

in this study. Others have reviewed professionalism issues related to computer and social media use.^{12,13}

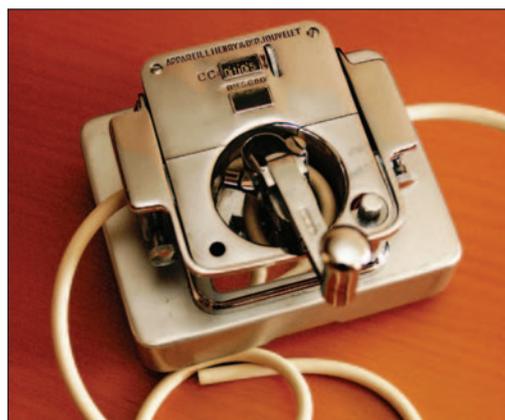
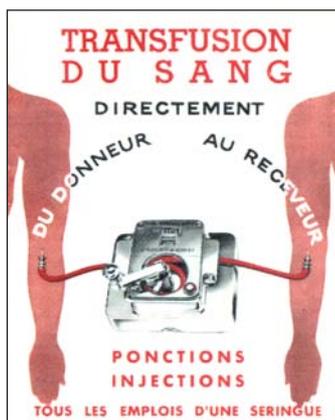
In summary, anesthesia providers spent sizable portions of case time performing non-record-keeping applications on AIMS workstations. This use, however, was not independently associated with greater hemodynamic variability or aberrancies in patients during maintenance of general anesthesia for predominantly general surgical and gynecologic procedures. Future work may further investigate the clinical impact of computer workstation (or other electronic device) usage, or address the appropriateness of non-record-keeping activities in an analysis of the professionalism of anesthesia care teams during patient-care activities.

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ANESTHESIOLOGY REFLECTIONS FROM THE PIERRE VIARS MUSEUM

The Henry and Jouvelet Transfusion Apparatus 1934



This apparatus was created in 1934 by Dr. P. Jouvelet and Dr. L. Henry to enable blood transfusion "from arm to arm," from the donor to the receiver. The *left panel* shows a contemporary advertisement written in French: *Blood transfusion directly from the donor to the receiver: withdrawal and injection, using a single syringe*. The risk of clotting was very limited and there was no possibility for air entry. A flow counter (in cc) provided the total amount of blood transfused. From 1950 to 1975, it was an essential tool of the French anesthesiologist in the operating room, not for direct "arm to arm" blood transfusion but as a rapid infusion and/or transfusion device. The rate depended on the manual rotation velocity through the handle. This apparatus became electrically driven but this increased the risk of air embolism when the infusion vial was empty. This is the reason why an air detection device located in the output intravenous line was introduced.

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