Opening Statement: Welcome Our New Dean and Surgeon Satisfaction

It is my pleasure to introduce the department to our new Dean, Dr. Etta Pisano. Dr. Pisano comes to us from the University of North Carolina where she served as Vice Dean for Academic Affairs at the School of Medicine. The department and I are looking forward to working with her as she continues to expand the significant patient care, education and research initiatives of the College of Medicine and University. You can all learn more about her in this edition of Sleepy Times.

In the April edition of Sleepy Times, I discussed the substantial improvement in patient satisfaction that has occurred within our operating rooms at University Hospital, Ashley River Tower and Rutledge Tower. This month, I would like to highlight the results of our latest Surgeon Satisfaction Survey. In February, our yearly survey was sent out to all our surgeons. Fifty three surgeons completed the survey by the end of March. As chairman, it is very beneficial to be able to poll our surgeons and find out what they perceive as areas of strengths and weaknesses of our department.

Some specific positive comments include:

- EXCELLENT with the very sick patients - I always feel very safe in the OR and I have seen our anesthesiologists save lives.
- I think we have a clinically excellent group of anesthesia attendings and feel very comfortable knowing that they can handle most complex and challenging patients.
- A very knowledgeable and professional group of doctors
- I appreciate the change in policy where regional blocks are administered in holding instead of in the OR. Attendings with interest in MSK anesthesia are consistently outstanding.
- Overall, it is a very cohesive group who work together well and are focused on efficient patient care.
- Friendly service
- Timely start of first case
- All the anesthesiologists are professional and a pleasure to work with. Everything that they do is for the benefit and safety of the patient.

They also identified areas in which we need to improve:

- Turnover, Turnover, Turnover
- More flexibility with room scheduling

Finally, we asked the surgeons to provide additional comments:

- Ultimately, the success of my practice here at MUSC depends on future improvements in the effective dispensation of surgical cases; without it, I will certainly fail in my goals.
- I love this OR and its staff. I have made comments not to be critical but rather to take the team to be the best in the country. We have the right anesthesiologists to do this.

What I learned is that our surgeons truly value our commitment to excellence in patient safety and care. They really get the importance of what we do and how we enable them to succeed in their professional goals. Please read more in Sleepy Times about this year’s results and thank them for contributing.

SPECIAL POINTS OF INTEREST:

- Surgeon Satisfaction Reports
- Dr. Etta Pisano Selected as College of Medicine Dean
- Dr. Jerry Reves’ Final Lecture as Dean of the College of Medicine

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### 2010 Surgeon Satisfaction Results:

#### 3. Pre Op Clinic

<table>
<thead>
<tr>
<th></th>
<th>1 Low</th>
<th>2 Below Average</th>
<th>3 Average</th>
<th>4 Above Average</th>
<th>5 High</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ease of appointment</td>
<td>2.8%</td>
<td>5.3%</td>
<td>31.6%</td>
<td>39.5%</td>
<td>21.1%</td>
<td>3.71</td>
</tr>
<tr>
<td>Registration process</td>
<td>2.8%</td>
<td>0.0%</td>
<td>41.7%</td>
<td>41.7%</td>
<td>13.9%</td>
<td>3.64</td>
</tr>
<tr>
<td>Accommodation of walk-ins</td>
<td>5.4%</td>
<td>2.7%</td>
<td>32.4%</td>
<td>37.8%</td>
<td>21.6%</td>
<td>3.68</td>
</tr>
<tr>
<td>Education of patients</td>
<td>2.8%</td>
<td>13.0%</td>
<td>38.9%</td>
<td>33.3%</td>
<td>11.1%</td>
<td>3.36</td>
</tr>
<tr>
<td>Ease of lab draws</td>
<td>2.7%</td>
<td>2.7%</td>
<td>43.2%</td>
<td>32.4%</td>
<td>18.9%</td>
<td>3.02</td>
</tr>
</tbody>
</table>

#### 4. Pre Op Area

<table>
<thead>
<tr>
<th></th>
<th>1 Low</th>
<th>2 Below Average</th>
<th>3 Average</th>
<th>4 Above Average</th>
<th>5 High</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do anesthesiologists see patients in a timely fashion?</td>
<td>2.2%</td>
<td>8.0%</td>
<td>31.1%</td>
<td>35.6%</td>
<td>22.2%</td>
<td>3.67</td>
</tr>
<tr>
<td>Do anesthesiologists conduct themselves professionally and interact well with patients?</td>
<td>0.0%</td>
<td>0.0%</td>
<td>6.0%</td>
<td>35.6%</td>
<td>55.6%</td>
<td>4.47</td>
</tr>
<tr>
<td>Are appropriate patients offered regional analgesia for post op pain?</td>
<td>2.5%</td>
<td>2.6%</td>
<td>37.5%</td>
<td>30.0%</td>
<td>13.0%</td>
<td>3.00</td>
</tr>
</tbody>
</table>

#### 5. Intra Operative Care

<table>
<thead>
<tr>
<th></th>
<th>1 Low</th>
<th>2 Below Average</th>
<th>3 Average</th>
<th>4 Above Average</th>
<th>5 High</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are attendings prompt in arriving in the room?</td>
<td>0.0%</td>
<td>6.8%</td>
<td>27.3%</td>
<td>43.2%</td>
<td>22.7%</td>
<td>3.82</td>
</tr>
<tr>
<td>Does the attending facilitate the anesthetic preparation and induction?</td>
<td>2.2%</td>
<td>2.2%</td>
<td>26.7%</td>
<td>37.8%</td>
<td>31.1%</td>
<td>3.93</td>
</tr>
<tr>
<td>Does the attendings' demeanor contribute to a productive workplace?</td>
<td>0.0%</td>
<td>0.0%</td>
<td>20.0%</td>
<td>40.0%</td>
<td>40.0%</td>
<td>4.20</td>
</tr>
<tr>
<td>Is the change over of attendings during a case minimized?</td>
<td>2.2%</td>
<td>8.9%</td>
<td>33.3%</td>
<td>35.6%</td>
<td>20.0%</td>
<td>3.62</td>
</tr>
<tr>
<td>Are you routinely notified of the attendings' change over?</td>
<td>20.5%</td>
<td>34.1%</td>
<td>22.7%</td>
<td>11.4%</td>
<td>11.4%</td>
<td>2.59</td>
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### 2010 Surgeon Satisfaction Results Continued:

#### 6. PACU Post-up

<table>
<thead>
<tr>
<th>Question</th>
<th>1 Low</th>
<th>2 Below Average</th>
<th>3 Average</th>
<th>4 Above Average</th>
<th>5 High</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the wake ups reasonably quick and smooth?</td>
<td>0.0%  (0)</td>
<td>2.3%  (1)</td>
<td>30.4%  (18)</td>
<td>38.6%  (17)</td>
<td>22.7%  (10)</td>
<td>3.82</td>
</tr>
<tr>
<td>Is pain adequately controlled in PACU?</td>
<td>0.0%  (0)</td>
<td>0.0%  (0)</td>
<td>27.3%  (12)</td>
<td>47.7%  (21)</td>
<td>25.0%  (11)</td>
<td>3.98</td>
</tr>
<tr>
<td>Are attendings attentive to dealing with PACU or ICU problems?</td>
<td>2.3%  (1)</td>
<td>2.3%  (1)</td>
<td>27.9%  (12)</td>
<td>41.9%  (18)</td>
<td>25.8%  (11)</td>
<td>3.86</td>
</tr>
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</table>

#### 7. Post Op Care

<table>
<thead>
<tr>
<th>Question</th>
<th>1 Low</th>
<th>2 Below Average</th>
<th>3 Average</th>
<th>4 Above Average</th>
<th>5 High</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the anesthesia service round regularly on patients with regional blocks for post op pain?</td>
<td>0.0%  (0)</td>
<td>-4.6%  (2)</td>
<td>10.0%  (3)</td>
<td>16.7%  (7)</td>
<td>14.3%  (6)</td>
<td>45.2%  (19)</td>
</tr>
<tr>
<td>Is the anesthesia service prompt in responding to post op pain problems?</td>
<td>0.0%  (0)</td>
<td>7.0%  (3)</td>
<td>32.6%  (14)</td>
<td>20.9%  (9)</td>
<td>9.3%   (4)</td>
<td>30.2%  (13)</td>
</tr>
<tr>
<td>Are anesthesiologists responsive to dealing with other post op problems?</td>
<td>0.0%  (0)</td>
<td>8.8%  (3)</td>
<td>29.5%  (13)</td>
<td>27.3%  (10)</td>
<td>22.7%  (10)</td>
<td>13.0%  (6)</td>
</tr>
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</table>

#### 8. Operating Room Management

<table>
<thead>
<tr>
<th>Question</th>
<th>1 Low</th>
<th>2 Below Average</th>
<th>3 Average</th>
<th>4 Above Average</th>
<th>5 High</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do anesthesiologists facilitate room turn over?</td>
<td>11.4%  (5)</td>
<td>13.6%  (6)</td>
<td>40.9%  (18)</td>
<td>27.3%  (12)</td>
<td>6.6%   (3)</td>
<td>3.05</td>
</tr>
<tr>
<td>Are schedule changes readily accommodated?</td>
<td>11.4%  (5)</td>
<td>13.6%  (6)</td>
<td>22.7%  (10)</td>
<td>34.1%  (15)</td>
<td>18.2%  (8)</td>
<td>3.34</td>
</tr>
<tr>
<td>Are anesthesiologists involved in operating room efficiency?</td>
<td>11.1%  (5)</td>
<td>13.3%  (6)</td>
<td>28.3%  (13)</td>
<td>26.7%  (12)</td>
<td>20.3%  (9)</td>
<td>3.31</td>
</tr>
<tr>
<td>Are there significant differences among attendings regarding room turn over?</td>
<td>12.2%  (5)</td>
<td>4.9%   (2)</td>
<td>29.3%  (12)</td>
<td>31.7%  (13)</td>
<td>22.0%  (9)</td>
<td>3.46</td>
</tr>
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</table>
Dr. Ray Greenberg, President of MUSC, announced on Wednesday, March 31st, that Dr. Etta Pisano, Vice Dean for Academic Affairs at the School of Medicine of the University of North Carolina, has accepted the position of Dean of the MUSC College of Medicine. Dr. Pisano is expected to begin her new role as of July 1, 2010, but may be here periodically between now and then to facilitate the transition. Etta D. Pisano, M.D., has served as Vice Dean for Academic Affairs in the UNC School of Medicine since June 2006. She is also Kenan Professor of Radiology and Biomedical Engineering and Director of the UNC Biomedical Research Imaging Center, which studies ways to develop and use technology to treat cancer and heart disease, among other ailments. Dr. Pisano’s research centers on improved technology development for breast cancer diagnosis. This includes research projects involving the entire process, from development of new hardware and software to clinical trials of existing imaging devices to the effects on patients of current clinical practice. Dr. Pisano received an A.B. in Philosophy from Dartmouth College, and her M.D. from Duke University. She performed her residency at Beth Israel Hospital, where she was also Chief Resident, and interned at the Pensacola Educational Program. A fellow in the American College of Radiology and the Society of Breast Imaging, Dr. Pisano is board-certified in diagnostic radiology. She has received many honors and awards for her contributions to the improvement of breast imaging and its role in cancer diagnosis. Dr. Pisano received the Health Breakthrough award from Ladies’ Home Journal in 2006 in honor of her work as PI in the Digital Mammographic Imaging Screening Trial (DMIST), which showed that digital mammograms are as reliable as film mammograms and are better at finding breast cancer in young women and those with dense breast tissue.

Dr. Pisano was elected to the Institute of Medicine in 2008. She is a member of the Radiological Society of North America and the American Roentgen Ray Society and is a past-president of the Association of University Radiologists. She serves as chairperson of the American College of Radiology Imaging Network Breast Committee and the International Digital Mammography Development Group.

We welcome Dr. Pisano to her leadership position as our new Dean at MUSC!
Dr. Jerry Reves’ Final Lecture as Dean of the College of Medicine

“Professionalism in Anesthesiology”

Jerry Reves, MD
Dean, College of Medicine
Medical University of South Carolina

Tuesday, May 25 at 6:30am
College of Health Professions, Room 204A

MUSC Health
ANESTHESIA & PERIOPERATIVE MEDICINE
Society of Cardiovascular Anesthesiologists Annual Meeting Highlights

The SCA held its 32nd annual meeting in New Orleans from April 24-28, 2010. MUSC was well represented. Dr. Jake Abernathy developed and moderated the fellows program this year which included complex case poster presentations and a how-to-get-involved-in-the-society session. It was a wonderful session that benefited our two fellows, Drs. Daryl Reust and Eric Nelson. Jake has developed an even more ambitious fellow program for next year’s 33rd annual meeting to be held in Savannah, Georgia. He also lectured on “Epicardial echocardiography in the operating room: when and how can it help?”

Dr. Reust presented his work entitled “Directed interstitial measurements of tranexamic acid reveals organ specific heterogeneity in pharmacokinetic profiles.” It was well received. Dr. Scott Reeves continued to be very busy as the Secretary Treasurer and member of the Executive Committee for the Society. He lectured on “An adult patient with a history of congenital heart disease.”

ASA Washington Legislative Congress

2010 has been more politically charged than any year in the past decade or two, and the biggest pieces of legislation revolved around healthcare. As we learn of the compromises that the House and Senate Democrats made with each other, all healthcare providers are trying to clarify the environment within which we will work once the laws take effect. To this end, a contingent of anesthesiologists visited Capitol Hill in an effort to affect improvements with current legislation.

The department facilitated the opportunity for us to be educated in painful detail regarding the most recent legislative changes, how they might change, and how this package, in total, will effect the care we deliver. Additionally, much of our effort was invested to guide legislators toward amendments that will benefit our ability to deliver high-quality anesthesia to patients in South Carolina. To be (even the smallest) part of the law-making machinery is inspiring.

As one of the residents in attendance, I am charged with representing my peers and also bringing the knowledge and advocacy obtained in D.C. back to our department. I look forward to sharing with you all the information and impressions of the trip in person. Others from the department in attendance were Drs. Tara Åhlberg and Bassam Kadry (both residents) and Dr. Fred Guidry. We each can agree or disagree with individual policies, but to be unaware or disinterested of the changes in motion is no longer a viable mindset.

Meet the New Nurse Practioner in Pre Op

My nursing background includes multi-service med-surg wards, Burn Unit, ICU, L&D, Post-partum, OB/GYN and Family Practice Clinics as well as a Fleet Hospital in Saudi Arabia to support Desert Shield and Storm. I have been a nurse for 30 years, 20 of those served on active duty in the United States Navy, 12 years as a Family Nurse Practitioner.

In 2005, when I completed my tour at Marine Corps Recruit Depot in Parris Island, I relocated to Charleston. I’ve worked at MUSC on 6 West, med-surg / trauma ward and for the past 3 years have been with the Joint Replacement Program.

I have 4 darlings (3 out of the “nest”), and a husband, also retired military. I like to swim and grow where I am planted. I am happy to be a part of the team!

Valerie Sutton
THE ELECTRONIC TEE HAS ARRIVED

Have you ever been successful in finding an intraoperative TEE report on a patient who you know had a TEE? I didn’t think so. Until now they were carefully filed away in the scanned documents section of Oasis amongst the operating room reports. After much hard work and IT help, it is my pleasure to announce that we now have an electronic TEE report. We created the new report with two simple goals in mind: 1) to better communicate echocardiographic diagnoses to caregivers both inside and outside of MUSC and 2) create a database that will enable research investigations regarding intraoperative TEE.

All TEEs performed by the Department of Anesthesiology will be reported through a program called Apollo. Apollo is a medical database program that allows users to input data into discreet fields and then has the ability to generate a report based upon those data.

Why an electronic report? Because the valuable information we captured in the intraoperative TEE was not effectively being communicated to other physicians, including other anesthesiologists. Now that the report will be instantaneously available in Oasis, the information will be better shared.

How do I view the report? The reports can easily be viewed in eCareNet Viewer (Oasis) in the Transcription Column (TRNSCR). Under this section you will find our reports labeled “Anesthesia TEE”. In this section you will also find echocardiograms performed and interpreted by the cardiologists along with Operative reports and Cardiac Catheterization reports. It, therefore, seemed a natural place people would look.
**THE ELECTRONIC TEE HAS ARRIVED... CONTINUED**

*I am echo certified but never got trained or cannot remember how to use the new system, what should I do?*  
Please contact Amy Alexander and she can help you get acquainted with the system.

**Jake, you clearly do not have the expertise to have pulled this off. Who really did the work?**  
Amy Alexander in the Heart and Vascular IT department deserves the credit for making an idea a reality. Kristen Taylor, Associate Director of UMA Billing and Coding, deserves the credit for creating a system that will allow easy billing from the electronic chart. Without the effort and energy of these two ladies, the electronic TEE report would not exist.

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**MESSAGE FROM THE PAIN CLINIC**

Happy National Nurses Week… “Nurses: Caring Today for a Healthier Tomorrow”…

I traveled again to Columbia to attend The Center for Nursing Leadership Conference - Annual 2010 Nursing Summit “Leadership in an Era of Perpetual Change: What does it Take?”

A new model of Leadership involves:

**PURPOSE:** inspiring vision and the ability to effectively communicate

**PERSONAL:** profound self-knowledge and self-awareness with a combination of commitment and capability; integrity with courage and the desire to continually learn and improve

**PEOPLE:** equality and respect for all aspects of diversity to create and sustain a positive work environment

**PROCESS:** be comfortable with change and embrace it; take a risk and face problems and issues directly taking “unpopular” action when necessary

Today nurses must acknowledge and accept the challenge to “care for today for a healthier tomorrow.”
****

**APPLAUSE**

- Congratulations to Drs. Tom Epperson and Larry Field on being nominated as the new Executive Committee members.
- There were no new babies this month, but wedding season has begun! Congratulations to Drs. Tara Ahlberg and Dwayne McClerklin on each of their weddings! Dr. McClerklin and his wife honeymooned in St. Lucia, while Dr. Ahlberg will soon be enjoying time with family and friends at Isle of Palms.

**AN UPDATE FROM THE UPDATE ON CPB BY: ERIC NELSON, MD**

Last month I had the opportunity to attend the Update on Cardiopulmonary Bypass in Whistler, BC. This is an annual meeting sponsored by the Society of Cardiovascular Anesthesiologists for anesthesiologists, surgeons, nurses, and perfusionists. My primary reason for attending was to present a poster entitled “Dexmedetomidine v. Propofol as a primary anesthetic post CPB for fast track cardiac anesthesia.” Our research found much quicker extubation times and far less narcotic use with dexmedetomidine than propofol. All our patients had statistically insignificant CPB and cross clamp times. Their ages were also not statistically significant, and they had similar comorbidities. We also found that there was not a statistically significant difference in blood pressure either in the operating room or in the ICU postoperatively. Our data was well received by both fellow anesthesiologists and surgeons at the conference. Although our study had a small number of patients and was retrospective in nature, we hope to use the preliminary data to do a randomized study in the near future.

**Dexmedetomidine v. Propofol as a primary anesthetic post CPB for Fast track cardiac anesthesia**

| Background | Fast-track cardiac anesthesia (FTCA) facilitates early extubation, reduces hospital length of stay, and also reduces complications [1]. Dexmedetomidine (DEX) infusions begun in the ICU are safe and effective for post CABG sedation while also reducing the use of analgesics, tale-blockers, anteriotics, and narcotics when compared to propofol [2]. We set out to compare whether propofol or DEX, begun intraoperatively, was superior in time to extubation, opiate usage, and use of vasopressors by comparing the FTCA patients who had received DEX to a similar group of patients who had received propofol.

| Methods | Five patients in the past year who had been given DEX intranoperatively (Group 1) were compared to matched controls who had received propofol intraoperatively (Group 2). All patients had a preparative selenic fraction of greater than 50% and were free from significant comorbidities. We compared the groups for time from induction to extubation (hours intubated), morphine use, oxycodone use, mean arterial pressure in the OR and ICU, cross clamp time, and CPB time. Averages were compared using a 2-tailed student t-test.

| Results | The average age of Group 1 patients was 56.5 years old. Surgical population consisted of 3 AVRs, 1 CABG with a septal myectomy and one MVR. The 5 patients in Group 2 had an average age of 60 years and a surgical population of 2 AVRs and 3 CABGs. Group 1 patients were extubated on average after 8.8 hours while group 2 patients were extubated in 17.2 hours (figure 1). Group 1 patients required an average of 2.3mg of morphine in the first 24 hours compared with 22.5mg in Group 2. Group 1 patients required an average of 2.3mg of morphine in the first 24 hours compared with 22.5mg in Group 2. Group 1 patients required on average, 7mg of oxycodone compared with 22.5mg in Group 2 over the first 24 hours (figure 2). There was no statistically significant difference in blood pressure in the OR or in the ICU (figure 3). The cross clamp and CPB times did not statistically differ (figure 4). Two patients in the dexmedetomidine group required vasopressors while three patients in the propofol group required the use of a vasopressor.

| Conclusion | The study to compare whether propofol or DEX, begun intraoperatively, was superior in time to extubation, opiate usage, and use of vasopressors by comparing the FTCA patients who had received DEX to a similar group of patients who had received propofol. Patients in the DEX group were extubated sooner hours and far less patients in the propofol group. Patients receiving DEX also required morphine use with the amount of morphine and one third the amount of oxycodone in the first 24 hours after surgery. The reduction in time to extubation and use of opiates may justify the increased cost of DEX when compared with propofol. DEX appears to be a superior anesthetic to propofol for FTCA.

**References**


Other than the poster presentation, I attended numerous conferences and workshops. A large focus of the workshops was on reducing human error in the operating room via human factor analysis (HFA). HFA seemed to apply especially to the specialty of anesthesiology as there are so many compounding factors that may influence patient safety by not only what the anesthesia provider in the operating room is doing, but also the supervising attending and all the way up to the department leadership. I have summarized the basic premise for HFA, but I encourage you to read Scott Shappel’s paper entitled “The Human Factors Analysis and Classification System-HFACS.” The paper uses an aviation model, but it’s amazing how well it can be applied to anesthesia and helps to make what we do safer.
AN UPDATE FROM THE UPDATE ON CPB CONTINUED...

Most active failures are the result of numerous latent failures. That is, the final causative event in an error is typically due to numerous small mishaps, which when combined cause an adverse event. This was best described and illustrated by Reason in the early 1990’s with his “Swiss Cheese” model.

As described by Shappel, failures can be broken down into four categories: unsafe acts, preconditions for unsafe acts, unsafe supervision, and organizational influences. Unsafe acts occur from either errors, which are activities that do not achieve their intended outcomes, and violations which are a willful disregard of rules and regulations put in place for safety.

Although an error is typically the direct result of an unsafe act, there may be factors which caused this unsafe act to occur; these are the preconditions for unsafe acts. In anesthesia, preconditions for unsafe acts include being tired or mentally fatigued, coming to work sick, not recognizing one’s own limitations for a case, and even poor management of resources.

Still higher up the chain of failure is unsafe supervision. This is especially important in our field as attending anesthesiologists are supervising numerous rooms at a time. Anesthesiologists must be a proper role model to the resident or CRNA they are supervising. They also must provide guidance, training opportunities, leadership, and motivation to prevent inadequate supervision and thus reduce the likelihood of an error. Supervision also includes the correction of known problems and consistent maintenance of existing rules and regulations.

The final layer of latent failure that contributes to an active failure is organizational influences. These issues involve resource management which includes both personal and equipment. The overall working atmosphere or climate also is included in organizational influences. This climate is reflected in the chain-of-command, the delegation of authority, communication, and formal accountability of a department. Policy and culture are also important parts of the department’s climate. It is important to keep in mind that culture is “the way things get done here” and in some instances the culture does not follow formal policies which may result in failure. The last part of the organizational influence is the operational process. The organizational influence refers to how everyday activities are governed.
AN UPDATE FROM THE UPDATE ON CPB CONTINUED...

As you can see in the Swiss Cheese Model, although a single mistake or act may be the initiating cause of morbidity, we must keep in mind that other factors are at play. As physicians and patient advocates we have to look at ourselves and our department as a whole to do everything we can to stop latent failures as soon as they occur so there is not a “trickle down” effect which would lead to an unsafe act and thus morbidity or mortality!

Despite all the meetings and learning, we also had a lot of fun in Whistler. MUSC was represented by an entire cardiac team! Our department was represented by Jake Abernathy and myself. Surgery sent Will Yarbrough. Cheryl Morrisette was there from nursing, and Alicia Sievert represented our perfusion department. We competed in an Amazing Race style teambuilding activity around the town of Whistler. We learned to better communicate with one another and how to better work as a team. Unfortunately we didn’t win, but we blame that more on Cheryl falling and fracturing a bone in her foot than spending extra time at the beer tasting challenge.

Other than learning the importance of teamwork and communication in the operating room, I was also able to take away some of the latest trends in management of the cardiac patient. I also learned that our societies are always anxious for young anesthesiologists to be involved and to contribute, so I encourage everyone to get involved on some level. As for some parting pearls of wisdom: it is possible while skiing to use your face to stop, as long as you don’t mind getting kicked in the back of the head by yourself; the department does not reimburse for Cuban cigars, and Jake Abernathy has the perfect outfit for every occasion and is more often than not the best dressed person in the room.

A MESSAGE FROM YOUR COMPLIANCE MANAGER

An email recently went out to all faculty telling of the new changes to Anesthesia Manager. The changes included a change to the event "anesthesiologist present and medically directed case" to "anesthesiologists medically directing case" because we already separately document presence. The second change consisted of moving "anesthesiologist present for emergence" to the bottom of the event sent. This should be documented close to emergence, as we cannot claim presence at emergence and throughout the case until the case is ending. A new event "I or another attending anesthesiologists was immediately available throughout and present for all key/critical portions of the case", was also added. Keep in mind this attestation statement is required to meet the new CMS documentation requirement in order to bill for resident cases concurrent with another CRNA/resident case.

Jennifer Simmons, CPC, MA
Future Events

5/3 - Acid Base Management (CA2/3)
  Dr. Larry Field

5/4 - Update on Transfusion Medicine (Grand Rounds), Dr. Ray Greenberg

5/5 - ART Teaching Conference: Echo Review
  Dr. Andy Dick

5/10 - ACLS in the Perioperative Period: Advanced Provider (All Residents - Simulator)
  Dr. Jake Abernathy

5/11 - Anesthetic Care of the Patient with Traumatic Brain Injury (Grand Rounds)
  Dr. Julio Chalela

5/12 - Journal Club: Critical Care / Trauma
  Davis

5/17 - Guest Lecture
  Joe Meltzer, MD (Columbia University)

5/18 - Perioperative Management of the Patient in Sepsis (Grand Rounds)
  Joe Meltzer, MD (Columbia University)

5/19 - ART Teaching Conference: Echo Review
  Dr. Jake Abernathy

5/24 - Mechanical Ventilatory Support (CA2/3)
  Dr. Horst Rieke

5/25 - Professionalism in Anesthesia
  Dr. Jerry Reves

5/26 - ART Teaching Conference: Journal Review
  Dr. GJ Guldan

5/31 - CA 2/3 Board Prep Key Word Review

I HUNG THE MOON!

The department members below have been recognized by our patients and their peers.
This month’s drawing winner is Fran Zinko! Fran will receive a gift card.

Fran Zinko - stayed to make sure we all had breaks before she left on a Saturday. Thank you Fran for your help!
Kelly Bramhall - For doing a really outstanding job during first month and providing outstanding support to our Anesthesia providers. Also, for going the extra mile to help cover rooms.
Kathy Comley - Helped me start a difficult case. I really appreciate the extra hands.
Christine Coe - filling in on the OB floor for the residents the night before their inservice - good job on a tough call!
Cara Spaulding - Outstanding assistance to the Anesthesia tech section in helping cover shifts while we were short on personnel.
Tim Heinke - Working hard on a tough call night!
Beth Jennings - Helped me get started in PEDS - what a great help! Thank you!
Rick Kosinski - Started off with a bang taking over the periphery tech slot - doing a great job!
Cory Furse - Cory was patient and provided consistent guidance during a busy case in the OR on a Saturday. Thank you!
Katie Boan - An outstanding job supporting our Anesthesia providers - anticipating needs and attention to detail has enhanced the tech section’s ability to do the job. Kudos!
Marshall Kearney - helping to keep the section going - continuing to do a great job!
Zack Lamb - Stepping up and putting in the extra effort to support the tech sections missions while we were down three people.
Gustavo Andrade - Willing to stay late to start a case! Thanks!
Susan Hearne - Working hard on a tough call night!
Christine Coe - Staying late to help with a busy schedule.
Angel Mahan - Working hard on a tough call night
Mike Looper - Working hard on a tough call night
Ralf Schumann - helped start a difficult case. Your help was greatly appreciated!
All CRNAs - Thanks for a great rotation, wonderful teaching, advice and patience. Had a blast and appreciate everyone!

SAVE THE DATES:
- Faculty Development Journal Club, Monday May 24, 2010 from 5-7pm at Halo (170 Ashley Ave)
- This year’s Resident Graduation will be Friday, June 4, 2010
- 2010 Holiday Party: Friday, December 3, 2010 at the Charleston Yacht Club!

Note: You can see Dr. Carlee Clark’s Tanzania presentation and pictures by going to www.musc.edu/anesthesia

We Would Love to Hear From You!
If you have ideas or would like to contribute to Sleepy Times, the deadline for the June edition will be May 24, 2010.

This Month’s Contributors:
Scott Reeves, Will Hand, Valerie Sutton, Jake Abernathy, Cindy Fitzgerald, Eric Nelson, and Jennifer Simmons