Over the past month, we have all seen the devastation that has occurred in Haiti. A future faculty member, Laura Roberts, MD is serving on the USNS Comfort off the coast. Her description of the crisis should cause us all to take a moment and be thankful for all we have.

We have been extremely busy. To be honest, I've never worked this hard in my entire life. We started receiving patients on January 20th. The first 3-4 days were unbelievable. We admitted over 500 patients. We operated around the clock in 10 rooms. I had about 5 hours sleep in 4 days. Barely ate or drank anything. We just kept moving. The patients just kept coming. We've seen everything from traumatic amputations, burns, head injuries and medical illness including unusual disease states such as tetany with lockjaw. Those patients were challenging. Also saw most patients with extremes in condition with Hgb of 2-3 and K+ levels of 9 still alive. All patients required significant resuscitation and medical management all while surgery was in progress. The wounds and limbs we were treating were horribly infected and infested with maggots and debris. It's been sad to see so many people maimed and dying. So many orphans.

Since the start we've had more folks and supplies come in for reinforcement. The tempo has slowed a bit now but will gear up again as we begin discharging some of the folks we have treated thus far. Despite the devastation and the sad cases we've seen, it has been rewarding nonetheless. We have helped many people, and they are grateful. These are people who truly need assistance of every kind. All of us here are proud to be a part of this mission.

The MUSC response to Haiti from our orthopedic surgeons, the substantial effort of Dr. Dilantha Ellegala to establish a continued training presence throughout Africa and numerous other initiatives has resulted in our dean, Jerry Reves, establishing the MUSC Center for Global Health. Our department is on the leading edge of this initiative through our exploratory efforts in Tanzania. Carlee Clark along with her husband Brett have just returned from a two week evaluation in Tanzania. Our goal is to go and train anesthesia providers in order to vastly improve the safety and outcomes of surgical care. Once one location is up to speed, the department would concentrate on a new hospital. This will require a concentrated and sustained presence. A summary of Carlee’s initial visit is in this edition. Many might ask how anyone could make a difference in such a short period of time. The following is an email that was sent to a leader of the Madaktari organization describing the locals’ impressions of Dr. Clark.

Carlee is amazing, really amazing. She has a gentle way about her and she’s already so assimilated you would never guess she has only been here 1 week. She has already taught and learned a lot. If we would have a year of “Carlee’s” I think our anesthesiologists would barely need more visitors.

First impressions are so critical. Carlee and Brett were great departmental ambassadors and will make our future efforts easier. To learn more about Madaktari go to www.madaktari.org.
Before my recent trip, I had never been to Africa. I had never been on a mission trip either, but I had heard plenty of stories. I am not sure what I was expecting to find at Bugando, but my goal was to go there with an open mind. What I found was a group of amazing people trying to practice good anesthesia with limited resources and a mentality towards patient care that was inconsistent. I spent the majority of my time observing, asking questions and commending them when they did something well. This strategy served me well, and I quickly gained their trust. They talked to me about the hospital, the anesthesia training and the restrictions that they work under. What I learned was both fascinating and frightening at the same time.

I’ll start with a brief synopsis of the anesthesia department. There is one anesthesiologist. He participates in the daily morning report, but does not supervise like we do in the US. There are nine senior anesthetists. Two of them share the responsibilities of schedule making, equipment ordering and maintenance, and medication ordering. These nine anesthetists are responsible for the 24/7 coordination, administration and education in the six operating theaters at Bugando Medical Center, AND they only get paid a nurses salary. Right now there are 23 anesthetist students, and their training program is only 12 months long. A nurse who “monitors” the patients runs the PACU. The patients are suctioned, extubated and then watched for 5-15 minutes before being shipped back to the floor.

Now let’s talk about the operating rooms. They do approximately 200 cases a week in 6 operating rooms. The waiting list for surgery is almost 3 months long, and the patients have to pay up front or their case is cancelled. Patients can pay more and have their surgery sooner. The anesthetists try to keep the patient’s costs down by limiting medications or using local or regional whenever possible. On M/W/F there are between 50-60 cases, mostly ortho and general surgery. Tuesdays and Thursdays are filled with about 15 Ob/Gyn and eye cases. On the slower days the ORs get cleaned more and the patients get more time in the PACU. On busy days, it is impressive how well everyone works together to get things done as quickly as possible, but it is obvious that patient care suffers on these days.

How can they be helped? I thought about this the entire time I was there, and I have thought about it ever since I returned. They obviously need more equipment, but that isn’t really sustainable and not what Madaktari is striving for. They need well-trained anesthesia providers present, and they need to slow down. They have an efficient system, and how they do certain things makes sense given their restraints, but it could be safer. They would love to have well trained anesthesia providers there on a daily basis. They would love for their own medical students to take an interest in anesthesia and apply for postgraduate training. It was a very welcoming environment and one in which residents, CRNAs and attendings could all go and bring about change. I think this will be a great opportunity for the department of Anesthesia, and I’m excited to be a part of it.
MEET THE FACULTY

Kelly Grogan, MD
Kelly grew up on a small island on the Eastern Shore of Maryland and loves to be near the water. She attended Gettysburg College and went on to medical school at the Johns Hopkins School of Medicine. She remained at Johns Hopkins for her anesthesia residency and completed fellowships in Critical Care Medicine and Cardiac Anesthesia. She stayed on as an attending in the Cardiac Division for 5 years and was very involved in resident education. She loves to travel. Her other hobbies include photography, baking, kayaking, hiking, reading and needlepoint.

Frank Stewart, MD
Frank grew up in a small town in north Louisiana, attended college in Lafayette, LA, and medical school at LSU in New Orleans, graduating in 1978. He completed a five year Anatomic and Clinical Pathology Residency while working at and booking his hometown hospital’s emergency room for weekends. Looking for a change, he joined the US Navy, trained for six months to become a Flight Surgeon and served in Diego Garcia (British Indian Ocean Territory) for a year, followed by a year as an Airwing Flight Surgeon aboard the USS Ranger. After the Navy, he joined an Emergency Medicine group and worked in multiple states as an ER doctor. After a few years, he became an Anesthesia resident, just to eventually become a critical care specialist. During his residency at George Washington University in DC, he came to respect the challenging and rewarding practice of medicine our specialty represents. He followed by completing a fellowship in Pediatric Anesthesiology at Children’s National Medical Center. Since that time, he has worked primarily in Children's hospitals in Massachusetts, Arkansas, and Norfolk, VA. For five years he served as Anesthesia Chair for Operation Smile International, based in Norfolk, and has led multiple humanitarian medical missions in Africa, Asia, South America and the Caribbean. Dr. Stewart said, “I have found that my strengths and rewards come together in teaching, and look forward to working with you all.”

OR EFFICIENCY

Recently the department has started an OR efficiency initiative. Our initial goals are to have the patient in the room by 7:00am at ART and UH and 7:10am at RT with a surgical incision at 7:30 am. The expectation is that if the day starts off on time, the cases are more likely to stay on schedule. A complete reason for delay option set was established in OR manager so that OR leadership could identify specific reasons for delays associated with the patient (late arrival, violation of NPO status, etc), surgery (no H&P, no informed consent, etc), nursing (scrub nurse not available, no instruments, etc) and anesthesiology. Our first set of data is presented below for the month of January.

<table>
<thead>
<tr>
<th>Location</th>
<th>Patient in the Room (Average)</th>
<th>Average Surgical Incision Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashley River Tower</td>
<td>6:57 am</td>
<td>7:42 am</td>
</tr>
<tr>
<td>University Hospital</td>
<td>7:01 am</td>
<td>7:52 am</td>
</tr>
<tr>
<td>Rutledge Tower</td>
<td>7:20 am</td>
<td>7:39 am</td>
</tr>
</tbody>
</table>

This is an incredible initial effort which we can all be proud. We will continue to stress our efficiency as well as use OR management’s resources to improve our surgical start times!
APPLAUSE!

- Congratulations to the Faculty, Residents and Nurses of our Pain Management Clinic. In January the clinic achieved a Patient Satisfaction score that placed them in the 99th percentile. That is no easy task, and we commend them for their hard work and excellent results.

SURGICAL SITE INFECTION: ‘NO BUGS’ PROTOCOL UPDATE

SSI is a major cause of postoperative morbidity and mortality, and it is the second most common cause of nosocomial infections. In 2002, there were almost 300,000 SSIs in the United States alone, resulting in over 8,000 associated deaths. The mortality rate of patients with SSIs is approximately 2-12 times that of those who do not develop one. Furthermore, SSIs represent a significant and likely avoidable financial burden to the health care system. The direct costs that can be attributed to a single SSI are roughly $6,000, and it is estimated that SSIs accounted for somewhere between $3.5 and $10 billion in direct costs in 2007.

Current data would suggest that SSI rates are ~5-10% across all types of cases. We do roughly 22,000 OR cases each year at MUSC. This would predict roughly $6 million in costs attributable to SSI at MUSC each year! Much of this economic burden, and more importantly the attendant patient morbidity, is avoidable.

In January I gave a Grand Rounds on the prevention of surgical site infection (SSI) from an evidence-based medicine perspective (click to see Tegrity file). The current evidence in this area that is applicable to perioperative anesthesia care has been reduced to a protocol checklist. This protocol can be remembered by the mnemonic ‘NO BUGS,’ which stands for Normothermia, high FiO₂, proper dose and timing of anti-Biotics, mild Underventilation (E₄CO₂), Glucose control, and Surgical site preparation. In the next few months, a working group made up of members from the anesthesia, surgery, and nursing departments will decide upon the final protocol to be used in every OR case at MUSC. The figure in this article shows the checklist with the proper goals for each of the items in the protocol. You will see these appear on your anesthesia machines. Furthermore, a list of commonly used antibiotics and their proper intraoperative dosing and re-dosing schedules will be placed in each anesthesia workspace. Of course, there are exceptions to the implementation of every step of this protocol. For instance, some cases will call for the use of hypothermia (circulatory arrest), and some cases will need hyperventilation (traumatic brain injury with high ICP). However, the vast majority of cases should have this protocol followed, as each of these parameters has been shown to increase bacterial killing and reduce surgical site infection. The attendings, residents, and CRNAs from our department who are members of the working group will keep you informed about the progress of this project, as well as the dates of implementation.

<table>
<thead>
<tr>
<th>NO BUGS ‘Perioperative Protocol’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong>: Normothermia - <strong>Goal</strong>: ≥36°C</td>
</tr>
<tr>
<td>(pre-warm the OR, keep pt covered, forced air warmer, warm all IVs*)</td>
</tr>
<tr>
<td><strong>O</strong>: Oxygenation - <strong>Goal</strong>: FiO₂ &gt; 80% w/ PEEP 5cm H₂O**</td>
</tr>
<tr>
<td><strong>B</strong>: anti-Biotics - <strong>Goal</strong>: 1st dose given 1-30 min before incision</td>
</tr>
<tr>
<td>(proper drug, dose, timing, and intra-op re-dosing interval – every 2 half-lives***))</td>
</tr>
<tr>
<td><strong>U</strong>: mild Underventilation - <strong>Goal</strong>: ETCO₂ 40mmHg</td>
</tr>
<tr>
<td><strong>G</strong>: Glucose - <strong>Goal</strong>: 180mg/dL</td>
</tr>
<tr>
<td><strong>S</strong>: Skin prep - <strong>Goal</strong>: Chlorhexidine/Keystone Project Checklist</td>
</tr>
<tr>
<td>(use on all CVls, a-lines, and for surgical site prep)****</td>
</tr>
</tbody>
</table>

* Except for cases at Furledge Tower expected to be less than 30 min.
** For cases up to 12 hours in length. If >12 hours, use FiO₂ 60%. Additionally, for patient admitted to an ICU, FiO₂ 60% for first 6 hours post-op, then wean as indicated.
***A list is being developed to represent a commonly used anti-biotics list with proper intra-operative and perioperative re-dosing schedule.
****Includes: full body drape for all CVls placement and no concurrent placement of Foley during CVl placement.
CENTRAL LINE INFECTION PREVENTION

The Centers for Disease Control (CDC) estimates that 250,000 cases of central line—associated blood stream infections (CLABSI) occur each year, with a mortality rate of 12-25% for each infection. The marginal cost to the health-care system is $25,000 per CLABSI, or about $2 to $3 billion in excess costs annually. Fortunately, nearly all of these infections are preventable with simple modification of clinical practice behaviors and inexpensive interventions.

The Michigan Keystone ICU Project, a collaborative cohort study conducted by the Michigan Health and Hospital Association and John Hopkins University, reported significant reductions in catheter-related blood stream infections in Michigan ICU’s following the implementation of strategies aimed at modifying and reinforcing behaviors that promoted adherence to five CDC recommended central line infection prevention interventions. Incorporation of these interventions into routine clinical practice resulted in a 66% reduction in CLABSI in 103 reporting ICU’s sustained over the 18 month study period.

The 2002 CDC Guidelines for the Prevention of Intravascular Catheter-Related Infections are based on existing scientific data, theoretical rationale, applicability and economic impact. Category 1A recommendations are strongly recommended and supported by well-designed studies. All five CDC catheter-related infection interventions meet Category 1A criteria and are easily implemented and inexpensive. The recommended practices include proper hand hygiene prior to catheter insertion, disinfecting the skin with 2% chlorhexidine, use of full barrier precautions during central line insertion, preferential selection of the subclavian site for insertion (avoid femoral site), and prompt removal of unnecessary central venous catheters.

Strategies to increase compliance with these procedures included preliminary clinician education on the harm related to catheter related infections and the preventive strategies, developing and maintaining a central line cart with necessary supplies and equipment, use of a checklist to ensure adherence with infection prevention measures, designating a nurse to communicate non-adherence to the recommended strategies and stop the procedure during non-emergent CVL placement, a “removal of catheter” discussion as part of daily ICU rounds on every patient with a CVL, and quarterly feedback to clinical staff on CLABSI rates.

ROOM 2 CREW BY: SCOTT WALTON, MD

What is the Room 2 Crew? It is the diverse group of individuals that work regularly in the Children’s Hospital OR #2. Pediatric cardiothoracic surgery is performed day in and day out in OR #2. In that setting, a dedicated group of professionals are brought together for the benefit of the pediatric heart patient. The group includes the nursing team, perfusionists, housekeepers, patient technicians, CRNA’s, PA’s, surgeons and anesthesiologists.

Room 2 Crew meets daily for patient care and monthly for round table conferences that coordinate and direct improvements in patient care processes in the operating room. Occasionally a social meeting is held to foster esprit de corps and strengthen relationships.

The Anesthesia Department sponsored the January 26, 2010 Room 2 Crew social held at Fuel. The photos reflect the warm and collegial relationship among the crew members.
MEET THE NEW CHIEF RESIDENTS

Gabe Hillegass, MD

I’m honored that I was selected by my peers and the anesthesiology faculty to be one of the chief residents next year. I look forward to working with Will, Drs. McEvoy and Guldan, Leslie Fowler and the residents to continue to strengthen the residency program. I appreciate the positivity and well wishes that have been expressed to me from throughout the department. I hope your good ideas, candidness and encouragement will continue throughout the upcoming year.

I’ve been asked to write a little about myself for this article… I grew up in the Hampton Roads area of Virginia. I went to college at the University of Richmond where I met my eventual wife, Quinn. My medical degree is from Wake Forest University. My wife and I absolutely love living in Charleston. We treat our 1-year-old golden retriever, Henry, like he is our child as he goes just about everywhere with us. We are an active family that enjoys the outdoors. My wife is an avid runner who can run circles around me. We both come from big families and hope to continue to grow ours in the coming years. After residency I plan to complete a pain medicine fellowship. Once my training is complete, I will practice both anesthesia and pain medicine in the Navy. Quinn and I do not know exactly where this path will take us, but we are excited for the journey!

Will Hand, MD

Will made his way to MUSC as he continues to migrate south in search of year-round access to beach volleyball. He grew up in Milwaukee, Wisconsin attending Marquette University High School. He continued his career… or education rather, at Saint Louis University (SLU) majoring in Applied Mathematics. Will worked for a hedge fund before deciding to pursue medicine. He remained with his tradition of Jesuit education attending medical school at SLU School of Medicine. Will and his wife, Megan, recently celebrated the birth of their first child, Emily Reese, in September. He admits to investing most of his time into anesthesiaology, but he still tries to find time to play in a few beach volleyball tournaments (see below) during the summer and has been seen in the gym on occasion. Will is looking forward to serving the department and his fellow residents and hopes to bring incremental improvements to the program and the care delivered at MUSC.

MUSC Intramural Volleyball Champs!
The team ”Spike the Epi” defended its MUSC intramural championship by defeating a team of medical students at Harper Student Center. The team completed an undefeated season with significant contributions from newcomers Jerell Brown and Rob Bartlett. Rob suffered a mid season injury, but the team endured. The finals were highlighted by a momentum shifting block by Greg Ivy and a few timely side-outs by Will Hand. We're recruiting for next year to continue the dynasty!
ANESTHESIA MANAGER CHANGES

An attempt is frequently made by Dr. Field to improve the work flow on PICIS. Please review the current changes.

- The event stating “Anesthesiologist present and medically directing case” was changed to “Anesthesiologist medically directing case”  
  › **Reason:** We are already separately documenting presence

- “Anesthesiologist present for Emergence” was moved to the bottom of event set.  
  › This and the new CMS requirement should be documented close to emergence, as we cannot claim presence at emergence and throughout case until the case is ending

- A new Event “I (or another attending anesthesiologist) was immediately avail…….” was also added.  
  › **Reason:** This attestation statement is required to meet the new CMS documentation requirement in order to bill for resident cases concurrent with another CRNA/resident case

- The warming blanket statements were changed.  
  › **Reason:** New SCIP requirements require the term “active” warming blanket (i.e. Bair Hugger) for credit if Temp requirement not achieved. If you only use passive (regular) blankets, then a Temp > 36 C must be recorded 30 min before or 15 min after End of Anesthesia is required to get credit for this goal.

- “Patient evaluated immediately prior to induction” was removed from MD Documentation and added to all airway event sets and macros.  
  › **Reason:** This Joint Commission requirement can actually be documented by any anesthesia provider, and the JC was recently upset when this statement was documented by attendings after the induction. Placing it within all induction macros will ensure timing satisfies the JC’s desires.
**Anesthesia Manager Changes Continued...**

- The name of the ICU Anesthesia Stop Macro was changed to Anes Stop_Record Discharge Macro. This will discharge the record when activated.
  
  › **Reason:** To end and DISCHARGE a record, this macro can be deployed from Anes Manager when you are completely finished documenting in Picis. This completes our records anywhere PACU Manager will not be used (NORA sites as well as ICUs).

  WARNING: Since the record is discharged once deployed, you then will not find the record in the Transfer bin to reopen the record. It will go to discharged records instead.

- Cerebral Oxygen Saturation was added as a Manual Entry item in device data.
  
  › **Reason:** Self-explanatory, but user must remember to manually type data since there is no automatic data collection available for this field.

- Booking ID, Case record ID and Account (Patcom) number have been added to all census lists in AM except Current patient sessions and Transfer patients. Current patient sessions and Transfer patients have the account number only.
  
  › **Reason:** Increased search options for end user.

### Checking for Device Data

Select Device Data Flowsheet from the Menu on the left of the screen.

<table>
<thead>
<tr>
<th>Flowsheets</th>
<th></th>
<th>Look in Real-Time Variables for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia Home Page</td>
<td></td>
<td>Hemodynamic Monitor Data</td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td>Ventilator and Gas Analyzer Data</td>
</tr>
<tr>
<td>Fluids</td>
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<tr>
<td>Lab Results</td>
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<td>Anesthesia Gases and Vitals</td>
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<td>Invasive Monitoring</td>
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<td>Trends</td>
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<tr>
<td>Device Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications and Vital Stats</td>
<td></td>
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</tbody>
</table>
February marked two years since the opening of ART. Our case volume has been growing steadily and so has our Anesthesia team. We are currently a group of 25 CRNAs and 7 Techs. We currently perform anesthesia for 325-350 OR cases and approximately 375 NORA cases per month.

In January, CRNAs Liz Byrd and Margaret Winnicki passed national boards and started their MUSC careers at ART. Anesthesia Tech Ben McClain has rejoined us after his lengthy assignment in Afghanistan. Ashley Yarbrough is back at ART after spending the last couple of months at home with her new twin daughters.

The Anesthesia Techs are actively involved in patient care in the OR and the NORA sites. They provide critical anesthesia support in the off-shifts. To help advance the Tech’s anesthesia knowledge, an Anesthesia Tech study guide was put together by Paul Dancy, Amanda Harper, Candace Jaruzel, Tim McAdams and Regan Weston. The guide can now be found on the Anesthesia intranet. Other recent Anesthesia Tech educational events have included in-services by the CRNAs (airway management techniques, induction sequence demonstration and team member roles, DLT assembly and function, arterial line/IV prep, patient positioning). Mike Andrews, biomed guru, gave the Techs an in-service on the Avance anesthesia system, focusing on machine functions and advanced trouble-shooting.

The CRNAs are enjoying their involvement with the Simulation Center. The Fiberoptic Intubation and Difficult Airway Management course give us the opportunity to fine-tune our airway skills. Thanks to Jane Swing, Lester Kitten and Don Pagley for continuing to facilitate these courses. Jane and Jennie Cannon became certified ACLS and BLS instructors in the fall. They were trained in the Simulation lab by Dr. McEvoy on the skills check off portion of ACLS. This has been very popular with the CRNAs, as it provides a realistic training environment for leadership during Maydays. As usual, babies are in the works for this spring and summer at ART. We’ll keep everyone posted.

On a final note, I would like to say thank you to Dr. Guidry for his leadership at ART. As I “rounded” with the CRNAs last quarter, he was recognized several times for his ability to keep our group working smoothly together, for his collaborative approach to giving anesthesia, for his outstanding communication skills and for his calm nature during times of stress. Teamwork is a priority at ART and we appreciate Dr. Guidry’s efforts to keep us all moving in the same direction.

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**It’s a boy!**

Please help the Department congratulate and welcome the son of Dr. Peter Goodnight!

“Benjamin Goodnight”

2/27/10

7lbs, 7oz
Future Events
3/1- Surgery (CA 2/3), Dr. Tzabo
3/2- Anesthesia for Thoracic Aortic Aneurysm Repair and Endovascular Stenting (Grand Rounds) Dr. Finley
3/3- ART Teaching Conference: Electrophysiology Lab, Dr. Wharton
3/8- Strategies for Blood Conservation in Cardiac Surgery (CA 2/3), Dr. Reust
3/9- M&M, Dr. Harvey
3/10- ART Teaching Conference: VAD Evaluation with TEE, Dr. Finley
3/10- Journal Club: Cardiothoracic, Dr. Reeves
3/15- Anesthesia for Patients with Valvular Heart Disease for Non Cardiac Surgery (CA 2/3), Dr. Reeves
3/16- Perioperative Management of the Patient with a DES (Grand Rounds), Dr. Nielson
3/17- ART Teaching Conference: VAD, Dr. Toole
3/22- Should there be a Morphine Revival? (Guest Lecture, All Residents) Dr. Glen Gravlee (UC Denver)
3/23- Recent Issues in Cardiac Anesthesia (Grand Rounds), Dr. Glen Gravlee (UC Denver)
3/24- ART Teaching Conference: TEE Review, Dr. Abernathy
3/29- Perioperative Pacemaker and Defibrillator Management (All Residents), Dr. Nelson
3/30- Cerebral Protection in Cardiac Surgery (Grand Rounds), Dr. Guldan
3/31- ART Teaching Conference: Journal Review, Dr. Guldan

I HUNG THE MOON!

The department members below have been recognized by our patients and their peers. This month’s drawing winner is Tina Willet! Tina will receive a gift certificate to Shine Tavern.

Tina Willet- For making sure we are all where we should be. You pretty much rock!
Marc Hassid- Unselfishly taking both PEDS and PEDS HT call to help a fellow faculty member in time of need.
Candy Johnson- Thanks for your collegial support! You’re a great team player!
Greg Ivy- Thanks for your collegial support! You’re a great team player!
Myra Coe- Switching cases. She is always willing to help for everyone’s benefit.
Kathleen Williams- Her kindness and compassion in dealing with my terminally ill cousin and his wife in the pain clinic, as well as her continued kindness and concern for our family.
Kim Adams- Switching room assignments and never losing her smile.
Regina Backman- For helping me through a difficult period of time when I needed help.
Ray White- Always being a team player; switching rooms without ever complaining.
Larry Banks- Long, tireless hours and keeping us going and always making sure we “shine” as a department. Thanks so much for all your help!

*It’s important that we recognize our fellow colleagues when they are going above and beyond the call of duty. “I Hung the Moon” cards can be found on the 3rd and 5th floors in the Department of Anesthesia administrative areas.

SAVETHE DATES:
- This Year’s Resident Graduation will be Friday, June 4, 2010
- 2010 Holiday Party: Friday, December 3, 2010 at the Charleston Yacht Club!

Note: You can see pictures from the 2009 Holiday party by going to www.musc.edu/anesthesia