia, 2) “Time Out” prior to skin incision, and 3) “Sign Out” before the patient leaves the operating room. Many of the checks are already routinely done at MUSC but surprisingly few operating teams accomplish them all consistently, even in the most advanced settings.
MUSC ADOPTION OF A UNIVERSAL PRE-PROCEDURE CHECK-LIST CONT...

The Safe Surgery Saves Lives Program concept has been endorsed by 301 professional societies, health organizations, ministries, and non governmental organizations including American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology-Head & Neck Surgery, American Association of Neurological Surgeons, American Association of Nurse Anesthetists, American College of Surgeons, American Society of Anesthesiologists, Anesthesia Patient Safety Foundation, and Association of periOperative Registered Nurses.

More information can be found at: http://www.who.int/patientsafety/safesurgery/en/

The process recently got even more impetus from a NEJM article published on January 14th that showed a reduction in surgical mortality in eight trial hospitals that adopted the checklist. This article got wide mention in the lay press.

Last fall, Nestor Esnaola believed that MUSC should give serious consideration to adopting the check list and that ART would be a good venue to use as a pilot. A working group consisting of Dr. Esnaola, Peggy Anthony, Jodi Weber, Rebecca Weill and I met to modify the WHO list for our use and designed a pilot study at ART using selected general and vascular surgeons. The WHO surgical checklist was slightly simplified and modified to provide for "checks" on intraoperative processes which have been shown to reduce perioperative complications and/or are part of various, national pay-for-reporting/pay-for-performance programs.

The trial was conducted and the results were positive. The nurses, anesthesia providers, residents, and surgeons involved in the pilot study felt that the surgical checklist was user-friendly, valuable, and improved communication/collegiality in the OR. Of note, the median times to complete the “Time Out” (prior to skin incision) and “Sign Out” portions (before the patient leaves the operating room) of the checklist were each only around 1 minute.

The current version of the checklist was drafted after the group met again to modify/simplify the form based on feedback from the pilot study.

As a totally unrelated event, JCAHO conducted a site visit at ART and were unhappy with some of the “time outs” that they witnessed. Although some of this was due to the introduction of electronic charting in the OR, JCAHO also cited the fact that various members of the healthcare teams failed to stop their activities and actively participate in the time-out process. JCAHO mandated revision of the current policy and an audit process to check the performance of time outs going forward. MUSC must perform satisfactorily on these audits. In another unrelated event, JCAHO tightened their time out standards for all institutions in 2009.

It was decided to use the WHO check list as modified by the working group for the new JCAHO mandated expanded time out. The working group met again to introduce modifications to make the form work in the non surgical procedural areas.

Our responsibility in the holding area in connection with the check list is to asses the patient for the need for beta blockers, the presence of a potentially difficult airway, and the possibility of significant blood loss. In addition to checking these boxes on the form, the assumption is that we will take appropriate precautions to deal with these potential problems (difficult airway cart in the room as an example).

There will be a fairly conventional time out in the OR prior to incision but in addition to the items considered before, there will be a group discussion of any special surgical instruments, implants, or images, the critical parts and duration of the procedure, the need for an ICU bed, and reminders to us about hypothermia prevention, antibiotic prophylaxis, and glucose control. It is critically important that this be done every time and done well. Our cooperation and participation is vital.

At the end of the procedure there is another review of the procedure and the patient’s special post op needs.

In its initial use, the check list has substantially improved communication among all in the procedure room and reduced the number of “gotchas.”

Adoption of these changes in all procedural areas was mandatory for MUSC as is your participation in the process. Please let us know if you see a better way to do this. If done with the proper attitude, the check list will improve patient care and the collegial atmosphere in our ORs.
APPLAUSES

It is with great excitement that I inform you all that we received funding from NIH to study the effect of Transcranial Magnetic Stimulation (TMS) and its effect on post operative pain in our gastric bypass population. As you will recall, we demonstrated a 40% reduction in morphine use in our pilot study of 40 patients. This R21 grant will begin in February and is valued at over $400,000. The study will be conducted at Ashley River Towers under the direction of Drs. Jake Abernathy, Larry Field, Scott Reeves, Karl Byrne and Jeff Borckardt. Our research personnel will also be significantly involved including Heather Beeson, Haley Moore, Will Beam and John Germeroth. The addition of other faculty and resident participation is welcomed.

DEPARTMENT PUBLICATION


I HUNG THE MOON

The departmental members below have been recognized by our patients and their peers. This month’s drawing winner is Tammy Matusik!

Latha Hebbar-Assisting with patient Carolyn Darden and being a good team member.
Heather Beeson-Helping decorate the Christmas tree. Always willing to pitch in at any time.
Patrice Brown-The great, easy, painless drawing of blood. I would return for more.
Kim Crisp-Going above and beyond the call of duty. Setting up for snacks on the 3rd floor SEI while still attending to the front desk. Great job Kim!
Valerie Bailey-Went out of her way to help. She is a knowledgeable, helpful, friendly asset to MUSC.
Tammie Matusik- Helping decorate the Christmas tree. Always willing to pitch in at any time.
Annie Williams-Transmitting EKGs over to the office for processing. Also for always making sure the EKG orders are in.
Richard Ancrum-Your hard work and generosity to the department of Anesthesia. You’re always so quick to help when we need you.
Dwayne McClerklin-Being a strong patient, staff, and CRNA advocate.
Haley Moore-Helping decorate the Christmas tree. Always willing to pitch in at any time.
Candy Johnson-Showing strong leadership and flexibility. Being a strong CRNA advocate.
ESSENTIAL STANDARDS FOR DRESS
COLLEGE OF MEDICINE

Recently, the College of Medicine has adopted a Standards for Dress policy “see below.”
Simply put, “dress professionally.”

OBJECTIVE
This MUSC College of Medicine dress code allows our faculty and staff to work comfortably and safely in the workplace, while projecting a professional image to MUSC patients, co-workers, professional learners and visitors. These faculty and staff standards of dress are based on respect for those with whom we interact and are a part of the MUSC Standards of Behavior. A neat and clean appearance reflects positively on the Medical University of South Carolina.

ESSENTIAL GUIDELINES FOR DRESS:

CLINIC -- Clothing suitable for clinic and office wear will be clean and neat in appearance. Whether in campus offices, labs or clinics, all faculty and staff are expected to dress professionally. Normal dress for physicians will include white coats or suit/sport coats when in clinic areas. Men will wear neckties with their coats. Pediatricians and pediatric providers will observe standards set within their department. Scrub clothing is appropriate only for the ORs and similar procedural areas.

LABORATORY -- For practical reasons, standards for dress in research or teaching laboratories may be guided by the lab director. Laboratory safety, OSHA regulations and cleanliness will also dictate appropriate dress in these areas. When laboratory faculty and staff members enter clinical areas the broader clinic standards always apply.

Neckwear -- Neckwear should be appropriate: in clinic settings neckties and scarves should be chosen to reflect professionalism.

Slacks, Pants, and Suit Pants -- Slacks and pants that are made of natural fiber, blends or synthetic material may be worn. These slacks and pants would normally have an ironed crease or equivalent.

Examples of inappropriate or unprofessional attire for work include jeans, sweatpants, camouflage pants, exercise pants, shorts, bib overalls, leggings, and any spandex or other form-fitting pants such as people wear for biking or slacks that do not provide adequate coverage when bending or kneeling.

Skirts, Dresses, and Skirted Suits -- Casual dresses and skirts, and skirts that are split at or below the knee are acceptable. Dresses and skirts should be of a length at which the wearer can sit comfortably in public, hems usually about 2” below the middle finger when standing with arms extended downward.

Examples of inappropriate and unprofessional attire for work include short tight skirts, mini-skirts, skorts, sun dresses, beach dresses, and spaghetti-strap dresses.

Shirts, Tops, Blouses, and Jackets -- Inappropriate and unprofessional attire for work includes tank tops, midriff tops and other low cut, revealing tops; clothing with potentially offensive words, terms, logos, pictures, cartoons, or slogans; halter-tops, strapless tops, sweatshirts, and t-shirts unless worn under another blouse, shirt, jacket, or dress. Over-sized scarves or other clothing or jewelry items that could pose safety concerns for patients and wearer alike are not allowed.

DISCUSSION
Generally, casual clothing is not suitable for the professional setting. Professional dress and professional conduct are always linked in the minds of those who see us at work. No guidelines can cover all contingencies, so faculty and staff employees must exert a certain amount of judgment in their choice of clothing to wear to work. If uncertain about acceptable, professional business casual attire for work, please ask a supervisor or the Human resources staff.

CONSEQUENCES
Consistent disregard for these essential standards for dress, a part of the MUSC Standards of Behavior, will lead to disciplinary action under the relevant personnel policy and/or the MUSC faculty handbook. Individual employees may be asked to leave work and return wearing appropriate attire. It is the responsibility of the departmental chairperson to model and enforce the standard.
Announcing Upcoming Mini Symposium

Introduction to Transesophageal Echocardiography

March 28, 2009

Gazes Auditorium, Charleston, SC

Course Purpose: This course is designed to benefit anesthesiologists interested in learning about perioperative transesophageal echocardiography (TEE) and intent upon gaining sufficient knowledge and experience to integrate this modality into their clinical practice. The scope and pace of this course is specifically designed for those with little or no TEE experience.

Learning Objectives: Upon completion of the course the participant should: Understand the basic physics of ultrasound imaging; understand the operation and optimization of TEE ultrasound machines; be able to understand and interpret 2-D TEE images of the normal heart; be able to recognize global and regional left ventricular dysfunction; be able to recognize significant aortic, mitral, and tricuspid valve pathology; be able to assess left and right ventricular filling; be able to apply TEE outside of the operating room.

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<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>7:30 – 8:00</td>
<td>Breakfast</td>
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<tr>
<td>8:00 – 8:30</td>
<td>How TEE Images are Created (US Physics)</td>
<td>Will Whiteley, MD</td>
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<td>8:30 – 9:00</td>
<td>Making a Perfect Image (Knobology)</td>
<td>Jake Abernathy, MD</td>
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<td>9:00 – 9:45</td>
<td>The Standard Exam</td>
<td>Larry Field, MD</td>
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<td>9:45 – 10:15</td>
<td>Leg Stretch</td>
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<td>10:15 – 10:45</td>
<td>The Main Squeeze (Ventricular Function)</td>
<td>Cesar Rodriguez-Diaz, MD</td>
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<td>10:45 – 11:30</td>
<td>Going With the Flow (Doppler Echocardiography and hemodynamics)</td>
<td>Will Whiteley, MD</td>
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<td>11:30 – 12:15</td>
<td>Lunch</td>
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<td>12:15 – 13:00</td>
<td>Mitral Valve</td>
<td>Scott Reeves, MD</td>
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<td>13:00 – 13:45</td>
<td>Aortic Valve and Aorta</td>
<td>Livia Marica, MD</td>
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<td>13:45 – 14:15</td>
<td>The Forgotten Side (Tricuspid Valve and the Right Ventricle)</td>
<td>GJ Guldan, MD</td>
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<td>14:15 – 14:45</td>
<td>Can we use this thing outside the OR? (TEE for the ICU)</td>
<td>Scott Reeves, MD</td>
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<td>14:45 – 15:15</td>
<td>Wait, this isn’t TEE (Epicardial and Epiaortic Ultrasound)</td>
<td>Jake Abernathy, MD</td>
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<tr>
<td>15:15 – 16:00</td>
<td>Little Boy Blue (Congenital Heart Lesions)</td>
<td>Tommy Burch, MD</td>
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Future Events
2/2 – Neuroanesthesia Lecture “All Residents”
   Jeana Havidich
2/3 – Postoperative Complications in PACU (Grand Rounds)
   Melinda Bailey
2/9 – DEA Documentation and Narcotics Wastage
   “All Residents” Professionalism, Tom Brown
2/10 – M&M
   Susan Harvey
2/11 – ART Teaching Conference: TEE Review
   Jake Abernathy
2/12 – Journal Club PACU Annual Bowling Competition “All Residents”
2/16 – Anesthesia for Neurological and Psychiatric Disease Lecture “All Residents,” Susan Harvey
2/17 – PONV (Grand Rounds), Gan
2/18 – ART Teaching Conference: Post Pneumonec- tomy Pulmonary Edema, Payne
2/23 – Pediatric Anesthesia Lecture “All Residents”
   Diane Hankes
2/24 – Emergence Delirium in Pediatrics (Grand Rounds), Cory Furse
2/25 – ART Teaching Conference: TEE and the Critical Care Patient, Larry Field

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 20, 2009.

This Month’s Contributors: Scott Reeves, Matt McEvoy, Fred Guidry, Brenda Dorman, Wendy Ewing, Jennifer Simmons, and Cindy Fitzgerald

The department recognized the substantial contribution of our CRNAs and SRNAs during the 10th Annual National Nurse Anesthetists Week. The department offered separate lunches at Ashley River Tower, Rutledge Tower, and the University Hospital in recognition of a job well done.