MESSAGE FROM THE CHAIRMAN
-SCOTT REEVES, MD, MBA

December is my favorite month of the year. It is a time for family and friends as we celebrate the holidays and the year’s end. It is also a time for personal reflection. As we typically over eat and indulge our children with two many presents, it is all too common for me to think about what I am doing to make the world a better place. Am I just a consumer or do I actually give back? I think many at MUSC are contemplating that very question. One area in which we can give back is global health. Matt McEvoy and Rob Bartlett were our first faculty and resident team to travel to our sister hospital in Mwanza, Tanzania. They were very well received, and the faculty at Bugando Hospital as well as all of us got a glimpse of the great opportunities available through a collaborative relationship.

Our involvement in Tanzania clearly follows the 2010-2015 MUSC strategic plan, Changing What’s Possible. Our president, Dr. Raymond Greenberg, laid out MUSC’s vision for the next five years.

Vision Statement: The Medical University of South Carolina strives to:

- Provide an excellent, collaborative education to our students
- Deliver the highest quality, state-of-the-art patient-centered care
- Be a world leader in the creation of new knowledge and its application
- Serve the health care needs of the citizens of South Carolina while expanding outreach to people throughout the world.

Mission Statement: Improve health and maximize the quality of life through education, research and patient care.

With our Vision and Mission statements in mind, a strategic plan was organized for the next five years around four overarching themes:

- Interprofessional/Interdisciplinary Collaboration
- Entrepreneurialism
- Technology/Innovation
- Globalization

This edition of Sleepy Times will highlight MUSC’s strategic plan around globalization and our involvement to date. In future editions the other three areas will be discussed. For a complete review of the MUSC strategic plan please see, www.musc.edu/strategicplan.

As we all prepare for the holidays, I challenge you to consider the question. Who will we send? Who will answer, SEND ME?
The faculty, staff, and trainees at MUSC are currently actively engaged in collaborative global partnerships in the areas of education, public health, clinical care, and research. To date, our globalization efforts have improved the quality of life of individuals locally, nationally, and globally, provided valuable skills and knowledge to participants, generated scientific evidence, created additional revenue, enhanced our ability to recruit students, fellows, residents and faculty who share an interest in global health, and elevated the reputation and visibility of the Medical University worldwide.

Our students benefit from exposure to and participation in global efforts. In order to build on these achievements and to capitalize on the diverse opportunities available to expand our global efforts, MUSC has chosen to make globalization a strategic priority. Becoming a more comprehensive global resource will require a university-wide cultural shift. In keeping with cultures around the world, this shift will require a strong family centered culturally sensitive focus with keen attention to closing the gap on health inequities and an understanding of human needs across the age span. University personnel may require an increased awareness of the benefits of the global focus, training in techniques, policies, and procedures to expand their work to global entities, and support to carry out their work in near and distant environments in ways that require creative thinking.

**Objective 1. Build an infrastructure that supports collaboration, coordination, and a commitment to sustainable globalization activities highlighting the unique strengths of MUSC.**

**Strategies**

A) Elevate the existing Center for Global Health in the College of Medicine to a University Center for Global Health in order to facilitate and coordinate interprofessional/interdisciplinary global initiatives on campus. This will require the engagement of an experienced leader in global health to develop a sustainable business plan. The following are specific goals and activities to be achieved by the Center:

I. Coordinate the global health resources at MUSC and disseminate MUSC global health outcomes

- Conduct and maintain an inventory of global activities in the university
- Connect relevant resources to achieve synergy and reduce redundancy
- Identify and understand the needs of global and local partners
- Identify successful models in existence internally and externally, and explore the use of these models
- Collect and disseminate outcomes related to global health activities across the enterprise
- Coordinate university response to global health crises
- Serve as a resource for training and project management

II. Develop creative, sustainable funding sources for global health initiatives

- Develop Collaborations with private, nonprofit and philanthropic business partners for economic development for global health initiatives
- Support MUSC faculty, staff and students in the production of proposals for research, programs, and philanthropic funding
MUSC STRATEGIC PLAN 2010-2015—GLOBALIZATION CONTINUED...

Strategies

B) Advance the culture of the university to embrace global initiatives

- Incentivize MUSC academic and clinical entities to encourage recruitment and retention of faculty, staff and trainees with global interests
- Incentivize and reward faculty, staff and trainees for participation in global initiatives
- Incorporate global activities into performance evaluations when appropriate
- Broaden promotion and tenure criteria to include global activities as optional criteria
- Increase global perspectives in health language and culture with the university

Objective 2. Position MUSC to be recognized as a leader in global health initiatives

Strategies

- Integrate global health education into MUSC curriculum
- Support the outreach of education, specialized clinical services, and research globally
- Promote education about global health at local and global levels
- Develop collaborative agreements with other top global health centers
- Promote research on health inequalities, disparities and social determinants in health
- Promote evidence-based interventions that reach underserved populations
- Build collaborations with other institutions and communities across South Carolina

MUSC—Changing What’s Possible Around the World
This past September I had the opportunity to return to Haydom, Tanzania with the Madaktari Program. This trip was special for many reasons. I had the opportunity to see where and how the Madaktari program originated. In addition, I had the fortune of making this trip with several other MUSC physicians: Drs. Dilantha Ellegala and Sunil Patel from the Neurosurgery department, Dr. Del Schutte from Orthopedics, and Drs. Eric Powers and Peter Zwerner from Cardiology. I described my trip to many as a week spent at a medical church camp. We stayed in hospital housing with the visiting Norwegian physicians, nursing students and medical students. We ate all of our meals together, attended morning medical rounds, went to the daily sala or church service, and conducted radiology rounds together. I even managed to change a few dirty diapers at the hospital orphanage. The rest of our time was involved in patient care where I spent an entire day with the anesthetists doing cases with Dr. Schutte. Several days were spent seeing patients and teaching the medical students and neurosurgeons how to do a preoperative evaluation for neurosurgical patients. Together, Dr. Patel and I helped them do their first thoracic laminectomy. I also taught them how to do an epidural steroid injection under fluoroscopy, which required a little “MacGyvering,” but in the end the patient felt better than she had in years. Drs. Powers and Zwerner were all over the hospital with their handheld ultrasound diagnosing structural heart diseases and changing management. Getting to visit their hospital, participate in taking care of their patients, and teach them how to use what they have to practice better medicine was a privilege. What made this trip unforgettable was that I was able to do this while getting to know and work with MUSC colleagues. I am even more inspired to continue our involvement in Madaktari because not only will we be helping the people of Tanzania, but we might also be making healthcare at MUSC better by building relationships with other departments.
Rob Bartlett and I travelled to Mwanza, Tanzania in October and November of this year. Rob was there for a month and I was there for two weeks. While there, we picked up on the great work that Carlee Clark had previously done, and the story continued…. I will try to capture some snapshots for you, and I am afraid that you will see some snapshots of me in Rob’s account of our trip!

Bugando Medical Center is a 900-bed tertiary care hospital that sits atop the highest hill in Mwanza overlooking the beautiful Lake Victoria. However, the hospital in picture is contradistinction to the natural surrounding, as you will find 2-3 patients in many of these 900 beds! There is no such thing as a ‘maximum capacity’ alert for Bugando. The surgical population at Bugando normally has very advanced disease, which occurs for several reasons. First, the access to healthcare in Tanzania is very poor. There are tremendous socioeconomic barriers and just paying for travel to the hospital is prohibitive for many families in outlying villages. Second, most of the patients with a palpable mass or significant symptomatology go to the traditional healer first (essentially a witch-doctor). During these visits, the patients often receive burns or cuttings over their body. They then wait for weeks, months, or years before seeking help at Bugando after the incantations have failed. Thus, patients often present with very advanced disease that places them at greater perioperative risk.

There is a nurse anesthetist school at Bugando, which is headed by Dr. Matasha. Each class has roughly 10 students and the coursework lasts for 12 months. Carlee talked about the daily routine previously. In short, the goal is to have pre-op rounds in which all of the cases and case plans are presented to Dr. Matasha. The students then spend the day in the OR with the senior anesthetists; and, there is a goal to have a didactic curriculum in place, but this does not appear to happen regularly. Our department will have a huge opportunity for impact in this aspect of education. The opportunities for teaching are unlimited. I am excited that we will have an ongoing ACGME-approved rotation for our CA-3’s, and I hope that residents, faculty, and CRNAs in our department can be a part of our continued presence there. I think that Rob can say that he learned a ton about teaching and learning in a cross-cultural setting!

Speaking of that, Rob did an excellent job with the lectures that we had planned for him to give. Of course, one of the main things that is needed on adventures like this is flexibility and patience. So, while we went with a teaching plan in hand, only a portion of it was executed. Rob and I would talk each afternoon about what we had observed that day as the real learning needs, and he often spent long hours at night re-working (or creating de novo) his PPT presentations for the students. Rob was already an excellent teacher, but he advanced even further in his teaching skills while there. His teaching actually led to practice change in monitoring by the end of the month!
Again, I am excited by the educational opportunities at Bugando. Rob’s efforts are reflective of what can happen as our department makes a concerted effort over the next 5-10 years at Bugando. (For a vision of where we can be headed, read Peters JL, et al. Anesthesia Teaching in Ghana: A 10-Year Experience. Intl Anesthes Clin, 2010; 48:23–37) There are only 2 nurse anesthetist schools in Tanzania, a country of 40 million people! Thus, the graduates there will treat a vast population of people in need.

The stories that we could tell, the memories that we collected, and the friends that we made are precious. From the 4 year-old in tamponade with a septic pericardial effusion to the 45 year-old lady with a 17 kg uterine mass(!!!) to the patient with tetanus and a massive PE in the ICU, the medical care is challenging in a very resource-limited environment. The memories of learning to use the E.M.O. machine (and getting anesthetized at the same time!), learning a better position for spinals, and experiencing multiple, likely preventable perioperative deaths makes a multi-colored collage for reflection. Finally, the faces and smiles of the lovely Tanzanians who give their best each day and are eager to learn caps off the experience. At the end of the day, and in this season of thanksgiving, it is good to be reminded that human beings are created with intrinsic worth and that it is a blessing to be in medicine, a profession of service with challenges and blessings that are rarely experienced elsewhere in life.

As we look to the future at Bugando, I am excited about our partnership. As mentioned, the educational needs are great from pre-op to the OR to the PACU. However, I believe that an improved educational program can lead to low-cost, sustainable changes in the healthcare system that will have lasting effects for years to come. And now, a parting thought…I think that in this time of economic stress and need for cost-consciousness, we could learn a lesson from Bugando Medical Centre about how to brand healthcare at MUSC?
It has been two weeks since I returned from Tanzania. Every day I am confronted with situations that take me back to my time at Bugando Medical Center. These are especially evident as I work within an American medical system that is touted as the best in the world with what seems to be unlimited resources and skilled practitioners. Anesthesia in particular has become one of the safest specialties thanks to expensive resources like improved drugs, monitors and equipment. Operating within this American model it is often easy to forget that we are fortunate compared to the rest of the world.

The Bugando Operating Theatre is located on the second floor of a nine story 900 bed referral hospital. The monolithic structure is perched ominously atop a hill overlooking the Mwanza town and scenic Lake Victoria. Inside the OR, it is composed of six rooms with windows to the outside air. Each has a relatively new Datex Ohmeda machine and monitor, but is supplied with only oxygen, halothane gas, and exhausted CO₂ absorbent. The ET tubes, monitors, and circuits are reused between cases. Initially the task of developing an anesthesia program with these limited resources can seem daunting. After being in Africa for a period of time you start to remove yourself from an American medical model of unlimited resources, and begin to focus on the one resource that can be changed, even with the 50kg transatlantic baggage weight limit.

Bugando has a team of one anesthesiologist, 14 senior nurse anesthetists, and 10 nurse anesthesia students who each have varying degrees of training in medical knowledge. Over the one month of time spent there, it was obvious that this lack of knowledge leads to a wide range of anesthetic quality and vigilance. This is where our department has the opportunity to send residents and faculty to bring basic anesthesia knowledge and safety to the Bugando Theatre as resources are slowly making their way into Africa. We have the opportunity to ensure that when they arrive, the Anesthetists of western Tanzania have the knowledge to put them to good use.

Bugando Hospital, overlooking the town of Mwanza
Subject: First weekend

Carlee and Dr. Reeves,

Thanks for the hints. There are two Cornell residents and one Dartmouth med student currently at Bugando. They seem to be great and are going to make this a fun experience. On Friday we went to a lecture on the relationship between STI's and HIV that was given by a visiting professor of epidemiology from London School of Hygiene. It was a very informative evidence based lecture at a local research and epidemiology institute just outside of town. On Friday I got to the hospital around noon and just scratched the surface on meeting the anesthesia group, so tomorrow will be the big day. Of interest to you, the Cornell residents and Tanzanians had just finished running a code while Hilkka oriented me to the ICU that involved a 29 year old female who was POD 7 from Csxn. Apparently she had a rough perioperative course that included possible postpartum cardiomyopathy vs PE, and then finally some form of SIRS/Sepsis with respiratory failure. The code apparently was one of the few run here in some time. According to the residents it went fairly well with rhythm identification, cardioversion, and drugs (epi/atropine no amiodarone or Lido avail). The Cornell grads did feel the airway management was slow. Hopefully they can text us in the future if it looks to be a challenge and need/want some back up. The woman unfortunately died and an autopsy was performed on Saturday with no real answers except pulmonary congestion. Definitely highlighted some lack of resources. Apparently no chest films currently due to a lack of developer, and lab work is frequently either not submitted or lost after submission due to a very inefficient paper/human lab handling system. Will try to keep up at least once a week and maybe 2x per week.

Asante sana,

Rob

Rob and Matt on Safari in front of a Hippo Pond

Rob with an EMO ether vaporizer & Mr. Mkama, a senior Anesthetist
Tuesday, October 26, 2010 9:23 AM

Dear Department,

Rob and I have had an interesting day today. Carlee's presence here in the past made for great groundwork as we have begun to spend time in the hospital. Patients here are often very sick because surgical issues (particularly oncologic) are not found until they are present on physical exams (such as ovarian tumors, myomas, etc). Rob and I helped take care of a number of patients today. One patient was a 4 year-old girl named Rosa who had a huge pericardial effusion - most likely from Tb. She was anemic, HIV+, and had terrible splenomegaly. [One person mentioned that "at 4 years old she already had hospitalitis" from her many experiences with the healthcare system. She was an amazing and beautiful little girl who was calm and controlled, but showed a tremendous amount of fear behind her stoic eyes.] It was enjoyable to talk with the anesthetists and Dr. Matasha about how to induce and manage such a patient. Interestingly, the effusion was several hundred cc's - huge for a 12kg 4-year-old - but there was also a large amount of collagen in a fibrous collection around the heart. The surgeon said that this is typical for patients that are immunocompromised.

We also spent some time rounding in the ICU with several residents from Bugando as well as some folks from the U.S. This afternoon Rob gave a lecture on the basics of oxygenation and ventilation. He did a great job and was right on target for where the students are from a knowledge standpoint. They asked him to lecture every day that he could!

It has already been a great experience. Also, we went to Yoga last night on the southern beach of Lake Victoria with several of the folks here! I am sure that this will make most of you laugh. I know that I looked ridiculous and likely spoiled the peaceful hour for most people. Rob once lost his balance and fell into a nearby volleyball net. We are sore today, but it was fun!

Internet hear is slow and often doesn't work, but we will write as we can.

Blessings,

Matt
Subject: First OR day together

Carlee,

Thanks for the email. We found out from Matasha yesterday that they have a curriculum they would like us to follow. We will try to photocopy it and get it to you. Either the students were much more advanced by Feb or we have a different skilled batch. Right now we are just trying to tread water with the basics of oxygen in and CO2 out. It could be a language barrier but they have been fairly open in the OR setting and seem to have very little basic medical knowledge. This includes things like basic circulation and basic respiratory physiology. Will talk with Matt and we will be in touch. In other news.....Case in OR 3 today was a pericardial window on a 4 year old with symptomatic orthopnea/dyspnea. Case was a little rocky. We were able to convince them to IV induce with Ketamine over Propofol and attempt to maintain SV however pt did dip some and required a semi-urgent Left thoracotomy. Window revealed weird collagen accumulations throughout the pericardium that the Surgeon thinks are due to immune suppression and poor ability to granulate to a complete scar????? I guess better than the alternative which would have been good scar formation and terrible restrictive pericarditis. We have pictures and hopefully will bring back the echo. Hope all is well.

Rob
Hujambo,

Swahili greetings from Tanzania. Our first week is coming to a close in Tanzania and it has been packed with excitement, frustration, and every emotion in between. This experience is a wonderful lesson in both life and medicine. Tanzania is full of vibrant colors and people who are exceedingly welcoming and eager to share their culture. At the same time it is contrasted with the harsh reality that life is not always easy or fair in Tanzania, and unfortunately once admitted to the hospital it is often met with pain, suffering, and even death.

The OR’s at Bugando remain busy and perform a wide variety of surgical cases ranging from simple ENT, to Ortho trauma, to large Gyn Onc abdominal tumors, and even a thoracotomy. The case variety is remarkable considering their very limited resources. The senior anesthetists (comparable to our CRNA’s) perform all the cases here without the help of an MD and by in large do a good job with the resources. My personal project has been teaching ten Nurse Anesthetists students who are in their 1st month of training. Every day I gain more respect for my past teachers as I struggle to explain the concepts to a very eager group of students with varied backgrounds in medicine. With the wide range of Theatre (OR) cases there have been an equally wide range of anesthetic techniques. There are many areas that we can improve with our continued presence at this Hospital. Intraoperative monitoring and vigilance are variable and likely related to combination of a lack of knowledge about the monitors and their relation to physiology, and, in the case of the students, a sense of being overwhelmed by the OR setting. However, it is early in their training and every day we continue to make gains with increased routine utilization of capnography and pulse oximetry in both the OR and especially in the PACU. (The PACU is especially scary because at the end of cases, patients are taken to the PACU intubated and left on RA ETT until they open their eyes, at which time they are suctioned, extubated, and then taken to the wards without any consistent monitoring) Daily we see the remarkable resilience of the human body!

(continued on next page…)
The most interesting case of the week, beside the three 36 cm ovarian masses, occurred while I was lecturing. A Left Thoracotomy for achalasia was performed by the duo of Kimaro, one of the best anesthetists who have only 10 days of CT anesthesia training, and our own Matt McEvoy. Using a main-stemmed single lumen tube and pre-operative Paravertebrals (Matt) the young man flew through the anesthetic and woke up with good analgesia which is lacking considering most patients get limited (IV Demerol 50mg or Ketamine induction) or no analgesics until they reach the ward. Despite what we would consider inadequate analgesia, the patients are often very stoic and rarely complain of pain perioperatively (kind of a nice change from the states).

Outside of the OR life has been a similarly positive experience. Our evenings are spent working on lectures for the coming days and playing scrabble or doing Yoga with the medicine and pediatric residents from Cornell. Looking forward to continuing to share our experiences and hopefully excite others to join us in the future!

Kwahiri,

Rob

PS. Gabe I have several of the pictures that you requested of Dr. McEvoy doing Yoga. (pictured right)

Friday, November 05, 2010 9:44 AM

Week two in Tanzania

Hujambo,

Two weeks down and one to go. Dr McEvoy departed Tanzania yesterday after a wonderful two weeks of teaching and more importantly learning about the Anesthesia department and the challenges the anesthetists are faced with daily. This past week since I last communicated has provided a wide variety of experiences in culture, academics and tourism.

Our week started over the weekend with a whirlwind 24 hour trip to the Serengeti that served two purposes. First was to visit one of the greatest and largest game parks in all of Africa. The highlight of the trip was watching a male Cheetah stalk and kill a gazelle and then watch three lionesses corner a large Cape buffalo only to be defeated by the buffalo! The second reason for going on Safari was to avoid the presidential election that took place. The election was peaceful and to date the aftermath has been devoid of the bloodshed that plagued many of the past African elections.

Work this week has been slow but encouraging. I think the anesthetists are starting to get used to our faces and starting to ask more questions. This week I taught lectures on the Machine and monitors and on the autonomic nervous system. With each lecture the students seem to open up more with good questions. Hopefully that is a sign that my teaching is improving and that they are beginning to trust my experience and not that they understand me less.

(continued on next page…)}
PROJECT MADAKTARI:  
FIRST IMPRESSIONS OF MWANZA, TANZANIA FROM DRS. MATT MCEVOY & ROB BARTLETT

In the Theatre this week I have been involved in several challenging cases including a pyloric stenosis on an under-resuscitated 1 month old, an emergency exlap on a two year old with a 5 day old bowel obstruction and the beginnings of sepsis, and finally a 10kg mucinous ovarian tumor with 7 liters of mucinous ascites. Outside of the OR Matt and I were consulted by the medical ICU team to aid in the management of a patient with tetanus who acutely decompensated. Upon arrival we spent some time working on the 1970's-80's ventilator at the same time as we supported a falling blood pressure. We were able to borrow the hospital's sonosite and obtained a TTE image that showed a failing right heart and a hypercontractile, but empty, LV consistent with likely Large PE. Given the paucity of labs and imaging, absolute confidence in a diagnosis is difficult, but the clinical thought process to arrive at your diagnosis is a great reminder of how much we rely on this data in the US.

I will leave you with one thought before my halothane headache worsens to the point that I need nap (too much peds with no scavenging system). “The natural law of inertia: Matter will remain at rest or continue in uniform motion in the same straight line unless acted upon by some external force.” It feels good to be a part of that initial external force and know that, if continued by an enthusiastic group of attendings and residents, we could make an impact on Tanzanian anesthesia and patient safety under anesthesia. Unlike so many other failed NGO's that go in with a fat wallet and attempt to buy change in this continent, we can take the approach of providing knowledge and a consistent external presence that can mold future providers across Tanzania.

Cheers,

Rob

PS. Go easy on a jet lagged McEvoy and see everyone in a week.
The William W. L. Glenn lecture was established by the American Heart Association in 1989 in honor of Dr. Glenn, a pioneer cardiac surgeon who made important contributions to the treatment of congenital and acquired heart disease. Dr. Glenn was the first surgeon to hold the office of President of the AHA. Past recipients of this honor include Drs. William Norwood Jr., Denton A. Cooley, Sir Magdi Yacoub, Craig Miller, and Tirone David to name a few. This year’s presentation entitled “The Creation of Cardiac Anesthesiology,” was delivered by our very own Dr. Jerry G. Reves. Congratulations!!

AHA COUNCIL IN CARDIOVASCULAR SURGERY AND ANESTHESIA

Scott Reeves, GJ Guldan, Larry Field and Jake Abernathy recently attended and contributed to the SAAA annual meeting in Washington, DC. It is a meeting composed of all the anesthesiology chairmen, program directors and subspecialty fellowship directors. It is a chance to learn about the opportunities and challenges facing our residency and fellowship programs in the area of education and research. This year Jake Abernathy lectured on “Simulators and Fellowship Training” and Scott Reeves on “Diversity: Until it Does Not Make a Difference Anymore: A Practical Attempt.”
Congratulations to Stefanie Robinson, pictured left, for receiving the Medical Student Research Award during Student Research Day 2010, held Nov. 5 in the MUSC Wellness Center.

The College of Graduate Studies Perry V. Halushka MUSC Student Research Day offers a chance for researchers to showcase their work. Stefanie Robinson took home first prize for her work this past summer on Transcranial Direct Current Stimulation (tDCS) in total knee replacement patients.

**New Additions to the Family!!**

**Congratulations to Sylvia Wilson and her husband Joe to the latest edition of their family, Kyle, born November 16, 2010!!**

**Congratulations to Jonathan and Kitty Diller for giving birth to TWINS, Gabriel and Caroline, on November 3, 2010!!**

Kyle Joseph Rohrbacher Wilson  
6 lbs 4 oz

Gabriel Allen Diller  
5 lbs 8 oz

Caroline Marie Diller  
4 lbs 13 oz
ANNOUNCEMENTS

Families Helping Families

The Department of Anesthesia will be sponsoring two families of five this Holiday Season. If you would like to participate we would love your help in one of the following areas!

1) Make a CASH DONATION (tax deductible) and let us do the shopping!

2) Please PURCHASE THE ITEM and let us know so we can mark it off the list.

3) Families would love non-perishable food items as well so GIFT CARDS TO WAL-MART, TARGET, OR OTHER GROCERIES would be helpful.

Two notebooks with this information are available and will be located with Rhonda Smalls on 3rd floor of SEI, and Regina Backman at 4th floor ART.

If you have questions or would like to turn in a donation, please contact Leslie Fowler - Fowlerl@musc.edu

Department of Anesthesia and Perioperative Medicine
Medical University of South Carolina

INVITES YOU AND YOUR GUEST
TO CELEBRATE THE SPIRIT OF THE SEASON

Carolina Yacht Club
50 East Bay Street

Friday, December 3, 2010
7:00 p.m.

R.s.v.p. 792-5699
Cocktail buffet/music/dancing
Future Events/Lectures
12/1– Acid-Base Balance (CA1), Dr. Clark
12/1– Renal Physiology & Anesthesia (CA1), Dr. Clark
12/3– HOLIDAY PARTY!!!
12/6– Guest Speaker (All Residents), Dr. Kathryn McGoldrick, NYMC
12/7– Post Operative Cognitive Dysfunction (Grand Rounds), Dr. McGoldrick
12/8– Anesthesia for Patients with Liver Disease (CA1), Dr. Hebbar
12/8– Hepatic Physiology & Anesthesia (CA1), Dr. Hebbar
12/13– Anesthetic management of age related disease (All Residents), Dr. McEvoy
12/14– M&M, Dr. Harvey
12/20– Physics of Anesthesia (All Residents), Dr. Mark Rice, UF
12/21– Physiology of Aging (Grand Rounds), Dr. Mark Rice, UF
12/25– HAPPY HOLIDAYS!!!

I HUNG THE MOON!
Don’t forget to nominate your co-workers for going ‘Beyond the Call of Duty’. I hung the Moon slips are available at the 3rd floor front desk, and may be turned in to Rhonda or Kim. Thanks so much!!

Karen James: Going beyond the call of duty with helping me set up my paging groups!!
Kim Crisp: Being a good trainer and making sure I had all tools needed to perform my job!!
Theresa Morgan: Outstanding Nurse Anesthetist Care under extreme conditions (OR17)!!
Susan Craven: Facilitating a group effort of assistance during a busy trauma in OR17 & for having compassion for staff!!
Greg Ivy: Willingness to help with trauma on Monday in OR17 & staying to support staff. Really appreciate your hard work & caring!!
Mickey Ballister: Assertiveness in helping with level 1 trauma this past Monday. Thank you for your efforts!!
Myra Coe: Excellence - Myra set up a co-worker’s room – who called in sick - When I came in to pick up the room every thing was ready, all I had to do was see the patient!!
Latha Hebbar: Sharing her knowledge with CRNAs in a patient, kind & respectful way. Very much appreciated!!
Marshall Kearney: Wonderful assistance with multiple awake fiber optics in the EO along with a very busy OR on Friday night!!
Beth Jennings: Beth helped me start a kidney TX. It was to start at 0600 and she stayed till I was comfortable. Great team player!!

SAVE THE DATES:
- Holiday Party: Friday, December 3, 2010, Carolina Yacht Club
- Resident Graduation, Friday, June 24, 2011,