MESSAGE FROM THE CHAIRMAN:
-SCOTT T. REEVES, MD, MBA

During 2011, the department underwent an extensive process to develop a five year strategic plan which was finalized in January 2012. The purpose of the process was to develop a strategic plan that would ground us and give us direction as changes in healthcare reform started to occur. The strategic plan focuses on five areas which include clinical care, education, faculty development, research, and finance. The whole plan can be found HERE.

Over the past 18 months, many changes have occurred at MUSC. Now is a good time to review our initial assumptions and to take stock in our progress. Over the next six months, I plan to use my opening statement as an opportunity to review each of the five areas starting with clinical care. I welcome an open departmental dialog on how we are doing in each area and appreciate your thoughts being emailed to me.
**Mission:** To provide outstanding comprehensive, patient centered perioperative clinical services that dramatically improve the quality of care and patient outcomes across the surgical continuum.

**Vision:** To be recognized as a nationally and internationally acclaimed academic department recognized for excellence and value in perioperative healthcare. In addition, we recognize that we must be able to adapt, grow, and respond to rapid and at times disruptive changes in health care if we are going to be able to carry out our mission and practice according to our expressed values. Maintaining the status quo will not be sufficient. Instead, we need to effect continuous improvement in the quality, safety, and scope of care that we provide in order to increase the importance and value of our abilities and services to our patients their families, and to the medical center.

**Objectives:** Expand our current perioperative clinical services to better manage our patients from the interval of altered physiology that begins with the onset of surgical illness and ends with the return to the baseline that was present prior to the surgical illness. Our areas of focus are illustrated below:

- **Improved Preoperative Evaluation and Optimization Services:**
  - Preoperative Clinic Restructuring
    - Staffing restructure, scheduled appointments
  - Better Identification of Patients Requiring Preoperative Evaluation
    - Preoperative Roadmap
  - Standardized Recommendations and Practice Patterns
    - Preoperative labs and medication administration
    - Better adherence to practice guidelines
    - Improved communication
  - Improved inpatient preoperative evaluation

- **Improved Pain Management Services in Both Adult and Pediatric Patients:**
  - Increased number of regional anesthesia (blocks, catheters)
  - Improved responsiveness and management of current catheters
  - Create acute pain service at ART with new resident rotation
  - Consult service for chronic pain patients with acute pain issues (i.e., chronic pancreatitis)
  - Expanded management – caring for patients from catheter based management to oral pain management

- **Advanced Postoperative Management Patient Subsets:**
  - Orthopedic Joint Patients
    - Manage patient from preoperative optimization to rehab
    - Management plan to allow patient start PT the day of surgery
  - Destination Breast Reconstruction
    - Help develop standardized preoperative and intraoperative care plans
  - ENT Reconstructive Surgical Patients
    - Test group – management of patients in the postoperative period
Clinical Care Continued...

- Improved recognition and perception of our specialty within the medical community and by our patients.
- Performance Metrics:
  - Improved patient satisfaction
  - Improved surgeon satisfaction
  - Improved anesthesia satisfaction
  - Decreased costs by eliminating unnecessary testing
  - Decreased costs by decreasing procedure cancellations

Clinical care has always been a significant strength of our department. The fact that MUSC is the #1 hospital in South Carolina is testimony to the high quality care delivered. As noted in italics, the department recognized that disruptive changes in health care would occur. We are experiencing this with the rapid growth of our percutaneous (TAVI, LVADs, etc.) and robotic procedures. Our quality improvement efforts that we do alongside the hospital (Central line infections initiative, SCIP measures, etc.) and departmental specific (RIPCHORD) patient safety initiatives are excellent. Our iVITAL software program is an industrial leader in OR management, and is being transitioned to provide similar information at the time of EPIC is implemented.

The preoperative clinic was an area of concentration. Progress has been slow but under the leadership of Drs. Kelly Grogan and now Tod Brown, a new expanded and restructured clinic has opened. Preoperative labs, medication and NPO algorhythms are being rolled out. Soon we plan to have scheduled appointments for our orthopedic joint patients, which will fulfill an Advanced Postoperative Management goal. Our Pain Management capacity has greatly increased with the start of a regional service at ART in FY 13 and RT in FY 14. The addition of Ryan Nobles has brought new technology and therapeutic chronic pain options to our patients.

Our performance metrics remain high with the operating rooms frequently winning patient satisfaction awards. We still have work to do in decreasing unnecessary testing, improving in room times, turnover and surgeon satisfaction. I am proud of the progress that has been made on the Clinical Care goals over the past 18 months and welcome hearing your thoughts.

Pain Clinic Luau as a Thanks to Residents Great Work

From Left to Right: Dr. Arthur Smith; Christina Bunke, RN; Cindy Fitzgerald, RN; Liza Dooley, Dr. Ryan Nobles, Rhonda Haynes, and Dr. Jarret Todd
A veteran is someone who, at one point in his life, wrote a blank check made payable 'To My Country' for an amount up to and including my life."

We live in difficult times. There is much unrest and conflict in the world. As a country of moral and just people, we have become involved in this unrest and conflict. We will mark the 12th anniversary of Operation Enduring Freedom on October 7th. This war has been fought with an all-volunteer militia. In just a few weeks, one of our own Anesthesia Family members will join these brave men and women for his 3rd deployment during this war.

Major Chris Devine will have his “boots on the ground” in Afghanistan on September 22nd for a four month tour of duty. He will be the Medical Crew Director for a five man air-evacuation team.

Like many soldiers, Chris came from a military family. His father is a Veteran of the Vietnam war. He flew over 200 combat missions while serving as an Air Force fighter pilot. His wife, Dawn was also in the Air Force. They met in New Mexico. Chris graduated from Harding University in Arkansas with his BSN in 1996. He then joined the Air Force as an active duty officer in 1998. He remained on active duty until 2005. He saw his first deployment in the summer of 2002 to Kandahar, Afghanistan. He left on the day of his son Ethan’s first birthday. During that three month deployment, Chris served as a member of a CCAT (Critical Care Air Transport) team. His mission was to transport critically injured DOD personnel from Afghanistan to Germany. His second deployment came in the summer of 2004. He was deployed to Landsthul Regional Medical Center (LRMC) in Landsthul, Germany. LRMC is the largest military hospital outside of the continental United States. There, Chris worked in the ICU caring for injured soldiers, sailors, airmen, and marines. Chris separated from active duty and joined the Air Force Reserves in 2005 in order to attend the Nurse Anesthesia program here at MUSC. He graduated in 2008 and accepted a position at Trident Hospital in North Charleston. Chris became a member of the MUSC CRNA staff in January of 2012. I was a part of the peer interview team that met with Chris. I was moved by his passion and dedication to help and heal the injured soldiers that he met. I have a son in the Marine Corps and I thought to myself...If my son is ever injured in the line of duty, I hope that someone like Chris will be there to make sure he is safe and cared for.

We are honored to have such a hero walking amongst us. We pray for his safety and look forward to his return home. Thank you for your service, Chris. I know there is another mother out there who has a son or daughter who needs you. We gladly share you with that soldier.
CONGRATULATIONS TO DR. SYLVIA WILSON
PHYSICIAN OF THE MONTH AWARD

“Dr. Wilson exemplifies MUSC excellence at its finest. This past week a GYN patient was brought from an inpatient unit to our unit for an emergency procedure. The patient took a turn for the worse during transport and required emergency resuscitation. Dr. Wilson whom was an attending anesthesiologist in the unit that day had already been relieved to go home and noted the crisis in the PACU. She did not hesitate to don a pair of scrubs and accompany the patient to the OR emergently and lead the team. It is no doubt without Dr. Wilson’s leadership, knowledge and composure the outcome for this patient could have been dire. Though this is only one example of her professionalism; we can assure you on a daily basis that Sylvia exemplifies this type of care and attentiveness to the whole patient. Sylvia is also a nursing advocate and values and respects nursing’s opinions and input in the care of patients. She demonstrates strong interpersonal skills and a positive working relationship with her peers, other faculty and staff members.”

CONGRATULATIONS TO DR. SCOTT T. REEVES FOR THE COMPLETION OF THE 3RD EDITION OF A PRACTICAL APPROACH TO TRANSESOPHAGEAL ECHOCARDIOGRAPHY

“Dr. Scott T. Reeves for the completion of the 3rd edition of A Practical Approach to Transesophageal Echocardiography.”
RESEARCH CORNER:

CONGRATULATIONS TO DR. JAMES ABERNATHY AND THE DEPARTMENT’S CONTRIBUTION TO PATIENT SAFETY WITHIN THE CARDIAC OPERATING ROOMS

Circulation

Patient Safety in the Cardiac Operating Room: Human Factors and Teamwork: A Scientific Statement From the American Heart Association

on behalf of the American Heart Association Council on Cardiovascular Surgery and Anesthesia, Council on Cardiovascular and Stroke Nursing, and Council on Quality of Care and Outcomes Research

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CONGRATULATIONS TO JOE WHITELEY, MD; WILL HAND, MD; JASON TAYLOR, MD; DAVID STOLL, MD; AND BETHANY WOLF, PhD FOR PUBLISHING THE FOLLOWING ARTICLE

Anesthesia & Clinical Research

Review Article Open Access

Epsilon-Aminocaproic Acid in Liver Transplantation: A Three-Year, Retrospective Review

Joseph R Whiteley, William R Hand, Harrison L Plunkett, Jason M Taylor, W David Stoll and Bethany J Wolf

Medical University of South Carolina, Charleston, USA

Whiteley et al., J Anesth Clin Res 2010, 4:6
http://dx.doi.org/10.4172/2155-6146.1000328
Pediatric anesthesiology is officially recognized!

Pediatric anesthesiology has been officially recognized as a subspecialty of anesthesiology by the American Board of Medical Specialties (ABMS)! Subspecialty designation was approved and announced by the ABMS in April 2011. Our pediatric anesthesiologists at MUSC are preparing for the certification examination that is being given for the first time in October 2013. By year’s end, pediatric anesthesiologists will be professionally on par with most other pediatric specialists who enjoy board certification. This process has been long awaited by those practicing the specialty for years but without any official process to demonstrate expertise.

Your pediatric anesthesia division will soon have many more board certified pediatric anesthesiologists than any other South Carolina hospital.

Pediatric Acute Pain Service

Some surgical procedures are so painful that anesthesia is needed postoperatively. Specifically, epidural and other types of regional anesthesia are continued in the postoperative period to optimize difficult to control postoperative pain.

Pediatric patients at MUSC have the pediatric acute pain service available 24/7 to provide consultation and regional anesthetic blockade for severe post-surgical pain. The surgical procedures that routinely require postop regional analgesia are repair of pectus deformity, thoracotomy, and repair of bladder extrophy. In all of these situations, surgical and anesthesia planning prior to the operation permits the regional analgesia block to be placed preoperatively. Placement of regional analgesic block preoperatively allows the patient to awaken from the operation with optimal pain control and greatly simplifies block placement.

Dr. Cory Furse has been instrumental in making this service available to our pediatric patients. He was joined in 2012 by Dr. Gregg Schnepper whose fellowship training focused on regional blockade in pediatric patients. They together lead our group to make regional analgesia available and effective for all Children’s Hospital surgical patients.

Safety Begins with a Good Handover

When patients move from an ICU to the operating theater and vice versa, care is handed over to a new team of providers. These handovers are often the source of missed information that can result in oversights and confusion. The pediatric anesthesia division is 100% supportive of the ICU/OR handover initiative that is being standardized in the Children’s Hospital. We expect that a standardized approach to patient handovers will result in optimum patient care and greatly increase collaboration between the ICU and operative teams. By closely collaborating in the handover process, we will further enhance an already close working relationship.
INTRODUCING FAER STUDENT FLORA SIMMONS

Flora Simmons – is a fourth year student working as a FAER MSARF recipient. She is from Beaufort, SC by way of TN. In 2010, she graduated from USC in Columbia with a B.S. in biology and minor in African Studies. She worked as a resident advisor throughout her four years at USC. During her free time she enjoys white water rafting, swimming, and hiking.

Flora became interested in medicine at an early age and has volunteered in many clinics, including makeshift clinics in Uganda. She became especially interested in anesthesiology during her 3rd year surgery clerkship, thanks to several helpful attendings taking her under their wings. She will be applying for anesthesiology residency this fall and looks forward to spending the next 12 weeks getting to know the department.

UPCOMING RESIDENT TEE CONFERENCE, SEPTEMBER 14, 2013, GAZES AUDITORIUM

7:30 – 8:00  Coffee
8:00 – 8:30  How TEE Images are Created (US Physics)
Dr. Kelly Grogan
8:30 – 9:00  Making a Perfect Image (Knobology)
Dr. Jake Abernathy
9:00 – 9:40  The Standard Exam
Dr. Tim Heinke
9:40 – 10:00  Leg Stretch
10:00 – 10:30  The Main Squeeze (Ventricular Function)
Dr. Eric Nelson
10:30 – 11:00  Going With the Flow (Doppler Echocardiography and hemodynamics)
Dr. Alan Finley
11:00 – 11:30  Mitral Valve
Dr. Alan Finley
11:30 – 12:30  Lunch
12:30 – 13:00  Aortic Valve and Aorta
Dr. Kelly Grogan
13:00 – 13:30  The Forgotten Side (Tricuspid Valve and the Right Ventricle)
Dr. George Guldan
13:30 – 14:00  TEE for Noncardiac surgery
Dr. Jake Abernathy
The Importance of Faculty Maintaining an Updated CV for ACGME

The implementation of the Next Accreditation System (NAS) by the ACGME has increased the need for annually updated and accurate CV information for each faculty member. In a nutshell, the ACGME will be using a Continuous Accreditation Model. This means program data for the Core program and both of our ACGME accredited Fellowship programs must be submitted annually. Based on the annual data that is submitted, other data requested (case logs, duty hour logs) and program trends, a site visit could be initiated. However, if each annual report is submitted and appears satisfactory to the RRC, we will not have scheduled site visits, but instead a 10 year self-study period. As of today, each of our programs are set to be reviewed in 2021.

Working with your administrative assistant to enter your scholarly activity, memberships, and leadership roles into the FAIR system is KEY to the success of the residency and fellowships. The graphics below should explain the various systems and acronyms for getting the information where it ultimately belongs.

FAIR, CV, ADS, NAS, ACGME…Why me?

- FAIR– Faculty Academic Information Reporting (MUSC)
  -CV– Curriculum Vitae
- ACGME– Accreditation Council for Graduate Medical Education
  -ADS– Accreditation Data System (what holds the data)
  -NAS– Next Accreditation System (how the data is used)

FAIR ≠ ADS
The two databases do not communicate.

What does this mean to you?
Your scholarly activity is a VITAL piece of the annual report to the ACGME.

A “diagnostic” site visit can be triggered if the annual data submission indicates a potential problem. (Ex. pattern of duty hour violations, lack of scholarly activity, low scores on faculty or resident surveys and many other reasons.)

Help is here!

1. Each administrative assistant has been trained on entering data from your CV into FAIR.
2. Meet with you admin on a quarterly or bi-annual basis. Your CV information can and will be accessible for use by the residency program coordinator once it has been entered.
3. Information from FAIR is transferred to ADS for ACGME’s Review.
4. Dr. Abernathy, Dr. Field, and Dr. Guldan are happy, and so is Dr. Reeves.
CME REFRESHER COURSE MEETING, KIAWAH ISLAND, SOUTH CAROLINA
JUNE 25-29, 2014

“We have put together an exciting program with nationally and internationally known guest speakers, including faculty members from Duke, Wake Forest, MUSC and UNC.

Our course is open for registration now, with a 15% early registration discount, and is approved for up to 28.5 AMA PRA Category I credits, or 26 AANA CE credits. The registration link is:


We have also arranged to have a MOCA approved simulation course at MUSC, just prior to the conference, for those who need to complete this as part of their MOCA requirements. The MOCA simulation course registrants will receive a $200 discount if they are also registered for the Kiawah Carolina Refresher Course.

Let me know if you would be willing to do this, and if you have any further questions. Thank-you for your help and support. We wanted to give plenty of advance notice for those interested in attending, who must submit their meeting requests a year in advance.”

Best regards,

David Hardman, MD, MBA
Professor of Anesthesiology, Vice Chair Professional Affairs
Department of Anesthesiology, University of North Carolina at Chapel Hill
**Trunk Blocks Brochure**

**Pain control after surgery**

After surgery nearly everyone has pain. This is called acute pain and will naturally decrease as the body heals. Controlling pain is a team effort. At MUSC, the Department of Anesthesia and Perioperative Medicine has a special team of doctors called the Regional Anesthesia Pain Service (RAPS). Your surgeon may request RAPS to use advanced techniques to effectively help with your postoperative pain.

**Do I need a nerve block?**

That is entirely up to you and your surgical team. The RAPS team will offer a nerve block at the request of a surgeon, anesthesiologist, or patient. Each patient will be visited and evaluated on an individual basis.

This booklet has been prepared for you by the Regional Anesthesia Pain Service, a division of the Department of Anesthesia and Perioperative Medicine. The purpose is to inform you of possible methods of postoperative pain control prior to your surgery.

While regional anesthesia can sometimes be used as your primary anesthetic in the operating room, often it is used for postoperative pain in addition to general anesthesia for your operation. Your surgeon and anesthesiologist will work with you to develop a plan that is best for you.

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**Nerve Blocks for the Chest and Abdomen: Epidurals, Paravertebral & TAP blocks**

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Anesthesia and Perioperative Medicine

167 Ashley Avenue Suite 201
925 9th Street
Charleston, SC 29403-9120

Phone: 843-792-1222
Fax: 843-792-1222

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MUSC
Anesthesia and Perioperative Medicine
Regional Blocks for Chest and Abdomen

What is a nerve block? Numbing medicine (local anesthetic) is injected below the skin near a set of nerves. The numbing medicine blocks the nerve’s ability to sense pain from your surgical site which decreases the amount of pain you feel after surgery.

What is a continuous nerve block? Numbing medicine may be given as a single injection or as a continuous infusion. A thin, hollow tube (about the size of fishing line) is placed below the skin close to a nerve. This is later connected to an infusion pump to deliver a specific dose of local anesthetic continuously.

How is an Epidural block placed? Numbing medicine is placed in the center of your back near a set of nerve roots just outside your spinal cord.

How is a Paravertebral block placed? Numbing medicine is placed on the side of your back near a set of nerve roots just after they leave the vertebral cord.

How is a Transversus Abdominis Plane (TAP) block placed? Numbing medicine is placed on both sides of your belly between the different muscle layers.

How is a nerve block placed? Your anesthesiologist will determine the best location to place your block. This can be done with physical exam or use of a special ultrasound camera to help determine exactly where your nerves are located.

After an intravenous (IV) line is started, a few monitors will be placed. You will be provided with oxygen and mild sedation for your comfort. Numbing medicine is placed below the skin. A needle is inserted in the area where the skin is numb and slowly advanced to a specific area near the nerve to be blocked. Numbing medicine will be injected into this space either through the needle or through a catheter (a thin, hollow tube) that is placed below the skin. The needle will be removed. The numbing medication will help with pain control after your procedure, although you still may need other pain medication after surgery.

How should I expect to feel? Numbness in the area of your surgical incision will likely be present while your catheter is in place. You may feel a “pins & needles” sensation near your surgical site which is normal. This often happens as the nerve block is wearing off. With an epidural, you may experience weakness in your legs and may not be able to urinate on your own without the use of a bladder catheter.

Could I still have pain with a nerve block in place? Yes. A nerve block does not guarantee that you won’t have any pain. Everyone’s nerves do not follow the same pathways and sometimes surgeries are more involved than initially intended. The Regional Anesthesia Pain Service will visit you daily to assess your pain, evaluate your continuous nerve catheter, and determine the best plan to control your pain.

What are the risks? Nerve blocks are generally very safe. All of the risks are very rare but include: infection, bleeding, incomplete block, headache, reaction to a medication, lung puncture, and in very rare instances damage to nerves.

MUSC
Anesthesia and Perioperative Medicine
**Grand Rounds for the Month of September**

Subspecialty Team Meetings  
September 3, 2013  
Medical University of South Carolina  
BE 110, 6:30am

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“Cognitive Assessment Project”  
September 10, 2013  
William Hand, MD  
Medical University of South Carolina  
Assistant Professor

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“Common Surgically-Associated Chronic Pain Syndromes”  
September 17, 2013  
Ryan Nobles, MD  
Medical University of South Carolina  
Assistant Professor

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“Massive Transfusion Protocols in Trauma”  
September 24, 2013  
Charles Smith, MD  
Case Western Reserve University  
Professor
Future Events/Lectures

Intern
5/September—Peripheral Vascular Disease, Dr. Nelson
19/September—Renal Failure, Dr. Sabbagh

CA-1
4/September—Anticholinergic Drugs and Cholinesterase Inhibitors, Dr. Stoll
11/September—Local Anesthetics and Adjuncts to Anesthesia, Dr. Hebbar
25/September—Adrenergic Agonists & Antagonists and Hypotensive Agents, Dr. Gunselman

CA-2/3s
3/September—Subspecialty Team Meetings
9/September—Office-based Anesthesia (Barash Ch. 33), Dr. Tobin
10/September—Cognitive Assessment Project, Grand Rounds, Dr. Hand
16/September—Management of Patients with Ischemia Heart Disease (Stoelting Ch. 1), Dr. Grogan
17/September—Common Surgically-Associated Chronic Pain Syndromes—Grand Rounds, Dr. Nobles
23/September—Trauma Anesthesia Checklist—All Residents, Dr. Smith (CWRU)
24/September—Massive Transfusion Protocols in Trauma—Grand Rounds, Dr. Smith (CWRU)
30/September—MET/Code M&M, ART Staff

I HUNG THE MOON
Don’t forget to nominate your co-workers for ‘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!!

Dr. Jennifer Matos—has helped out on L&D on more than one occasion in the past couple weeks in her free time. It was much appreciated by the OB anesthesia team and the patients.

Sam Tripp, CRNA—Staying beyond your work time to help with a busy OR cheerfully and did it with a smile! Truly commendable!

Dr. Joshua Terry—Thank you for your help on L&D on the busy days we have had there. It is truly appreciated!

Chris Devine, CRNA—Helping transport and start a STICU on a patient. Thank you!

Peggy Kittridge, CRNA—For making and decorating the doctor’s lounge at the RT operating room.

Holiday Party: December 7, 2013
Location: Carolina Yacht Club.

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We Would Love to Hear From You!

If you have ideas or would like to contribute to Sleepy Times, the deadline for the October edition will be September 23, 2013.