Happy New Year!!! I cannot believe we are starting another year already. Time really flies the older one gets. We ended 2010 with a bang as we completed our RRC site visit and interviewed over 100 resident applicants for this coming summer.

This year will be a banner year as growth is everywhere. The department has expanded to twelve residents per class which will bring new opportunities and challenges. Frank McGowan has already moved his lab into the Children’s Research Institute (CRI) and has been holding monthly departmental and congenital cardiac research meetings. When he starts on January 31, I expect he will hit the ground running and will greatly expand our departmental translational research offerings and clinical education opportunities of our pediatric divisions. Will we also be building a new children’s hospital? I hope so!

January also marks basketball season for the Reeves’ family. Carolyn is a senior and Townsend a sophomore on the Wando basketball teams. As I watch these games, I am always excited about the enthusiasm expressed as the players prepare to enter the game. The sense of anticipation and focus is inspiring and is very evident in the two pictures below. So whether we are bringing in a new team, such as the new opportunities that will soon be available to the pediatric divisions, or individual players, through our faculty mentoring and global health initiatives, I challenge us all to Get in the GAME!
MUSC STRATEGIC PLAN 2010-2015: PART 2 OF 4
INTERPROFESSIONAL/INTERDISCIPLINARY COLLABORATION

In the December edition of *Sleepy Times*, the MUSC strategic plan was discussed. If you will recall the plan was organized for the next five years around four overarching themes:

1. Interprofessional/Interdisciplinary Collaboration
2. Entrepreneurialism
3. Technology/Innovation and
4. Globalization

In December, I emphasized the component of Globalization. This month we will discuss Interprofessional/Interdisciplinary Collaboration.

**Interprofessional / Interdisciplinary**

*Co-Chairs: Dr. Judy R. Dubno / Dr. Philip D. Hall*

**Goal Statement**

MUSC will be a leader in interprofessional/interdisciplinary practices by building on existing activities and fostering an environment that rewards innovative and integrated education, research, and patient care.

MUSC has been at the forefront of the national and international efforts to institutionalize Interprofessional/Interdisciplinary (IP/ID) education, research, and clinical care. In 2007, our leadership in this effort was enhanced by our 10-year educational Quality Enhancement Plan, Creating Collaborative Care (C3). Its guiding statement—Learning Together; Transforming Health—expresses an ambitious agenda to be reached through collaborative means. The University’s goal is to be a national and international leader in IP/ID education, research, clinical care and thereby transform health. Among other benefits, IP/ID efforts will better prepare the future workforce of South Carolina.

The objectives and strategies emphasize a three-stage process of assessment, implementation, and evaluation of IP/ID initiatives. While implementing this process and as a consequence of it, we also aim to create long-lasting IP/ID resources within MUSC, across our mission. Health care and biomedical research will be more effective when we work together, open to each other’s perspectives, eager to look for solutions we could not find on our own. We want MUSC faculty, staff, and students to serve as exemplary collaborators when working with patients and colleagues.
**Objective 1:** Foster existing initiatives and develop new opportunities that encourage interprofessional/interdisciplinary integration and experiences.

**Strategies:**

*Identify, assess, and analyze models*

- Evaluate existing campus and community models of IP/ID collaboration and disseminate successful program elements through education and publication across the University, State, and Nation.
- Determine the beneficial and constraining impacts of infrastructure on IP/ID effectiveness
- Create a framework of success criteria to assess current IP/ID programs and initiatives

*Implement and Disseminate*

- Ensure that systems of evaluation, including promotion and tenure, reward IP/ID collaboration
- Facilitate acquisition of IP/ID skills through continuing education opportunities for students, staff, and faculty
- Create new models and expand shared clinical and research resources for IP/ID education, practice, and research
- Improve the quality and safety of patient care through the development of IP/ID teams
- Increase the frequency of and venues for communication about IP/ID collaboration
- Create a University-wide educational database to maximize efficiencies and increase IP/ID opportunities

Evaluate outcomes using predetermined metrics, such as course evaluations, satisfaction surveys, clinical outcomes, publications, grants, and financial contributions, both qualitative and quantitative

**Objective 2:** Develop opportunities within and outside the institution and create partnerships with others to establish IP/ID collaboration as an ongoing University commitment.

**Strategies:**

- Secure private and public sources of funding
- Encourage the development of Centers of Excellence that promote IP/ID activities
- Develop and launch new degree programs that promote or require IP/ID collaboration for best outcomes, which include cross-college and cross-University courses and research opportunities
- Unify the leadership of IP/ID initiatives within central administration
- Seek funding to create endowed chairs for programs that promote or require IP/ID collaboration for best outcomes

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“MUSC’s commitment to interprofessional and interdisciplinary activities has been ardent. As a nationally recognized leader in this area, we found that our momentum allowed us to seek our own best practices, while challenging ourselves on how to expand them in ways across all aspects of our mission.”

- Judy Dubno, PhD & Philip Hall, PharmD, Co-Chairs
Over the past six months, Dr. Carlee Clark has been hard at work to get our Tanzania, Africa initiative to be recognized by the American Society of Anesthesiologists. She has been successful as demonstrated by our recent recognition on the ASA web page.

Dr. Carlee Clark
With my arrival to the Department of Anesthesia came some added knowledge and experience in working with Audio/Visual Equipment. The first mission objective was to begin renovations to Conference Room 314. The current educational set up consisted of a simple whiteboard with a projector that was limited to a small image for presentations. The projector would have to be positioned on the table at just the right angle and position for it to work correctly.

With the help of Geoff Freeman, Director of Educational Technology Services, we have completely turned around 314 with the addition of a brand new SMART Podium. This allows the presenter to bring his presentation to life by using the interactive pen display to make notes everyone can see, all from the front of the room.

The 7 foot wide automated screen greatly enhances image projection. With the new installation of audio equipment, lectures can easily be recorded. This will greatly enhance the utility of the room.

In addition to our own renovations, CSB 429 has taken on a new look as well. A new paint job and new chairs has made the room more aesthetically appealing. The new chairs will definitely make a more comfortable arena for our residents to hear lectures.
Under the leadership of Dr. Susan Harvey, medical directors, (Drs. Guidry, and Wallace) and the Doctors of the Day at each institution, the department continues to lead in ways to improve OR efficiency and performance. In this month’s edition are shown November’s data on First Case in room times, pre-op delay reasons and average turnover times. The first case initiative has been a big success and the data demonstrates our results accounting for all delays. Despite our success, the institution and our department can continue to improve.

One way to move these numbers even higher is to work on the most common reasons for the delays outlined in the table. Finally, the OR management group will soon be turning our attention to room turnover. At a quick glance, one can see that at UH and ART, turnover is averaging right at one hour and at RT, 35 minutes. We can do better and specific metrics will be developed in the New Year to help.
The excellence of our simulation center under the leadership of Dr. John Schaefer was recently recognized when the ASA approved MUSC as a MOCA Simulation Center. Simulation is part of the new American Board of Anesthesiology’s recertification program. This is big news for the department and anesthesiologists in South Carolina and the Southeast as this important certification can now be offered in Charleston at MUSC. The following materials answer the most frequently asked questions about this process.

### Frequently Asked Questions About Simulation Courses Offered for Part IV MOCA® Credit

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>1. Why is simulation part of ABA recertification (MOCA)?</td>
<td>The American Board of Medical Specialties requires the American Board of Anesthesiology (ABA) to include practice performance assessment and improvement in Part IV of the Maintenance of Certification (MOC). The ABA recognizes simulation training as an innovative approach to assess a physician’s clinical and teamwork skills in managing critical events and included it in the Part IV Maintenance of Certification in Anesthesiology (MOCA®) requirements.</td>
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<td>2. Why simulation?</td>
<td>There are relatively few learning forms that help anesthesiologists maintain clinical competence in ways that impact patient care. Many simulation programs now offer this form of learning. There is a belief that simulation will be valuable for anesthesiologists to refresh and assess their life-saving skills.</td>
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<td>3. How much will it cost?</td>
<td>Each simulation program sets fees based on local costs, number and type of support personnel, and other institutional costs.</td>
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<td>4. Why are MOCA-compliant courses only offered at specific simulation centers?</td>
<td>To ensure high-quality learning experiences that meet the simulation requirements of MOCA Part IV, the ABA requested that the American Society of Anesthesiologists (ASA) establish standards and endorse simulation centers that meet those standards. Simulation-based courses fulfill one requirement of MOCA Part IV. Please consult the ABA website, <a href="http://www.theABA.org">www.theABA.org</a>, for a list of all MOCA requirements.</td>
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| 5. Are there core aspects common to all simulation courses that meet ABA requirements? | The ASA Committee on Simulation Education, in conjunction with the ABA, has established core curricular components for all simulation courses that are taken to satisfy ABA requirements. These include:  
  - A minimum of six hours of total course instruction  
  - Active participation in realistic simulation scenarios  
  - Post-scenario peer debriefing  
  - Management of difficult patient-care scenarios  
  - An emphasis on teamwork and communication  
  - All participants have at least one opportunity to be the primary anesthesiologist-in-charge (i.e., the “hot seat”)  
  - One instructor must be an ABA Diplomate (i.e., a board-certified anesthesiologist)  
  - The instructor-to-student ratio must be no greater than 1:5 |
| 6. Are there any differences in courses offered at different centers?   | In addition to obvious differences like date, time, location, and institutional affiliation, courses may also differ in how the course content is organized and presented, instructor-to-trainee ratio, whether CME credit is offered, and cost. |
| 7. After I go to the course, how will I get my MOCA credit?             | To receive MOCA credit, the Diplomate must actively participate in the entire simulation course and complete a course evaluation and Practice Improvement Plan within three days of the course conclusion. Beginning 30 days after your course, you will receive three monthly reminders to complete a web-based attestation that includes a description of your Practice Improvement Plan. |
| 8. Can I participate in a simulation course that offers Part IV MOCA credit if I am not a MOCA Diplomate? | Licensed physician anesthesiologists who have completed their anesthesia residency training are allowed to participate in a simulation course that offers Part IV MOCA credit. However, the MOCA program requirements are specific to Board Certified anesthesiologists who have enrolled in the ABA MOCA program. These requirements are spread out over a 10-year period to ensure continuous learning and improvement. As a result, the required activities have specific completion dates. For example, a Diplomate who was certified in 2005 can complete a simulation activity between 2011 and 2015. This Diplomate would not receive credit for completion of a simulation course taken prior to 2011. |
| 9. Will I get CME credit as well as MOCA credit?                        | MOCA credit is independent of CME credit. Some centers may elect to provide CME credit. Contact the center where you will take the course for specific CME information about their courses. |
| 10. What can I expect to experience during a simulation course at an ASA-endorsed program? | Simulation courses are generally offered by ASA-endorsed simulation programs and directed by ASA-certified anesthesiologists. Course faculty must include individuals with demonstrated expertise in simulation-based education. The number of students is generally limited, with a high instructor-to-student ratio so that each participant can have a high-quality experience. Courses are designed to realistically recreate challenging clinical cases to allow participants to problem-solve in a manner that is similar to actual clinical experience. Faculty facilitates after-action debriefing, calling on all participants to contribute to the discussion about what went well and what could be improved. |
| 11. Do simulation-based courses focus on specific topics or clinical problems? | Topics that may be substantively addressed include:  
  1. Management of significant hemodynamic instability  
  2. Management of significant hypoxemia from any cause, including difficult airway
MUSC SIMULATION CENTER GETS ASA MOCA CERTIFICATION CONTINUED...

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<th>12. I only do subspecialty anesthesia. Will the course be relevant to my practice?</th>
<th>The MOCA-SUBS program is the only option for ABA Diplomates certified or recertified in a subspecialty in or after 2010. Diplomates awarded certification or recertification before 2010 may apply for subspecialty recertification as early as seven (7) years from their certification date and up to the application deadline of March 31, 2016. One requirement of the MOCA-SUBS program is participation in and completion of an ASA-endorsement simulation course. (Note: THE CONTENT OF SIMULATION COURSES FOR MOCA DIPLOMATES MAY NOT BE TARGETED TO SUB-SPECIALISTS)</th>
</tr>
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<tr>
<td>13. What is instructor-facilitated peer debriefing?</td>
<td>This is a process wherein a trained instructor/facilitator assists the participants as they review and reflect upon their own performances. It focuses on the learner and is designed to elicit thoughtful discussion after the simulation. This important element of the simulation allows the learner to sort out events, interpret what happened and develop strategies to improve performance.</td>
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<td>14. Will my performance during the course be evaluated?</td>
<td>Your performance during the course will be reviewed during the instructor-facilitated peer debriefing. However, you will not receive a formal, written evaluation of your performance. This is not a pass/fail exam, but an experiential learning opportunity that is designed to stimulate practice improvement.</td>
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<td>15. Will anyone besides the ASA and ABA know that I took an endorsed course or how I performed?</td>
<td>A notice of your participation will be sent to the ASA and ABA, but no report or record of your performance is given to other entities. Furthermore, each participant will be asked to sign a confidentiality agreement so that events and debriefings will not be discussed outside of the simulation experience.</td>
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<td>16. Can you assess my performance individually?</td>
<td>A valid assessment would require observation of performance of eight or more scenarios. Performance on several scenarios does not provide sufficient information.</td>
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<td>17. Will my performance be video recorded? How will these videos be used?</td>
<td>Most centers video record the simulation sessions to review performance during the instructor-facilitated debriefing. However, each center will use audiovisual technology differently, and you can discuss particular policies with the center that you select.</td>
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<td>18. I’m anxious about performing in front of my peers. How will this be handled?</td>
<td>Performance anxiety is normal, and instructors are aware of and sensitive to it. This important concern will be acknowledged and addressed at the beginning of each course. It is crucial that all participants agree to maintain the confidentiality of what happens at the simulation center.</td>
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<tr>
<td>19. Will my peers discuss my performance with others after the course?</td>
<td>Each participant will be asked to sign a confidentiality agreement so that events and debriefings will not be discussed outside of the simulation experience.</td>
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<td>20. Mannequins are plastic, not real people. How can this be realistic?</td>
<td>There are limitations in the technology. However, the mannequins, in conjunction with an effective story and other participants, can still provide an emotive experience.</td>
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<td>21. Will what I learn in the course have any effect on my care of real patients?</td>
<td>The course is designed to be relevant to the challenges of real patient care. It is certainly our hope that what you learn will help you to optimize your skills and behaviors. The simulation programs in ASA's Simulation Endorsement Network have demonstrated their ability to teach effectively using mannequin-based simulation.</td>
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<td>22. How will I interact with the other course trainees?</td>
<td>Some parts of the course involve presentation and discussion by the entire group of participants. A typical course has four to five participants going through the simulations (some might have more participants, but more than one room for simulation). The course contains several case scenarios. Participants rotate through different roles in the scenarios (such as the primary anesthesiologist, and one or more anesthesiologists who might respond if the primary person calls for help). Other roles in the rotation might involve observing a scenario in real-time on video, or acting as the scrub tech. All participants from all the different roles will undergo a facilitated debriefing together so that all viewpoints can be heard.</td>
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<td>23. Will I handle any cases by myself (as opposed to working in groups)?</td>
<td>Each participant has at least one scenario in which they are the primary anesthesiologist (sometimes described as “being in the hot seat”). That person may start the case from scratch, or may take it over from a preceding anesthesiologist (who may be played by an instructor). As in real cases, the primary anesthesiologist may call for help at any time, but it may take a while for help to be mobilized. The primary anesthesiologist and any helpers are expected to manage the clinical situation as they would in a real case, working collectively to optimize the outcome for the patient.</td>
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<td>24. How long does the course last?</td>
<td>The course requires a minimum of six hours.</td>
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<td>25. The course is pretty long. Will there be meal or other breaks?</td>
<td>Some centers may elect to divide a six to eight-hour course into two sessions, in which case meals may not be offered. Single-day courses include a lunch break.</td>
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<td>26. Is there anything I can do to prepare for my simulation course?</td>
<td>Since the course will focus on hemodynamic events, hypoxemic crises and teamwork skills, course participants may wish to review these topics in advance.</td>
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<td>27. How do I sign up for a simulation course?</td>
<td>See the ASA Simulation website <a href="http://www.asahq.org/sim">www.asahq.org/sim</a> for the list of Simulation Education Network (SEN) centers that offer simulation-based training. This webpage contains links to the centers’ websites, where information can be obtained about each center’s specific courses. Once you select a center, contact them directly to enroll. You may also click on the Calendar link on the ASA website and select the Simulation Education Network category to find programs submitted by SEN centers.</td>
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When I first agreed to help shop for the Families Helping Families Project, I had no idea how much work OR how much fun it would be. Not only did I experience the joy of helping brighten two families Holiday Season, but so did my children and husband as well. It took some explaining and a lot of repeating for my little boys, ages 3 and 5, to understand all the items we were purchasing were for other children and moms, but once they got it, they were hard to stop! They had a wonderful time being "in charge" of picking out toys for the boys and girls. A few times, I had to sneak items back on the shelf because of their enthusiasm. My husband Dean pitched in with picking out bicycles and hauling them in his truck as well as wrapping the boxes and boxes of presents piled on our living room floor.

I was amazed at how ready and willing our faculty, staff and residents were to give checks, cash and gift cards for two families they did not know but wanted to help. Our department raised over $1,400 dollars in cash donations; gift cards, toys, clothes, household items, books and a bicycle were also donated!

The two groups that were helped included two families of five, each with 4 children ranging in age from 6 months to 11 years. Each family member received everything on their wish list! With the donations we received, I purchased two to three sets of clothing for each member of the family, a set of pajamas, a jacket or coat, a blanket and shoes. Three lucky girls will get bicycles, one will receive an IPod, another a radio with headsets, and one child will have a Dora doll to love.

The little boys in the families will be playing with spider-man and transformer toys, and will have plenty of books to read. The two mothers will be able to outfit their kitchens with plates, pots, and even a set of curtains! Additionally, two gift cards were donated so the mothers could purchase groceries and other household items.

Overall, our department REALLY came through! I am very proud of the work we did as a group. It goes to show what can be accomplished when we all work together for a common purpose.
Beware of Similar Drugs!!

Can you identify the drugs in the figure below? Please be extra vigilant as you draw up and label medications. Recently, Fentanyl was converted to a vial similar to many more dangerous medications. How did you do with the identification process?

Moving Day for Dr. Frank McGowan!!

December 20, 2010 was the official moving day for Dr. Frank McGowan and his laboratory to the Children’s Research Institute (CRI). Dr. McGowan will be occupying lab space on the 6th floor. In addition, he will have his office on the 3rd floor of the Storm Eye Institute. We are all looking forward to his arrival!

Applauses!!

The American Medical Student Association and the College of Medicine held the 2010 Golden Apple Awards ceremony November 30th. The Golden Apple Awards honor teaching excellence across the curriculum. We would like to congratulate two members from the Department of Anesthesia and Perioperative Medicine for being nominated to receive the award:

Dr. Fred Guidry was nominated as a Faculty member by the Third and Fourth Year Classes for the 2009-2010 Academic Year

Dr. Rob Bartlett was nominated as a House Staff member by the Third and Fourth Year Classes for the 2009-2010 Academic Year
I discovered kitesurfing during my first year of medical school. One evening, as my wife and I were sitting on the beach, a lone kitesurfer came cruising by us. He was under tow of a giant kite that pulled him effortlessly in and out of the surf and lifted him up into the air with ease. I was amazed. It was quite simple; I had to learn to do it. Now four years later, having paid my dues and spent many evenings chasing the wind, I guess I could consider myself a kitesurfer.

Now five months into my training as an Anesthesia Resident I can’t help but find the similarities between anesthesiology and kitesurfing. Comparisons between the two are easy. To an innocent bystander, I imagine both seem interesting at first glance, but difficult to really understand. Both involve a labor intensive setup in which attention to detail is imperative. Most of the risks are involved in launching and landing. And once you are underway - you enjoy the ride, in what seems like cruising effortlessly while always looking out for any mishap which could come at any time.

Kitesurfing, much like practicing anesthesia, is a unique sport and the learning curve is quite steep. Eventually as I gained a little more experience in the surf, my anxious mindset gave way to personal routine, and my constant fear of the worst gave way to a deep respect for the consequence of adverse outcomes. Much like the OR, each time in the water is a learning experience. Small mishaps similar to missed A-lines, inadequate differential diagnosis, or miss-timed wake ups build character, while others give me a firm reminder of my limits. There is nothing like a difficult airway on a desatting patient or crashing a kite 100 yards offshore to get your adrenaline flowing, and make you appreciate the timely rescue from the more experienced colleague. With experience comes confidence, and most of your days are spent cruising, enjoying your surroundings, with constant vigilance and respect for a misadventure that could present itself at any time. At the end of the day, no matter your skill level, it is the unknown variables of the wind and waves, or unique comorbidities of each new patient that keep both kitesurfing and anesthesiology exciting. But regardless of how comfortable you may become on the water or in the OR, there is always more to learn.

So as I walk out of the OR after a busy day, I am glad to live in a city that allows me to step foot onto a beach in just 15 minutes. Conveniently so, the winds in Charleston usually pick up around 4pm and stay consistent until sundown. Whether it be in a gentle southwest sea breeze or a plundering northeastern storm, I have never been disappointed by my time on the water. I have found very few things in life that allow me to enjoy both the splendor of nature’s solitude and the shared excitement of that perfect session spent with good friends. Most importantly, whether your ride was perfect or less than desirable... at the end of the day you are still at the beach. All things considered, much like a day in the OR, I can’t think of anywhere else I would rather be.

Dr. Matt Crumpler Kite Surfing on Sullivan’s Island
The annual departmental holiday party was held on December 3 at the Charleston Yacht Club. Jerry and Jenny Reves were our member host. The department had a very large turnout of over 250 attendees. It was a very fun evening in a beautiful location with substantial free parking. Many have requested to return in the future. Enjoy the photos over the next two pages!!
ANNUAL HOLIDAY PARTY
ANNUAL HOLIDAY PARTY
Future Events/Lectures

1/3 – Pediatric Key Word Review, (CA2/3)
1/4 – Humanitarian Medicine (Grand Rounds), Dr. Stewart
1/5 – Anesthesia for Genitourinary Surgery (CA1), Dr. Clark
1/5 – Anesthesia for Patients with Renal Disease (CA1), Dr. Clark
1/10 – TBD (All Residents), Dr. Stricker (CHOP)
1/11 – Management of the Pediatric Difficult Airway (Grand Rounds), Dr. Stricker (CHOP)
1/12 – Anesthesia for Patients with Endocrine Disease, (CA1), Dr. McClerklin
1/12 – Anesthesia for Patients with Neuromuscular Disease, (CA1), Dr. McClerklin
1/17 – Common Pediatric disorders with craniofacial abnormalities, (CA2/3), Dr. Freely
1/18 – M & M, Dr. Harvey
1/24 – Neonatal and Pediatric Physiology, (CA2), Dr. Theruvath
1/25 – The Care of the Anxious Pediatric Patient and Family, (CA2/3), Dr. McMillan (MIISD)
1/26 – Management of Patients with Fluid & Electrolyte Disturbance, (CA1), Dr. Field
1/26 – Fluid Management & Transfusion, (CA1), Dr. Field
1/31 – TBD, (All Residents), Dr. Panni (UF)
2/1 – TBD, (Grand Rounds), Dr. Panni (UF)

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!! This month’s drawing winner is Erin Straughan, CRNA. Erin will receive a gift certificate. Congrats Erin!

Catherine Tobin: No outstanding medical student grades after fall audit.
Michelle Rovner: No outstanding medical student grades after fall audit.
Larry Field: No outstanding medical student grades after fall audit.
Katie Boan: Excellent work training and orienting our new anesthesia techs
Ken Grismore: Great job training & orienting our new periphery tech.
Cara Spaulding: Outstanding work in training and orienting or new techs.
Glenda Ross: Able to get badge access for me to this building; Always goes above and beyond for the department.

SAVE THE DATES:

- Resident Graduation, Friday, June 24, 2011, Charles Towne Landing