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

INAUGURATION OF DAVID COLE, M.D. MUSC PRESIDENT

On October 9, 2014, David J. Cole, MD, was inaugurated as the seventh president of the Medical University of South Carolina. I hope each of you had the opportunity to be a small part of the historic event. For those of us that have worked with David in the operating rooms over his many years at MUSC, we know he will be a truly remarkable president. He will be successful foremost because he cares about people. He cares for his patients, fellow faculty, residents, students, and staff.

As he stated in his inaugural address:

“When I first started down this path, I believe I was motivated by a general thought that I could possibly do some good in a field that I found interesting. What I discovered as I continued in this career was a simple truth - medicine is about people, not achievements, surgical procedures, grants or clinics... But I will tell you that it took me 10 years to come to understand that what makes the difference, or not, is your ability to connect with your patient as a person, in other words... your humanity: for them to understand that you actually care, and that you will do everything in your power to help.

I am looking forward to his patient-centered beliefs and management style, which will propel us forward as an institution. He has started out rapidly by convening a group of university leaders across all of the colleges to develop a University-wide strategic plan. It is this new strategic plan that he hopes to finish in early 2015 that will be our road map for the future.

If you missed his inauguration, pictures can be found at; https://depthtml.musc.edu/pr/photogalleries/2014/inauguration/

In addition, Sleepy Times has reproduced an interview with Dr. Cole from the fall edition of Progress Notes.
“MUSC WELCOMES ONE OF ITS OWN AS NEW PRESIDENT”
PROGRESS NOTES, FALL EDITION, MUSC'S MEDICAL MAGAZINE

On July 1, 2014, David J. Cole, M.D., assumed the presidency of the Medical University of South Carolina. Dr. Cole established his national reputation as a skilled surgeon, noted researcher, and medical education leader for the most part at MUSC, having served in numerous executive positions at this institution over the past 20 years. He is the former Chair of the Department of Surgery and immediate Past President of MUSC Physicians. Progressnotes invited him to share his vision for MUSC.

PN: Congratulations on being selected as our new president. How did it feel when you received that phone call?
DC: I think it was somewhere between disbelief, excitement, and relief. It took a while for it to sink in. I remain very honored and humbled to have been given this opportunity.

PN: Why do you think it’s important that MUSC has a practicing clinician as president?
DC: As a nation we’re going to have to change how we provide health care. We’ve been focused on the “what” of health care—what we have, what scans we could do, what procedures we could do—and there’s a clear need and opportunity for us to transform “how” we provide health care. We have to become more multidisciplinary, more team-based, and ultimately more patient-focused. That’s a cultural shift. Unless you’ve been in the middle of it, you don’t truly understand what the problem is and how to lead forward out of that. Honestly, I believe one of the reasons I was considered for this position is that there are inherent strengths in having a leader who has 20 years of clinical experience and knowledge plus enough presence at this institution to have established a solid level of trust.

PN: What is your vision for MUSC and its role in the transformation of health care?
DC: As I was noting previously, in the next five years we’re going to have to drive a fundamental transformation in how we provide health care. We’re being held more accountable, asked not to be wasteful. In the past, that sort of accountability was assumed but not really defined. Now, quality measures are a click away on the internet. We have to become a patient-focused, high-quality, value-based care provider. That’s what is expected by our patients.

PN: How important will affiliations with community hospitals and physicians be?
DC: Underlying my vision for providing patient-focused, high-quality care is an emphasis on efficiency of care. We have to be able to provide the right care for a patient at the right place at the right time. By definition, that means we need to start forming partnerships because not every patient needs to be at MUSC. We need to be a little more diverse and less siloed when we’re talking about achieving population health. We’re talking about maintaining health first, and that’s possible only through an alliance with community physicians.

Historically, a hospital CEO says a full hospital is a good hospital. That’s generally true, but now we need to start asking questions about whom we can best serve at the MUSC Medical Center. Do patients require the type of care that only we can provide? If the answer is yes, then they need to be here. If the answer is no, then maybe they need to be supported with our partnership with a local community hospital and physicians.
“MUSC WELCOMES ONE OF ITS OWN AS NEW PRESIDENT”
PROGRESS NOTES, FALL EDITION, MUSC'S MEDICAL MAGAZINE
CONTINUED ...

PN: How will you ensure that MUSC continues to attract the best future clinicians to its training programs?

DC: MUSC is emerging in the national academic medical center arena as a rising star. With our six colleges, we have our finger on the pulse of every dimension of health care. We have the ability to lead the way nationally in terms of multidisciplinary care and multidisciplinary education. We need to change the culture so that’s the expectation. To me, the exciting opportunity is that we can not only change the way health care providers interact with one another but also teach those new modes of interaction to our students. That’s how we will achieve the profound cultural shift that is needed.

We are already attracting high-quality students and residents to our programs. Why is that? Well, it’s the quality of our educators and clinicians. It’s our culture. I think MUSC provides a very dynamic, forward-thinking environment. We would rather do something, build something, than wait it out. That’s always been our strength. Part of the magic formula, if you will, behind our growth over the past 20 years has been that we’ve been able to share common purpose and figure out how to work together in a manner that’s productive rather than destructive. Students and faculty alike see something they want to be part of and choose to be here.

PN: How can MUSC continue to enhance its strong national profile in basic and clinical research at a time when research dollars are very scarce?

DC: Another challenge. You don’t have to read too many newspapers to hear about NIH and clinical funding being strained. As an institution, we need to acknowledge, align, and build on our clinical and basic research strengths. If we focus on our strengths and build into those domains, we will continue to receive national recognition. To do that, we’re going to have to intentionally diversify the financial base that provides support. That’s not to say that we shouldn’t be as competitive as possible for NIH funding, but there are many ways that we can get resources. One way is continuing to develop key industry partnerships based on our academic strengths. We need to identify the major programs that have enough of a name to attract industry partners that can provide resources for what we collaboratively need to do. Also, we need to be prepared to leverage new domains for funding, such as the Centers for Medicare and Medicaid Services and the Patient-Centered Outcomes Research Institute. Furthermore, we need to leverage more effectively our intellectual property. I think MUSC has an opportunity to continue to develop a more robust technology transfer platform that will add value to the institution.

Finally, strong development efforts provide critical resources for our programs. Obviously, as president, I am going to spend a significant portion of my time working on fundraising.

PN: Is there anything you’d like to add?

DC: Part of this position requires not only my presence, but also my wife’s as we are the external face of the institution. In the Department of Surgery we always tried to build a positive, forward-thinking culture that sent the message that we are family. It’s not “them” and “us.” We are “us.” I’d love to bring that feeling of engagement to the entire institution.
American Society of Anesthesiologists Annual Meeting was held October 11-15, 2014 in New Orleans. The theme for this year’s meeting was *Global Leaders in Outcome, Education, Safety and Discovery*. Twenty-two faculty attended and presented original research, were invited lecturers and led workshops. Our residents also assisted in educational workshops and participated in FAER scholar initiatives. A complete summary of activity is included in the table on page 5.
AMERICAN SOCIETY OF ANESTHESIOLOGISTS ANNUAL MEETING
CONTINUED ...

ASA 2014 – MUSC PRESENTATIONS – NEW ORLEANS – MORIAL CONVENTION CENTER

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<td>Bolin (fac) – Med Challenging Case (MCC01) – Thoracic Paravertebral Block for Refractory Tietze Syndrome (MC37)</td>
<td>Abernathy (fac) – Oral Presentation OR14-2 – Conducting a Work System Analysis to Map System Vulnerabilities in the Perioperative Medication... (A205S)</td>
<td>Schaefer (fac) – Hands-on Workshop (B24A) – Difficult Airway Workshop with Simulation</td>
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<td>Nelson (spkr) – 90 Min Panel (FN01) – Protecting the Lung During Cardiac Surgery: An Interdisciplinary Approach</td>
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<td>Abernathy – Poster Presentation (PO14-4) – Identification of System Vulnerabilities in the Perioperative Medication Delivery System... (A4114)</td>
<td>Herbert – Poster Presentation (PD12-1) – Impact of Skin-to-Skin contact on Maternal Pain Medication Consumption Following C-Sections (A4197)</td>
<td>Epperson/Whiteley – Poster Discussion (PD05-1) – Detection of Elevated Intracranial Pressure In Robot Assisted Laparoscopic Radical Prostatectomy (A5026)</td>
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<td>Covert – Medically Challenging Case (MCC02) – Successful Spinal cord Stimulator Trial &amp; Permanent Implant in Pt with Diabetic Peripheral Neuropathy on Chronic Dual Antiplatelet Therapy (MC2445)</td>
<td>Theravath (mod) – Refreshers Course Lecture (209) – Congenital Heart in the Adult Presenting for Non-Cardiac Surgery</td>
<td>Field/Furse/Hand/Tobin (fac) – Hands-on Workshop (B18B) – Perioperative ACLS Simulation</td>
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<td>Nelson (fac) – Hands-on Workshop (B05) – Pacingmakers and ICDs</td>
<td>Hassid (spkr) – Clinical Forum (CF03) – Adults with CHD Presenting for Redo Cardiac Surgical Procedures</td>
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<td>Furse/Redding (fac) – Hands-on Workshop (B23) – Perioperative Pediatric Advanced Life Support Simulation</td>
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CONGRATULATIONS TO THE NEW PEDIATRIC ABA SUBSPECIALTY BOARDED FACULTY

Tracy Wester, MD
Jake Freely, MD

Not Pictured: Grace Wojno, MD

SOCIETY OF THORACIC SURGERY (STS)
NATIONAL DATABASE
BY: JAKE ABERNATHY, MD

In the next few weeks, the Division of Cardiothoracic Anesthesiology, along with the Division of Pediatric Cardiothoracic Anesthesiology and Division of Pediatrics will take a gigantic step in the direction of providing metric-based quality care. With the support of MUSC and MUHA, we will begin supplying patient data to two very important databases, both housed within the Society of Thoracic Surgery Database. Both the Pediatric Congenital and Adult anesthesiology databases are modules that collect anesthesiology related data and link those data to the larger STS database.

The STS database was established in 1989 as an initiative for quality improvement and patient safety among cardiothoracic surgeons. It now contains more than 4.5 million surgical records and represents an estimated 94 percent of all adult cardiac surgery centers across the U.S. By leveraging a database of this size, the cardiac anesthesiology community will be able to better understand and demonstrate our value to the wellbeing of these complicated patients.

Quality metrics have become the language by which we all communicate. Unfortunately for anesthesiology, we do not own any of the PQRS measures. Surgical mortality, for instance, is currently attributed to the surgeon and surgeon alone. Through our participation in these databases, we will be able to identify quality measures that are directly attributable to anesthesiology. Doing so is a must for the future relevancy of our specialty.

We are excited to be participating and are looking forward to learning from the data to make our patients safer.
WAKE UP SAFE ANESTHESIOLOGY DATA SET  
BY: AMANDA REDDING, MD

Wake Up Safe is a pediatric patient safety organization whose goal is to identify and reduce serious adverse events in the perioperative period. The ultimate goal of Wake Up Safe is to implement change in processes of care that improve the quality and safety of anesthetic care provided to pediatric patients nationwide. The registry was also established for the purpose of quality improvement, using analysis of the adverse events for learning.

With currently 26 member institutions, each institution performs a root cause analysis of serious adverse events and then submits data regarding events. A benefit of Wake Up Safe membership is that, as an organization, it trains and educates its members in performing a root cause analysis. Additional benefits of becoming a member include the ability to participate in multicenter quality improvement projects as well as gain from having senior members from other institutions perform a site visit to examine our processes and suggest ways that we can improve at MUSC.

THE PEDIATRIC CARDIAC ANESTHESIA SECTION AT MUSC IS ENROLLING AS A PARTICIPANT IN THE CCAS/STS

Children with congenital heart disease are considered “high risk” to undergo anesthesia procedures. Despite the higher risk, the rate of serious adverse events is too low at any one center to deliver meaningful data regarding causality and associations. The Congenital Cardiac Anesthesia Society (CCAS) and the Society of Thoracic Surgeons (STS) worked jointly to create a multicenter database to objectively measure pediatric cardiac anesthesia practice patterns and the outcomes which result.

MUSC will participate in this database very soon. Enrollment in the database has required the Medical Center’s commitment of money and resources, which were negotiated with Danielle Scheurer, MD, the medical director for quality. Participation in this database is considered by many observers (US News and World Report) to be an institutional indicator of quality and safety.

When data collection begins, each patient undergoing a surgical procedure performed by the pediatric cardiac surgeons will have 8 pages of anesthetic specific data submitted which comprises more than 200 discrete data items. Collection of this extensive data set for each patient will require ongoing effort and commitment by each pediatric cardiac anesthesiologist, CRNA, the chairman, and the project abstractor.
THE PEDIATRIC CARDIAC ANESTHESIA SECTION AT MUSC IS ENROLLING AS A PARTICIPANT IN THE CCAS/STS NATIONAL DATABASE CONTINUED …

Additional details regarding the database can be found here:

http://www.ccasociety.org/STSdatabase/index.iphtml

Here are some the adverse event data reported thus far nationally:

1. None/Missing – 27,284 (98.1%)
2. Any Event – 542 (1.9%)
3. Airway – Total 338 (1.2% of total, 62% of events)
4. Unexpected Respiratory Arrest – 13
5. Unexpected Difficult Intubation – 89 (0.3%)
6. Stridor – 39 (0.1%)
7. Unplanned Extubation – 17 (0.1%)
8. Airway injury – 14 (0.1%)
9. Vascular Injury/Line Related – 203 (0.7%, 37% of events)
10. Arrhythmia requiring Tx with CVL – 8
11. Myocardial Injury with CVL – 0
12. Vascular Injury w CVL (Bleeding) – 22 (0.1%)
13. Vascular Access Issues (unable to obtain desired access within one hour of induction) – 111 (0.4%)
14. Hematoma – 11
15. Inadvertent Arterial Puncture – 50 (0.2%)
16. Intravenous/Intra arterial Air Embolus 1
17. Regional Anesthesia Related – 1 bleeding @ site
18. Drug Related Events – 68 (0.2%, 12.5% of events)
19. Anaphylaxis/Anaphylactoid Reaction 23 (0.1%)
20. Medication Administration (Wrong Drug) – 14 (0.1%)
21. Protamine Reaction requiring treatment – 22 (0.1%)
22. Cardiac Arrest Unrelated to Surgery – 52 (0.2%)
23. TEE – Related – 55 (10.1% of events)
24. Esophageal Bleeding/Rupture – 10
25. Extubation – 9
26. Airway Compromise w TEE – 36 (0.1%)
27. Neurologic Injury – positioning related 12

The relationship between particular anesthetic practices and outcome in pediatric cardiac anesthesia has not yet been published using the database. MUSC’s outcome data in pediatric cardiac surgery is among the best obtained anywhere worldwide. I am very proud that we will be participating in a database that will make pediatric cardiac anesthesia care safer for all patients!
ASA FAER SCHOLAR: MARC MCLAWHORN, MD

The Society for Neuroscience in Anesthesiology and Critical Care (SNACC) conference started with a special track for FAER residents concentrating on developing successful clinical research led by Dr. William Lanier, a neuroanesthesiologist, who is currently the editor and chief of Mayo Clinic Proceedings. We were taken step by step from developing and designing a study to gaining funding from the NIH and other organizations. While this was the primary emphasis of the first half of the meeting, there was also an emergency neurologic life support workshop that went over protocols for neurologic emergencies such as stroke, seizure, intracranial hypertension, and brain/spinal cord injuries for management in the ICU and perioperative settings. The second day focused on neuroscience issues in emergence from anesthesia and intraoperative catastrophes.

A beneficial part of this program is that we are matched with a mentor. I was paired with Dr. Michael Luke James from Duke who, in addition to finishing both neurology and anesthesiology residencies, has completed fellowship training in both neuroanesthesiology and neurocritical care. He spent some time growing up in New Orleans and took me to lunch at some of his favorite places. We went through career planning, and he invited me to spend 3-4 days at Duke later this year to work with him splitting time between the OR and ICU.

Finally, at the start of the ASA, we had a FAER dinner where we attended a talk on leadership in medicine by Dr. Colleen Koch, the Department Chair of Anesthesia at Johns Hopkins University. I am very appreciative of the experience and feel the subspecialty meetings at FAER offer insight into areas of anesthesia that residents might be interested in, along with the abundance of educational presentations at the ASA. I’d like to thank the department for the opportunity to attend this conference.

INVITATION TO PEDIATRIC CATH CONFERENCE
BY: SCOTT WALTON, MD

What is the Pediatric Cath Conference? If you want to learn about congenital heart disease and its treatment, in interesting one-hour chunks, you should attend the pediatric cardiac multidisciplinary surgical planning conference (AKA cath conference). The conference is held every Monday afternoon from 3:30 - 4:30 pm in the Pediatric departmental classroom.

Attending the conference are pediatric cardiologists, pediatric cardiac surgeons, pediatric cardiac anesthesiologists as well as the fellows, sonographers, PAs, and ANPs. The upcoming scheduled surgical cases are discussed in turn. Each patient is presented with a clinical vignette, pertinent imaging, and cardiac catheterization data. A group discussion is then conducted to arrive upon an optimal surgical treatment plan. If there is a significant likelihood of complications, these are discussed along with strategies for risk reduction.

The conference is primarily designed to assure that the patient receives optimal surgical and perioperative care. The entire care team becomes simultaneously aware of the planned surgical treatment, expected results and risk concerns. This environment is optimal for education. Perspectives from many disciplines are presented and more than 100 years of pediatric cardiac care experience goes into the planning of each patient’s care.

Please speak with Marc Hassid or me if you are interested in attending. You will be amazed at the effort and expertise that goes into planning each pediatric cardiac surgical procedure! Additionally, you will learn about congenital cardiac disease, surgery, physiology, imaging, risk stratification, risk reduction and perioperative care.
The first time Shelly Waters met Moonwatcher Records’ owner, Joe Taylor, she found herself facing an impromptu audition. The veteran producer had heard Waters’ demos but needed to hear the voice devoid of home-production trappings. So he said, “play something for me and sing.” Waters briefly flashed back to judging panels at youth beauty pageants, but quickly complied. “She got two bars out and that was enough,” recalls Taylor, who signed on to produce Waters’ Moonwatcher label debut, “Drive.” “For me her voice has that indefinable ‘it factor.’ I don’t know how else to describe it. She’s got what Shawn Colvin, Emmylou Harris and other great, iconic singers have—a voice with such distinctive character that you can easily recognize it.”

The uniqueness of Waters’ voice may have something to do with the twists and turns of her story. From a childhood in south Louisiana Cajun country to her Southeast coastal lifestyle today, there’s a lot of life in the songs Waters writes and sings. When asked to name influences she runs down a list of names drawn from country, rock and Americana, but then she gets a little antsy. “I never wanted someone to hear me in concert and say ‘wow, you sound just like so-and-so,’ she says. “I’m Shelly, that’s who I am.”

Waters’ songwriting mines experiences for universal emotions. Inspired by a tiny bird that perched on her boat while she was miles out to sea, “Need To Rest” uses the metaphor to point to life’s little resting places. “Drive” is a poignant seize-the-day reminder, inspired by a never taken father-son road trip and a personal metaphor for Shelly’s revitalized musical journey. “Little Old House” conjures up childhood memories of a simple, humble upbringing.

The songs are rootsy, soulful and catchy, with “great hooks,” as Taylor notes, while Waters’ sultry voice smolders at the center of the mix. It’s truly impossible to put “Drive” in one stylistic camp, owing to Waters’ gumbo of disparate influences. Both “Reaching for You” and “One and Only” (an homage to Patsy Cline) hearken back to the “swamp pop” of Waters’ upbringing—a regional subgenre perhaps best known for Phil Phillips’ 1959 hit “Sea Of Love” (later covered by Robert Plant and the Honeydrippers).

On the other hand, “State Line” is mid-tempo rock with just the right touch of funkiness, while “She Waits” is a storytelling, acoustic-based ballad comparable to any big Nashville hit. While there may be resonances with other iconic female singer/songwriters (both Emmylou Harris and Lucinda Williams come to mind) the product is “pure Shelly,” and a product of her undeniable creativity and soul.

In bringing her musical vision to life Waters has been assisted by a merry cohort of copacetic sidemen, from Grammy-nominated Joe Taylor (who lends his formidable guitar skills) to well-known session pros Randall Bramblett (Widespread Panic, Bonnie Raitt) on Hammond B3 and Rhodes piano, Blair Shotts (Rihanna, The Roots) on drums, and Sean O’Bryan Smith (Keith Urban, Lady Antebellum) on bass. Famed New York City recording engineer Mark Richardson (Alchematic Productions) captured the sound at Salt Creek Recording Studio and Grammy winning mix/master engineer Chris Theis (Theis Mix) put the final touches on the project.

Perhaps as a testament to Waters’ writing, singing and musicianship, these respected musicians are leaving the cozy confines of their usual studio habitats to hit the road with Shelly, playing dates that include shows with Loretta Lynn and Hooray For The Riff-Raff. “These players just love Shelly,” Taylor enthuses.
DAY OF CARING, NOVEMBER 14, 2014

Drop Box Locations:
1. SEI, 3rd Floor
2. Children’s Hospital 5th Floor Office Lobby
3. RT, Women’s OR Lounge
4. ART, 4th Floor

Any Monetary Donations Please Give to Michele King, SEI, 3rd Floor, Room 302

RESIDENCY INTERVIEW PREP
ANESTHESIA EMERGENCY MANUALS

Dear All,

The Perioperative Emergency Manuals are now in the operating rooms and peripheral sites. The manuals should be located on the Anesthesia Pyxis Workstation or near it.

When you are in the ORs or NORA sites, please take a moment to locate and browse through it. It covers many perioperative emergencies and can be very valuable should one of these events occur. It can also be used as a teaching tool when you are discussing one of these topics. I want to point out that the first page in the manual is a list of emergency and frequently called phone numbers.

I want to thank Michele King, Kim Crisp, Katie Smith, and the Anesthesia Tech team for assisting with this project.

Please feel free to send any comments, suggestions or questions my way.

Laura Roberts MD

MEET THE NEW ANESTHESIA TECH
SHANTA JAGER

Shanta began working at MUSC in 2003, with George Chajewski, in Dietetic Services/Catering and decided to enroll in Miller Motte Technical College to become a Surgery Technologist. After graduating with an Associate Degree, Shanta started working in Sterile Processing at Ashley River Tower. After working at ART for two years, she then started traveling as an instrument technician in hospitals throughout the state. Shanta has now returned home to MUSC trying something new in order to broaden her knowledge in the field of Anesthesia.
RESEARCH CORNER:
FOCUS: THE SOCIETY OF CARDIOVASCULAR
ANESTHESIOLOGISTS’ INITIATIVE TO IMPROVE QUALITY
AND SAFETY IN THE CARDIOVASCULAR OPERATING ROOM

FOCUS: The Society of Cardiovascular
Anesthesiologists’ Initiative to Improve Quality
and Safety in the Cardiovascular Operating Room

Atilio Barbeito, MD, MPH,* William Travis Lau, MD,† Nathaen Weitzel, MD,‡
James H. Abernathy, III, MD, MPH, FASE,§ Joyce Wahr, MD, FAHA,¶ and Jonathan B. Mark, MD,*

The Society of Cardiovascular Anesthesiologists (SCA) introduced the FOCUS initiative (Flawless Operative Cardiovascular Unified Systems) in 2005 in response to the need for a rigorous scientific approach to improve quality and safety in the cardiovascular operating room (CVOR). The goal of the project, which is supported by the SCA Foundation, is to identify hazards and develop evidence-based protocols to improve cardiac surgery safety. A hazard is anything that has the potential to cause a preventable adverse event. Specifically, the strategic plan of FOCUS includes 3 goals: (1) identifying hazards in the CVOR, (2) prioritizing hazards and developing risk-reduction interventions, and (3) disseminating these interventions. Collectively, the FOCUS initiative, through the work of several groups composed of members from different disciplines such as clinical medicine, human factors engineering, industrial psychology, and organizational sociology, has identified and documented significant hazards occurring daily in our CVORs. Some examples of frequent occurrences that contribute to reduce the safety and quality of care provided to cardiac surgery patients include deficiencies in teamwork, poor OR design, incompatible technologies, and failure to adhere to best practices. Several projects are currently under way that are aimed at better understanding these hazards and developing interventions to mitigate them. The SCA, through the FOCUS initiative, has begun this journey of science-driven improvement in quality and safety. There is a long and arduous road ahead, but one we need to continue to travel. (Anesth Analg 2014;119:777–83)

Please Click Here to View Full Article Online

NEW BABY IN THE DEPARTMENT

Congratulations Josh Terry, MD
Stella Kate Terry
Born October 22, 2014 at 4:37pm
7 lbs, 13 oz, 19.5 inches
HISTORY OF ANESTHESIOLOGY AND MEDICINE

Recently, a lot has been written about the top discoveries that have shaped our specialty. Over the months ahead, I hope to highlight some of the great achievements and discoveries in anesthesiology and surgery. If possible, the original manuscripts and/or news articles will be cited. These original reports are insightful in putting into context what was thought about each event at the time. They are almost like time capsules fixing the historical moment. I would welcome your input into the discoveries and advances chosen. We will start with a monumental 1963 article in JAMA identifying the value of a preoperative visit.

The Value of the Preoperative Visit by an Anesthetist

A Study of Doctor-Patient Rapport

Lawrence D. Egbert, MD, George E. Buttit, MD, Herman Turndorf, MD, and Henry K. Beecher, MD, Boston

The psychologic effect of the preoperative visit by an anesthetist has been compared with the effect of pentobarbital for preanesthetic medication. Patients receiving pentobarbital 1 hour before an operation became drowsy but it could not be shown that they became calm. Patients who had received a visit by an anesthetist before operation (informing them about the events which were to occur on the day of operation and about the anesthetic to be administered) were not drowsy but were more likely to be calm on the day of operation. The importance of the preoperative visit probably explains, in part, the difficulties previous investigators have had in showing sedative effects from barbiturates and narcotics before operation. The tremendous emotional significance to a patient of illness or an operation may explain why physicians are able to exert such influence upon their patients.

For years anesthetists have interested themselves in various combinations of narcotics and hypnotics in order to prepare their patients emotionally for operations. Surprisingly few authors have mentioned the possibility that the personalities of the surgeon, the anesthetist, or the ward personnel might have important effects in this preparation. For that matter, we have been unable to find any study demonstrating the assumed effect of a doctor-patient relationship. Little time is available for anesthetists to establish rapport with their patients; this short time, however, has permitted a controlled study to demonstrate the emotional benefit gained by patients from talking with their physicians.

Methods and Results

We have evaluated the psychologic condition of 449 private patients comparing the value of the preoperative visit of an anesthetist with the value of pentobarbital sodium in 218 patients, and then comparing the effects of two types of preoperative visit in 231 patients. The study included patients for most types of elective operations. Children under the age of 14 were excluded as well as were patients who did not speak English, psychotic patients, and patients scheduled for intracranial operations. Just before induction of anesthesia, a nurse technician interviewed each patient and recorded whether or not the patient felt drowsy, relaxed, or nervous; the technician also recorded his opinion about the patient’s appearance of drowsiness or anxiety. A general comment was made as to whether the patients’ preoperative psychologic condition was considered to be adequate or not adequate. The interviewing technician was unaware of both the type of preanesthetic medication which had been administered (except that all patients had received 0.4 mg to 0.6 mg of atropine intramuscularly about 1 hour before operation) and the nature of the preoperative visit. The patients were not informed that we were conducting a study.

1. Comparison of the Preoperative Visit with Pentobarbital (218 Patients).—Ward rounds were made for all patients on the afternoon before operation. In random order, approximately 22% of the patients received 2 mg/kg of body weight of pentobarbital sodium ordered to be administered intramuscularly 1 hour before operation the next day (44 patients). Sixty-two patients were visited by an anesthetist who discussed the patient’s condi-
HISTORY OF ANESTHESIOLOGY AND MEDICINE CONTINUED ...
THE DOCTOR PATIENT RELATIONSHIP.

The doctor patient relationship is the heart of the art
Of the practice of Medicine and all of its parts.
Without it we are naught but clerks of a sort
Whom you see even now in socialized marts.
So I pray to you all, save us from mort
Of our honored profession and its high veneration.
Individually perpetuate its stature forever
By always respecting the doctor patient relation.

—ROBERT LOUIS STEVENSON
EYEWEAR COMPLIANCE RE-AUDIT RESULTS

Recently the 4 anesthesia and surgical locations on campus underwent an eyewear compliance audit. There is room for improvement with all of us. It is important that we protect ourselves from accidental splashes.

<table>
<thead>
<tr>
<th>Site</th>
<th># Cases</th>
<th># Observed</th>
<th># Compliant</th>
<th>% Compliant by Site</th>
<th># Noncompliant</th>
<th>% Noncompliant by Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main</td>
<td>113</td>
<td>779</td>
<td>686</td>
<td>88.06%</td>
<td>93</td>
<td>11.94%</td>
</tr>
<tr>
<td>ART</td>
<td>45</td>
<td>267</td>
<td>248</td>
<td>92.88%</td>
<td>19</td>
<td>7.12%</td>
</tr>
<tr>
<td>RT</td>
<td>48</td>
<td>275</td>
<td>251</td>
<td>91.27%</td>
<td>24</td>
<td>8.73%</td>
</tr>
<tr>
<td>APC</td>
<td>20</td>
<td>108</td>
<td>108</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>226</td>
<td>1429</td>
<td>1293</td>
<td>90.48%</td>
<td>136</td>
<td>9.52%</td>
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</table>

Rate of Noncompliance by Role by Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Anesthesia Attending</th>
<th>Anesthesia Resident</th>
<th>CRNA</th>
<th>Surgeon</th>
<th>Surgery Resident</th>
<th>Circulator</th>
<th>Scrub</th>
<th>Med/Anesth Student</th>
<th>Perfusion</th>
<th>Other</th>
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<tbody>
<tr>
<td>Main</td>
<td>13.98%</td>
<td>20.43%</td>
<td>10.75%</td>
<td>10.75%</td>
<td>5.38%</td>
<td>19.35%</td>
<td>3.23%</td>
<td>6.45%</td>
<td>4.30%</td>
<td>5.38%</td>
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<tr>
<td>ART</td>
<td>5.26%</td>
<td>15.79%</td>
<td>0%</td>
<td>36.84%</td>
<td>21.05%</td>
<td>5.26%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>15.79%</td>
</tr>
<tr>
<td>RT</td>
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<td>0%</td>
<td>12.50%</td>
<td>41.67%</td>
<td>8.33%</td>
<td>8.33%</td>
<td>4.17%</td>
<td>8.33%</td>
<td>0%</td>
<td>16.67%</td>
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<tr>
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<td>0%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Total</td>
<td>10.29%</td>
<td>16.18%</td>
<td>9.56%</td>
<td>19.85%</td>
<td>8.09%</td>
<td>15.44%</td>
<td>2.94%</td>
<td>5.88%</td>
<td>2.94%</td>
<td>8.82%</td>
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Excluding APC

<table>
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<th>Site</th>
<th>% Compliant by Site</th>
<th>% Noncompliant by Site</th>
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</thead>
<tbody>
<tr>
<td>Main</td>
<td>97.27%</td>
<td>2.73%</td>
</tr>
<tr>
<td>ART</td>
<td>95.19%</td>
<td>4.81%</td>
</tr>
<tr>
<td>RT</td>
<td>89.09%</td>
<td>10.91%</td>
</tr>
<tr>
<td>Total</td>
<td>95%</td>
<td>5%</td>
</tr>
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</table>

Including APC

<table>
<thead>
<tr>
<th>Site</th>
<th>% Compliant by Site</th>
<th>% Noncompliant by Site</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>RT</td>
<td>89.09%</td>
<td>10.91%</td>
</tr>
<tr>
<td>APC</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>95.45%</td>
<td>4.55%</td>
</tr>
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</table>
GRAND ROUNDS FOR THE MONTH OF NOVEMBER

“Update on Carotid Surgery”
November 4, 2014
Thomas Brothers, MD
Professor
Vascular Surgery
Medical University of South Carolina

“Anesthesia Medically Challenging Case Conference”
November 11, 2014
Kassandra Gadlin, MD and Jermale Sam, MD
Residents
Medical University of South Carolina

“The Impaired Physician”
November 18, 2014
Diana Mullis, MD
Assistant Professor
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina

“The Risks of Surgery in Patients with Liver Disease”
November 25, 2014
Adrian Reuben, MBBS
Professor
Clinical Hepatology and Liver Transplantation
Medical University of South Carolina
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!!

Helen Harmon, CRNA; James Comley, CRNA; and Brian Wright; Anesthesia Tech: Helping me start a case with a difficult airway! Thank you!

Check out our website at: HTTP://WWW.MUSC.EDU/ANESTHESIA

Future Events/Lectures

Intern Lecture Series
20/Nov—Ventilator Management, Dr. Hand
CA.ls
5/Nov—Cardiovascular Physiology & Anesthesia, Dr. McSwain
12/Nov—Anesthesia for Patients with Cardiovascular Disease, Dr. Heinke
CA-2/3s
3/Nov—Anesthetic Management for Carotid Surgery PBLD (Barash Ch. 42), Dr. Nelson
10/Nov—Chronic Medical Problems and Management in Vascular Surgery Patients PBLD (Barash Ch. 42), Dr. Guldan
17/Nov—Adrenal Dysfunction PBLD (Stoelting Ch. 16), Dr. Sabbagh
24/Nov—Minimizing Complications in ICU PBLD (Barash Ch. 56), Dr. Field

Grand Rounds
4/Nov—Update on Carotid Surgery, Dr. Brothers (MUSC)
11/Nov—Anesthesia Medically Challenging Case Conference, Drs. Gadlin and Sam
18/Nov—The Impaired Physician, Dr. Mullis (MUSC)
25/Nov—The Risks of Surgery in Patients with Liver Disease, Dr. Reuben (MUSC)

Christmas Party: Friday, December 12, 2014
Carolina Yacht Club at 7:00pm

Sleepy Times

November 2014 Standard of the Month

Refrain from speaking negatively about others who are not present.

We Would Love to Hear From You!
If you have ideas or would like to contribute to Sleepy Times, the deadline for the December edition will be November 21, 2014.