MESSAGE FROM THE CHAIRMAN:

**STAND IN THE GAP!**

“SCOTT T. REEVES, MD, MBA

Recently, I heard a sermon on the passage found in the Old Testament book of Ezekiel 22:30, “I looked for a man among them who would build up the wall and stand before me in the gap on behalf of the land so I would not have to destroy it but I found none.” It was an indictment on the lackadaisical attitude and moral decay occurring during that time period. As I sat thinking about my personal life, do I really stand in the gap both at home and at work? Do I give extra of myself to my patients and treat work as a calling or profession rather than a job to be completed as rapidly as possible?

I contemplated the dedication of our pediatric division as they have helped several children recently with chronic pain diagnoses in a system that is not designed for them. Their success was achieved solely by their dedication and hard work which enabled them to overcome system obstacles. In addition, I recently received the following email from a friend who just happens to be a MUSC employee:

Scott,

I recently had surgery and was out of the office for a few weeks. The reason I share this with you is that one of your faculty members, Dr. Sylvia Wilson, took care of me and I wanted you to know what an amazing person she is. I was in incredible pain after surgery and not only was she very patient in answering all of my questions, she also recognized my severe pain and shared with me that she could give me something called “an anesthetic block” (I think that’s what she called it but forgive my memory for being vague) to help for the next 12 hours. It made a remarkable difference and made that first day bearable. She mentioned that many physicians still don’t know this type of “block” exists, and I will be sure to bring it up to any physician I meet!

Before life gets any busier, I wanted to stop and share with you, as a patient, how your doctors are doing their part to change what’s possible. While I’m sure I would have been fine without her extra attention, it made a difficult situation so much more bearable.

Thanks,

The faculty recently held a strategic retreat to establish our direction and priorities for the next five years. This month’s *Sleepy Times* will be the first of many looking at particulars of the plan in its five main areas of Education, Clinical Care, Research, Faculty Development and Finance. One thing is certain, the upcoming health care reform debate will put increasing financial and time pressures on us all. We will be asked to assume more perioperative care of our patients. As we do so, I would like to challenge us all to **STAND IN THE GAP!**
STARTING THE ‘JOURNEY’
Cancer fight leads East Cooper family to raise fund to help others
©POST AND COURIER, NOVEMBER 29, 2011, PAGE 1D

The adults in 5-year-old Ansley McEvoy’s life think big.

For most of the past year, they have been working toward a big event Saturday morning at Blackbaud Stadium on Daniel Island.

At 10:30 a.m., 1,458 people will hold up boards measuring 2-by-3-feet in the hopes of setting a Guinness Book of World Records' mark for the largest picture mosaic. The image will be one that Ansley drew of her family under a rainbow.

It will be a memorable moment for a family that started a cancer journey a year ago when Ansley was diagnosed with lymphoma.

Ultimately, Saturday's event will kick off an even bigger, more meaningful effort by the family: building a place for families with children in Charleston hospitals getting treatments that compromise their immune systems.

They want to call it The Journey House.

Stomachache

Life was as routine as it got this time last year for a large family when the youngest of Matt and Amy McEvoy's five children complained of a mild stomachache.

When it continued for two days, Amy took Ansley to the emergency room thinking it was appendicitis. An ultrasound led to a chest X-ray, which led to a CT scan.

"They (the doctors) said, 'There is something going on in this little girl's body.' It turned out to be Stage 3 cancer," recalls Amy.

Over the past year, the energetic child with an infectious smile and giggle has faced chemotherapy. "She's doing great right now," Amy adds.

Think big

Last winter, cancer survivor Mason Moise, whose daughter plays with the McEvoy of Mount Pleasant on the Palmetto Christian Academy basketball team, heard about Ansley. He wanted to do something for her.

"I asked them, 'What could we do to make Ansley smile?' They told me she likes cards," recalls Moise.

From there, he wanted to bring a lot of people together for an event to make one big card. So he contacted Guinness, and the idea for "Ansley's Attempt" was born.

Moise took a drawing from Ansley and gridded it out. With help from the McEvoy's and colleagues at The Jackson Group, they reached out to 11 local schools, 10 local churches and a group from San Francisco to draw each board. Initially, he aimed at 1,404 pieces, but when a group in Italy recently broke that previous record, Moise upped the ante to 1,458.

With the cards made, organized and stored in Moise's office in Mount Pleasant, all that is needed is more than enough people to arrive at Blackbaud Stadium at 9 a.m. Saturday to start putting the mosaic together.

The effort, which will be festive, doesn't stop there.

Ansley and her family, if it's not too windy Saturday morning, will watch the mosaic come together from a hot-air balloon. Moise also contacted Goodyear in the hopes of getting the Florida-based blimp to make an appearance on its way to the ACC Championship football game Saturday in Charlotte. Moise says he was promised "only a 10 percent chance" of an appearance.
STARTING THE ‘JOURNEY’
CANCER FIGHT LEADS EAST COOPER FAMILY TO RAISE FUND TO HELP OTHERS
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This drawing by Ansley McEvoy, a 5-year-old battling lymphoma, was converted into 1,458 2-by-3 foot pieces in an attempt to create the largest mosaic held up by people. The event, called “Ansley's Attempt,” will be held Saturday in Blackbaud Stadium.

Kick off Saturday
Last summer, the McEvoy family and Moise decided to wed Ansley's Attempt with The Journey House to kick off fundraising for the latter.

As of November, $25,000 had been raised, far short of the initial goal of $250,000. But the McEvoy family seems ready for the long haul to make The Journey House a reality.

"The diseases these kids have are big deals," says Amy. "There's no easy way to do this (build The Journey House) because there is no easy answer. If it takes years to make it happen, it will be worth it.

"... It's a vision we've been given and are praying that a lot of people will join in with us."

How to help
Volunteers are needed to make "Ansley's Attempt" a success.

Organizers are asking people to arrive at 9 a.m. Saturday at Blackbaud Stadium on Daniel Island to begin assembling the mosaic, to be held up starting at 10:30 a.m. The mosaic has to remain intact for 10 minutes to set a record for the Guinness Book of World Records.

For information on "Ansley's Attempt" or to donate to The Journey House, go to www.thejourneyhouse.org. To read about the McEvoy family's journey with cancer, go to www.prayingforansley.blogspot.com.

Reach David Quick at 937-5516.
DEPARTMENT FACULTY STRATEGIC PLANNING RETREAT: NOVEMBER 2011

The faculty held a five year strategic planning retreat in the Gazes’ auditorium on Saturday November 19, 2011. It was the accumulation of 8 months of preparation. As is obvious from the schedule below, it was a very busy day.

RETREAT SCHEDULE

7:30 AM Arrival and Breakfast

8:00 AM: Introduction and Summary of Current Events           Reeves
8:30 AM Finance Committee Report with Questions/Answers        Dorman
9:15 AM Professional Development Committee with Questions/Answers Guidry
9:45 AM BREAK

10:00 AM Research Committee with Questions/Answers            McGowan
10:45 AM Education Committee with Questions/Answers
   10:45-11:15 Medical students                               Tobin
   11:15-11:45 Residents                                     Clark
   11:45-12:15 Faculty                                       McEvoy

12:15 LUNCH

1:00 PM Clinical Care with Questions/Answers                  Grogan

2:30 PM Wrap Up                                              Reeves

3:00 PM Depart

The retreat was an opportunity to help set our direction for the next 5 years. Each subcommittee (Finance, Clinical Care, Faculty Development, Research and Education) will make edits to their proposals and submit a final plan to the faculty by December 9th. The faculty will then review each area and a final discussion will occur at the December 13 faculty meeting. The finalized plan will be posted the first week of January. Future editions of Sleepy Times will highlight each of the five areas.
Dr. Reeves giving his introductory speech and updating the faculty on current events.

Dr. McGowan talked about the Research committee and opportunities in Research.

Anesthesia Faculty listen intently to the day’s speakers.

Dr. McEvoy lead the speech on Faculty Education.

Here, Dr. Clark speaks on Resident Education.

Faculty members take a break during the day’s sessions.
DR. CHARLES WALLACE SELECTED AS GRAND MARSHAL FOR 2012 COMMENCEMENT CEREMONY!

The Department of Anesthesia and Perioperative Medicine would like to congratulate Dr. Charles Wallace for being appointed Grand Marshal at the 2012 Commencement Ceremony to be held this upcoming May. Dr. Wallace will be joined by Dr. Joseph R. Cantey, and the two of them will lead the procession out into the courtyard. This is a great honor being bestowed on a faculty member that is a long standing leader not only in this department but in the Hospital itself.

Dr. Wallace is also an alumni of MUSC, receiving his Medical Doctorate in 1969, and completing his Residency here in 1972 (see picture below). Currently Dr. Wallace holds the position of Medical Director of our Ambulatory Surgery Operating Rooms in Rutledge Tower.

NEW RESIDENT INTERVIEW PACKET

Dr. Rebecca (Becky) Payne, one of our CA3 residents, has put together a new brochure (pictured right) for our Residency Candidate interviews. Becky’s fiancé Michael Dussel, a graphic designer by trade, did an outstanding job in creating the brochure. A special thank you goes to both of them for all of their hard work. Great Job!

REbecca Payne, MD
CA3 Resident Physician
Multiple members of the MUSC’s Department of Anesthesia and Perioperative Medicine attended the 17th Annual Advances in Physiology and Critical Care presented by Wake Forest School of Medicine at the Wild Dunes Resort on the Isle of Palms, November 5-9. Lectures covered a variety of topics including perioperative stroke, pediatric and geriatric postoperative cognitive dysfunction, percutaneous coronary intervention before non-cardiac surgery, and medical tourism. Additional workshops included Advanced Cardiac Life Support, Difficult Airway Interventions and Peripheral Neural Blockade.

In addition to MUSC’s anesthesia faculty and nurse anesthetists in attendance, Drs. Frank McGowan and Sylvia Wilson also participated as part of the meeting program. Dr. McGowan presented talks on both the Adult Patient with Congenital Heart Disease (pictured below) and Anesthetic Neurotoxicity. Dr Wilson taught interscalene and infraclavicular peripheral block techniques at the Peripheral Neural Blockade workshop.

Next year’s meeting will be in West Virginia at the Greenbrier.

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**FAREWELL TO DR. TAM PSENKA**

Thank you all for the privilege of working and learning with you in the department over the last 12 years. It is with mixed emotions that I leave the department in early December of this year. I have the opportunity to focus a greater amount of my energies at home and on the playing fields with our four school age children. I will miss my colleagues and coworkers but will look forward to working with you again in the future. I wish you all the greatest success and achievement in the coming years. Thank you again for your support, dedication and friendship.

Very Best Regards,

Tamatha M. Psenka, M.D.

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Dr. Psenka is pictured here with her family. From left to right: Kate (7), Michael (13), Kyler (9), Mike, and Riley (11).

Dr. Psenka is pictured here with Drs. Wallace and Inabinet, and members of the Pre-Op staff.
December will mark the end of an era in Anesthesia and Pain Management. Ellen McClellan will end 38 years of employment with the department when she retires later this month. Ellen began her career as an insurance collector back in 1973 when UMA was known as PSO. She joined the department the following year billing anesthesia charges. When the department started a Pain Management Clinic, she took on the challenge of working with Dr. Bud Duc running the clinic and his schedule. She has been an integral part of the daily operations of the Clinic since the beginning, and has done an excellent job.

Cindy, one of our Pain Clinic Nurses, wrote the following about Ellen last year and it deserves to be repeated here . . .

**ExcELLENce**

Ambulatory Care/ Pain Management

Excellence is a word too easily used. Like “love” the term has lost the connotation of its original meaning and is often used in a self-serving manner. The “Puzzle Pieces of Excellence” include fundamental and adaptive competencies. Individuals who commit to excellence and deal with interpersonal stressors learn to listen effectively and share, analyze behavior, and therefore bring out the best in people. They also possess the ability to negotiate. Another piece of the puzzle is assertiveness. Excellence means being opinionated!

The Pain Management Clinic has one employee we are proud to label excELLENce. One who is committed to making a difference every day by doing the common tasks of work uncommonly well even when no one is watching.

We would like to express our gratitude to Ellen McClellan for being an essential piece of the Pain Management puzzle. Every day you make a difference. Thank you!! – Cindy Fitzgerald, RN III

It goes without saying that Ellen will be greatly missed by those of us who know her and who have had the privilege of working with her over the years, but at the same time, we wish her all the happiness in the world as she starts the next phase of her life.

Congratulations Ellen. We are all wishing you the best in your retirement!
CRNA CORNER: SYRINGE LABELING, PYXIS UPDATE
BY: WENDY EWING, CRNA

It’s that time of year again. No, I’m not talking about Christmas. It’s time to get ready for a Joint Commission visit. One way to get ready is to start and continue to label all drug syringes with the drug strength, the date and your initials. Propofol syringes also need to have the EXPIRATION time. If you are using the prefilled syringes, once you unwrap them, they need to have a date and your initials on them. If you draw up a medication and give it all right away, you don’t need to label the syringe, but it must be discarded immediately. Please label all syringes and make it a daily habit. Audits have already started.

While we’re talking about compliance, let’s talk about pushing buttons in the PYXIS machines. Pushing the button when you remove an item generates a charge and sends a request for restocking. Pushing the button when you remove the item is the easiest way to ensure you don’t forget to charge for something. The PYXIS machines are going through a Par Optimization project as we speak. The team working on the project is trying to improve the system by increasing, decreasing or deleting items based on a usage report. Going forward, it is very important to push buttons for all items removed, when you remove them, so the par levels can be kept constant. This will help to ensure you have the supplies you need and should decrease our supply costs. If you have problems with your PYXIS machine, report it immediately to your anesthesia tech, or call Larry Banks, so the problem can be fixed that day.

The Main anesthesia department just recently started using the disposable blades with the new Teleflex fiberoptic laryngoscope handles. In order to be compliant with infection control and to keep cost down, only the blade you are planning to use should be unwrapped. You may remove more than one blade from the PYXIS, but do not unwrap all of them and place them on top of the machine. At the end of the case, any unwrapped blades on the top of the machine will be discarded. Only open one blade at a time. It only takes a second to open another if you need a different size. Also, thanks to Mike Wolfman, there are plastic containers on the top of each anesthesia machine for all dirty airway equipment.

Now that all the serious business has been taken care of, I’d like to talk about the Main anesthesia CRNAs and anesthesia techs. We’ve been very busy the last couple of months with new arrivals. On September 12th, we welcomed into the world Tim and Beth Grannell’s son, Tyler Patrick. Not to be outdone, Mike and Dawn Sloan had Michael Ryder on October 14th. Erin Straughan didn’t think she’d ever deliver, but finally on November 1st Wells Louis arrived. And last, but not least, Joe Brown and his wife welcomed Madison Paisley on November 20th.

Congratulations to Ken Grismore, on successfully completing the ASATT certification exam on June 3rd. Larry Banks, Marshall Kearney and Cara Spaulding are the other certified techs in our department. They, along with all the techs, do a great job assisting our providers 24/7. Thanks for all you do!

On a sad note, Fran Zinko is retiring December 30th ending 14 years of employment at MUSC. Fran graduated from the MUSC Anesthesia for Nurses Program in 1994 and worked in Columbia for a few years before returning to MUSC in 1997. Since returning, she has worn many hats in the department and is the “go to girl” for answers and advice. Fran has mentored many students and new staff over the years. She will be missed. We’ll be celebrating her retirement in early January. The date and place will be announced soon.

Happy Holidays from the Main Anesthesia CRNAs and anesthesia techs.
Simulation Centers Get Boost From MOCA

One of the requirements of maintenance of certification in anesthesiology (MOCA) is to attend an approved anesthesia simulation course. The American Society of Anesthesiologists (ASA) has endorsed 27 simulation centers nationwide, including at such major institutions as Mount Sinai, Stanford University and Vanderbilt University. ASA president Mark Warner, MD, said the centers were selected based on their educational programs, facilities, and instructor experience.

Participants work as part of a small team but take turns being the primary anesthesiologist. Scenarios recreate challenging clinical cases, including “the management of hypoxemia and hemodynamic derangement and to emphasize teamwork skills in resolving such events,” Dr. Warner said. Each participant’s performance is videotaped and reviewed afterward, but is neither graded nor scored. “This is not a pass/fail exam, but an experiential learning opportunity that is designed to stimulate practice improvement,” the ASA says. According to David Brown, MD, president of the American Board of Anesthesiologists, past participants viewed the experience as positive, with 92% indicating it would change their practice.

Paul Kempen, MD, PhD, a general anesthesiologist at the Cleveland Clinic, in Ohio, remains critical. “The installation of simulators in university settings requires the investment of tremendous amounts of money. Now they want to create repeat and paying customers to use this equipment at preferred sites and finance it,” he said. “There is no protocol (yet) as to what should be simulated in terms of recertification, nor validation that it is effective in this setting,” Dr. Kempen added. “There are no tests required for simulation. It’s almost as if they are saying, ‘Just come, pay for it, and you’ll have a good time.’”

—T.A.

1 Cooper Simulation Laboratory, Cooper University Hospital, Camden, N.J.
2 Center for Medical Simulation, Cambridge, Mass.
3 Duke University Human Simulation and Patient Safety Center, Duke University Medical Center, Durham, N.C.
4 Texas Tech University Health Sciences Center, Lubbock, Texas
5 Stanford School of Medicine Center for Immersive and Simulation-based Learning, Stanford, Calif.
6 Stony Brook University Medical Center Clinical Skills Center, Stony Brook, N.Y.
7 University of Utah Anesthesiology Department Center for Patient Simulation, Salt Lake City
8 The Mount Sinai School of Medicine Human Emulation, Evaluation, and Education Lab for Patient Safety, New York City
9 Patient Simulation Center, University of Texas Medical Branch at Galveston
10 University of Virginia Health System Medical Simulation Center, Charlottesville
11 Howard and Joyce Wood Simulation Center, Washington University in St. Louis School of Medicine
12 Anesthesia Simulation Center, San Francisco General Hospital, University of California, San Francisco Department of Anesthesia and Perioperative Care
13 Northwestern Center for Clinical Simulation, Northwestern University Feinberg School of Medicine, Chicago
14 Peter M. Winter Institute For Simulation Education and Research, University of Pittsburgh
15 Institute for Simulation and Interprofessional Studies, University of Washington, Seattle
16 Oregon Health & Science University Anesthesia Simulation Services, Portland
17 Penn State Hershey Clinical Simulation Center, Hershey
18 University of Chicago Center for Simulation
19 University of Miami — Jackson Memorial Hospital Center for Patient Safety
20 UCLA Simulation Center, Los Angeles
21 Mayo Clinic Multidisciplinary Simulation Center, Rochester, Minn.
22 Vanderbilt University Simulation Technologies Program, Nashville, Tenn.
23 University of New Mexico School of Medicine, Anesthesiology Simulation Education Program, Albuquerque
24 Wake Forest University Baptist Medical Center Patient Simulation Laboratory, Winston Salem, N.C.
25 Beth Israel Deaconess Medical Center, Simulation and Skills Center, Boston
26 Medical University of South Carolina Healthcare Simulation Center, Charleston
27 University of Kentucky Department of Anesthesiology, Lexington
Switching from vials to prefilled syringes may save hospitals thousands of dollars each year by reducing drug waste, according to new findings presented at the 2011 annual meeting of the International Anesthesia Research Society.

Researchers at the Medical University of South Carolina, in Charleston, compared the amount of unused drugs before and after clinicians began using prefilled syringes in a 10-room operating room (OR) suite. They found that the switch cut both the likelihood for and the volume of unused drug drawn into a syringe that would need to be discarded after the procedure. Comparing two time periods covering fewer than 200 surgeries each, the researchers found that this reduction in waste saved $126 per day (abstract S-124).

Prefilled syringes likely reduce waste because they are sealed containers, ready to be used and able to be returned to the shelves if unused, explained study co-author Christopher Fortier, PharmD, manager of pharmacy support and OR services and clinical assistant professor at the institution.

Often, anesthesiologists will draw up medications into vials in the OR “just in case they may need it,” Dr. Fortier noted. But if that medication is not used, it must be discarded. In contrast, if a prefilled syringe is not used, clinicians can return it, unopened, he said. “In that way, you’re only using the product you need, when you need it.”

The system also cuts waste by reducing the amount of leftover medication in syringes, he added. For instance, an anesthesiologist may prepare 10 mL of a medication but use only 5 mL during surgery; the rest is discarded. But a 5-mL prefilled syringe would obviate the waste, Dr. Fortier said.

Prefilled syringes are more expensive upfront, Dr. Fortier said. However, the actual cost difference in materials alone is hard to estimate, as clinicians who draw their own must purchase the syringes, labels and needles—and add overhead costs by asking technicians or doctors to draw up medications out of vials prior to surgery.

To investigate whether prefilled syringes cut back specifically on drug costs by curbing waste, Dr. Fortier and his team measured the amount of discarded drugs—either unused or left over in used containers—from 154 surgeries (Phase I). They then compared that amount with what was wasted from 171 surgeries (Phase II) in which doctors used prefilled syringes.

The research was funded by an educational grant from PharMEDium, which sells prefilled syringes.

Fewer cases in Phase II had drug waste (38%) than did Phase I cases, in which 71% had discarded medications. When there were drugs to discard, the total volume decreased by 61%, going from 3,284 mL in Phase I to 1,266 mL in Phase II. As a result, the cost of drug waste fell from $3,106 in Phase I to $1,849 in Phase II, according to the researchers.

The drugs that had the greatest decreases in waste included lidocaine (90%), followed by succinylcholine and glycopyrrolate.

The current study did not look at safety with prefilled syringes, Dr. Fortier noted, but they have some important advantages over conventional syringes. Prefilled syringes are color-coded and have the name of the drug noted in different locations and angles on the syringe. They also contain bar codes that clinicians can scan to ensure they have the right drug.

When clinicians draw up medications from vials, they also must label the syringe, and mistakes can happen, Dr. Fortier said. By using prefilled syringes, “you’re improving safety in how it’s labeled. There’s no question what you’re picking up.”

Indeed, the Anesthesia Patient Safety Foundation has recommended that clinicians rely on prefilled or premixed solutions whenever possible, said Robert Stoelting, MD, president of the group, which has received support from PharMEDium.

The increased upfront cost may cause some clinicians to hesitate before adopting prefilled syringes, Dr. Stoelting said. “This research addresses this issue and thus will be helpful to other institutions when they consider cost versus benefit—considering safety, less risk for contamination and the ability of an anesthesia professional to do other tasks,” he said.
Echocardiography For the Anesthesiologist

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The authors have no relevant disclosures to report.

Transesophageal echocardiography (TEE) plays an important role in patient management during the perioperative period. It is routinely used during cardiac surgery but also has great value for the unstable patient undergoing noncardiac surgery. This article presents the anesthesiologist with a practical review of the basic TEE examination, ultrasound physics and fundamental principles, indications for TEE, the TEE certification process, perioperative use of transthoracic echocardiography (TTE), and the increasing use of 3-dimensional (3-D) echocardiography.

Basic Examination
Transesophageal echocardiography provides an excellent diagnostic and monitoring tool for anesthesiologists in the operating room. The TEE examination can be broken down into complete/comprehensive and abbreviated forms; the user may select either depending on the urgency of the situation and other clinical responsibilities.

As with any invasive procedure, the potential risks and benefits of TEE should be discussed with the patient and preoperative informed consent obtained. A study by researchers at Brigham and Women’s Hospital, in Boston, reviewed more than 7,000 TEE examinations and found rates of procedure-related morbidity and mortality of 0.2% and 0%, respectively. Although rare, the most common TEE-related injuries were odynophagia, dental trauma, malpositioning of the endotracheal tube, upper gastrointestinal hemorrhage, and esophageal perforation. Few contraindications exist to insertion of the TEE probe; these include dysphagia, odynophagia, significant reflux, hematemesis, history of gastric and/or esophageal pathology (a hiatal hernia is not a contraindication but may...
The Future of Anesthesiologists in Critical Care

Carlee A. Clark, M.D.
Clifford S. Deutschman, M.S., M.D., F.C.C.M.

A 2001 article written by several prominent American critical care anesthesiologists posed the following question: "Is there a future for anesthesiologists in critical care?" The article described the integral part that anesthesiologists worldwide have played in the initiation and development of critical care medicine as a unique specialty. The authors also, however, expressed concern regarding the limited involvement of U.S. anesthesiologists in critical care medicine, the dearth of anesthesiologists seeking critical care training, and the seeming indifference of our leaders to this important subspecialty. At the time this paper was published, less than 4 percent of the board-certified anesthesiologists held certificates of special competence in critical care medicine. A 2005 ASA Task Force Statement on Future Paradigms of Anesthesia Practice highlighted the aging of the population and the resultant increase in tertiary care facilities and critical care needs. This report suggested that broadening responsibilities of anesthesiologists as perioperative physicians mandated greater involvement in critical care practice and a pathway to ensure the development of increasing numbers of critical care anesthesiologists. It would seem that the stage had been set for a dramatic growth in the importance of critical care in the practice of anesthesiology in the United States.

In the interim, there have been some important changes, especially in academic practice. Following a 1993 survey of anesthesiology residents, Durbin and McLafferty suggested that earlier exposure in residency training and improved ICU education would increase resident interest in the subspecialty. Fifteen years later, the number of required intensive care unit (ICU) months in the basic residency in anesthesiology has increased from two to four, including one to two in the base clinical year. This increase in part reflects the active involvement of critical care anesthesiologists in residency program development on both the institutional and national level. The change also is the result of high-level involvement of anesthesiologist/intensivists in the Anesthesiology Resident Review Committee (RRC) of the Accreditation Council for Graduate Medical Education.

Continued on page 18

Carlee A. Clark, M.D. is Assistant Professor of Anesthesia and Perioperative Medicine, Medical University of South Carolina, Charleston.

Clifford S. Deutschman, M.S., M.D., F.C.C.M. is Professor of Anesthesiology and Critical Care, and Director, Sepsis Research Program, Perelman School of Medicine at the University of Pennsylvania, Philadelphia. He is President-Elect, Society of Critical Care Medicine.
ANNOUNCEMENTS

Congratulations to Dr. David Hall, CA0, for being nominated as the Teacher of the Month for the month of October 2011.

Dr. Hall was nominated by the Students of The MUSC College of Medicine.

Look for your invitation to the 2011 Department of Anesthesia and Perioperative Medicine Annual Holiday Party

To be held on Friday, December 2, 2011
Time: 7:00 p.m.
Location: Cottage on the Creek, Mt. Pleasant
GRAND ROUNDS FOR MONTH OF DECEMBER

“Physics and Anesthesia”
December 6, 2011
Jerell Brown, MD, MPH
Medical University of South Carolina

December 13, 2011
William Hand, MD
Medical University of South Carolina

“M&M”
December 20, 2011
Susan Harvey, MD
Medical University of South Carolina
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!!

Aly Cleveland: Taking the time to make sure her fellow CRNA’s were set up before a mandatory staff meeting.

Becky Payne: For Being a Superstar at the end of the Day! Transporting when she didn’t have to.

Future Events/Lectures
5-Dec– Anesthetic Implications of Neuromuscular Disorders, CA2/3, Dwayne McClerklin, MD
6-Dec– Physics and Anesthesia, Grand Rounds, Jerell Brown, MD, MPH
7-Dec– Anesthesia for Patients with Liver Disease & Hepatic Physiology and Anesthesia, CA1, Latha Hebbar, MD, FRCA
12-Dec– Hematologic Disorders, CA2/3, Eric Nelson, DO
19-Dec– Quarterly Program Director Meeting, All Residents, Drs. McEvoy, & Guldan
20-Dec– M&M
26-Dec– Merry Christmas!

Important DATE!

• Anley’s Attempt, Saturday, December 2 2011 Blackbaud Stadium
• Holiday Party, Friday, December 2, 2011, Cottage on the Creek ***NEW LOCATION!!

December 2011 Standard of the Month

Complete all mandatory training and maintain appropriate credentials/licensure.

We Would Love to Hear From You!
If you have ideas or would like to contribute to Sleepy Times, the deadline for the January edition will be December 19, 2011.