MESSAGE FROM THE CHAIRMAN:
-SCOTT T. REEVES, MD, MBA

Charleston: Nowhere Is Finer

October was a very good month for our fair city and department. Condé Nast Traveler magazine selected Charleston as the #1 tourist destination in the world for the first time, as well as naming it the top United States city for the second year in a row. Governor Haley made the announcement at Charles Towne Landing where she stated, “We beat out Florence, Italy. We beat out Paris. We beat out Sydney. We beat out all of these amazing places.” I have been very blessed and have had the opportunity to travel to many beautiful and exciting locations. I, too, frequently find myself thinking that the location is great, but it is not Charleston!

Just as Charleston continues to increase in the travel polls, our department is also no longer a secret. This year’s American Society of Anesthesiologists annual meeting allowed us to once again to highlight many of our excellent faculty, residents and medical students. We are world leaders in many areas including the use of cognitive aids in patient care decision making, simulation training of residents, and cardiac, regional, transplant and pediatric anesthesiology. Our OR management system, iVital, was one of the major technological breakthroughs in the exhibit hall and occupied much of Larry Field’s and Michael McEvoy’s time. Finally, our residency was approved to expand to 15 per year. We have much in which to be proud.
RESIDENCY COMPLEMENT INCREASE APPROVED
BY: MATT MEVOY, MD

The ACGME Anesthesiology Review Committee met last week. In this meeting, they approved our request to increase from 12 residents/year to 15 residents/year. We are excited to announce this increase! As was the case when we went from 9 to 12 residents/year in 2010, we plan to add 3 residents to the current intern class so that there will be 15 CA-1 residents next year. We will also plan to recruit and fill next year's intern class with 15 residents. We are excited for this expansion and the new educational opportunities that it will bring in anesthesiology and perioperative medicine!

The ACGME requires a large amount of supporting documentation when a request is made for an increase. These documents simply highlight all of the excellent clinical and educational work that occurs because of the efforts of everyone in the department. Congratulations to everyone and thanks for all of your hard work in our clinical and educational programs. I do want to take a moment to single out two groups of people very important and integral to this entire process. First, the residents. They work very hard and have done a great job with new rotations and expanding responsibilities, such as the new ART Pain Service and the Transition to Practice Rotation. I am proud of your hard work and leadership in the hospital. Second, as you all know, Leslie Fowler and Dawn Leberknight make the medical student, residency, and fellowship programs run and keep them in excellent order! So, a special thanks goes out to them as well!

DEPARTMENT DINNER AT THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS ANNUAL MEETING

Above (From left to right) Michael McEvoy; Sylvia Wilson, MD; Larry Field, MD; Mary Henry, MD; John Waller, MD

Below (from left to right): Alan Finley, MD; Scott Reeves, MD; Robert Harvey, MD; Matt McEvoy, MD
In October, many of our faculty, residents and summer research medical students presented at the ASA in Washington, DC. A sampling of presentation titles and duties are presented below.

**FACULTY**

Jake Abernathy  120 Minute Panel --*How to Keep Your Patients Safe Beyond FOCUS: The Collaborative Comes of Age* (speaker)
Workshop --*Intermediate TEE, The Great Vessels; Aortic Injuries* (faculty)
120 Minute Panel - *Perioperative Challenges in Aortic Valve Surgery*  
*Controversies in Aortic Valve Assessment* (speaker)

Carlee Clark  90 Minute Panel – *ACLS in the Perioperative Setting*  
*Real-life Cases* (speaker)

Larry Field  Workshop - *Ultrasound Applications for High Risk Perioperative Care*  
(faculty)

Alan Finley  90 Minute Panel - *Essentials of Cardiac Anesthesiology*  
*Essentials of Coagulation Management* (speaker)
AMERICAN SOCIETY OF ANESTHESIOLOGISTS ANNUAL MEETING CONTINUED...

Mark Hassid  
Clinical Forum - Adult Congenital Heart Disease – When You Cannot Find a Congenital Cardiac Anesthesiologist  
Major Abdominal Trauma Following Motor Vehicle Accident in an Adult with Repaired Tetralogy of Fallot (speaker)

Frank McGowan  
Clinical Forum – Adult Congenital Heart Disease – When You Cannot Find a Congenital Cardiac Anesthesiologist  
How Many, How Bad and How Do I Decide What to Do? (lead speaker)  
Refresher Course Lecture – Congenital Heart Disease in the Adult Presenting for Non-Cardiac Surgery (moderator)

Matt McEvoy  
90 Minute Panel - Updates and Controversies in ACLS With Case-Based Examples  
Cardiac Arrest in Special Situations: Pregnancy, Accidental Hypothermia, Drowning, Local Anesthetic Toxicity, Anaphylaxis (speaker)

Eric Nelson  
Workshop - Pacing and ICD Workshop  
Programming and Hands-on Training (faculty)  
Workshop - Basic TEE Workshop  
Basic TEE Views: Anatomy and Image Orientation (faculty)

Scott Reeves  
90 Minute Panel – Anesthetic Management for Thoracic Aortic Surgery  
Valve-sparing Aortic Root Surgery (speaker)
This past month I had the pleasure of attending the 2012 annual meeting of the ASA in our nation’s capital. In addition to the many educational opportunities the conference offered, I was able to give a medically challenging case poster presentation regarding fascia iliaca block for acute pain control in a trauma patient on maintenance Suboxone therapy. The whole process, from the initial write-up of the case, to standing beside my poster hanging on a cork board, answering questions from the moderating panel, and even learning to how to get a large poster tube on a plane, opened my eyes to the process of scientific communication and research presentation. The most significant interactions, though, came as other attendees came by my poster and discussed my case and shared similar experiences. I hope to be able to use this experience and the knowledge I gained from the conference to further support my practice at MUSC.
A RESIDENT’S EXPERIENCE AT ASA 2012
BY: ABDU ALGENDY, MD

This year I had the opportunity to attend the 2012 ASA meeting in Washington, DC. As the resident delegate for South Carolina, I had the opportunity to meet other residents representing their states at the House of Delegates meeting. It was an invaluable experience to learn how political decisions directly affect our practice as Anesthesia providers. Understanding that political involvement is critical to meeting the challenges our specialty face, such as underfunded Medicare payments for anesthesia services. I look forward to continue on the track of political involvement in advocacy involving such challenges.

Politics was not everything; educational sessions at the ASA were greatly beneficial as well. I attended a workshop on ICD/pacemakers, point counter point discussions and refresher course lectures. I listened to Robert Harvey and others present their medically challenging cases and talked with exhibitors and learned about the latest technology in our specialty. Outside of the Convention Center, my wife Aya and I had the opportunity to visit the National Geographic Exhibition for "1001 Inventions: Discover the Golden Age of Muslim Civilization" which uncovers a thousand years of advances in science and technology that have had a huge but hidden impact on the modern world. Also, Mark Henry and I enjoyed discovering ancient life and beautiful rare gemstones at the National Museum of Natural History. I would like to thank the Department of Anesthesia for giving us this great opportunity and supporting us in our educational endeavors.

Residents Abdu Algendy, MD and Robert Harvey, MD in Washington, DC for ASA
**NEW iVITAL APPLICATION ANNOUNCED IN POST & COURIER AND PRESENTED AT ASA**

On Saturday, Sunday and Monday in the Exhibition Hall, Dr. Field and Michael McEvoy were featured in the middle of the Picis booth, demonstrating the iVital iPhone/iPad app that has been created over the last year and a half. Thanks to many hours of hard work – including beta testing by many in the department – the app showed well, and interest was high. Over the 3 days of the exhibition, Larry and Michael completed at least 25 demos to overwhelmingly positive responses. Picis employees characterized the foot traffic as much higher than normal, with an emphasis on existing Picis customers coming by with eager anticipation, something that has been uncommon at prior conferences.

One particularly good demonstration – given to a customer who only has OR Manager installed – resulted in that customer telling a Picis Sales Representative, “OK. Now you can sell me Anesthesia Manager!” As a result of such a successful weekend, the department is anticipating a software license agreement in the coming months.

Michael McEvoy; Larry Field, MD; and Barbara Staruk (PICIS) demonstrating at Picis Booth at the ASA

After a long day of presenting Dr. Field takes a break in a Fuji chair at the ASA
NEW iVITAL APPLICATION ANNOUNCED IN POST & COURIER AND PRESENTED AT ASA CONTINUED...
©POST & COURIER, OCTOBER 22, 2012

Dr. Larry Field (left) and Senior Systems Engineer, Mike McEvoy, collaborated to create iVital, an app that they show to MUSC’s Director of Innovation and Entrepreneurialism, Thomas Finnegan. The app that Finnegan is helping the team to monetize enables doctors to track the vitals of patients in the operating room.

Tom Finnegan became director of the MUSC Center for Innovation and Entrepreneurship this summer and has been working with researchers and clinicians to get their devices, therapies or software—like iVital—into commercial use.
NORTH CAROLINA/SOUTH CAROLINA ANNUAL MEETING: CURRENT ISSUES IN PATIENT SAFETY, SEPTEMBER 28-30, 2012

Matt McEvoy and I had the opportunity to take our CA-1 residents to Myrtle Beach to attend the NC/SC annual meeting. This year’s meeting focused on patient safety. The weather was warm and overcast, but the meeting content was excellent. Matt spoke on *Perioperative Anesthesia Centric ACLS and Simulation* which highlighted much of the departmental research being performed in this area. The SC delegation recognized Dr. Fred Guidry with a Lifetime Membership Award for the significant contribution he has given to our specialty.

The residents had the opportunity to interact with leaders of our specialty including First Vice President of the ASA, Dr. Jane Fitch, Dr. Richard Dutton and Dr. Mark E. Nunnally. Dr. Fitch will be ASA president starting in October 2014.
Dr. Angela Mund recently transitioned into the AFN Program Director position following the administrative resignation of Dr. Anthony Chipas in August. Dr. Chipas will remain on faculty in the AFN division. Dr. Mund has been in the Assistant Program Director position since 2010. Prior to joining MUSC, she received her nurse anesthesia education at the Minneapolis MN Veterans Affairs Medical Center and her DNP in 2008 from the University of Minnesota School of Nursing. She served as faculty in the CRNA program at the University of Minnesota and maintained a clinical practice at the VAMC. Dr. Mund looks forward to assuming this leadership role in the College of Health Professions and working collaboratively with all providers within the Department of Anesthesia and Perioperative Medicine.
MEET THE NEW RESEARCH STAFF

Simone Chinnis joins Anesthesia as our new Research Nurse Coordinator. She relocated to Charleston from Miami, Florida, where she was the Research Nurse Manager of the CTSA-funded Clinical Research Center at UM’s Miller School of Medicine. She double majored in Spanish and Health Exercise Science at Furman University. After graduation, Simone gained employment with REACH 2010 at MUSC, which led to the pursuit of a Bachelor of Science in Nursing. She began her career in nursing as a Pediatric Cardiac Perioperative Nurse and was then recruited to work as a Research Nurse at the Clinical & Translational Research Center.

During her time of employment at the CTRC, Simone obtained a Master of Business Administration. Key aspects of her jobs in research consist of working to improve the quality of data collection, providing patient care and manifesting the highest standards of clinical research practice. Simone is enthusiastic about her position as a Research Nurse Coordinator and is looking forward to becoming an integral member of the research team.

RESIDENTS AS TEACHERS
BY: MATT MCEVOY, MD

One of the Educational Goals in our 5-year Departmental Mission Plan for Education was to develop a ‘Residents as Teachers’ curriculum. The ACGME desires for residents to have opportunities to develop their teaching skills outside of the clinical arena. As such, our residents devised a Medical Student Lecture Series last year under the direction of Dr. Tim Heinke and Dr. Tara Queener. It involves weekly lectures while medical students rotate with us and it is completely resident-run. In addition to this series, we have had a number of opportunities develop in which our residents are able to teach medical students outside of the OR, ICU, and Clinic. Over the past 3 years, they have participated in a number of workshops, including the SimMan Vital Signs Workshop, the Harvey Simulator Cardiac Auscultation Workshop, and the SimMan ECG and Basic Arrhythmia Workshop. We are proud that they continue to participate in these teaching opportunities and look forward to their continued participation in teaching physiology, pharmacology, and physical diagnosis to medical students. In the future, we will continue to develop this program and expand both the offerings in which our residents will teach and the educational opportunities in which they can learn to refine their teaching skills (lectures and workshops). Keep up the good work!
A Retrospective Evaluation of Intraoperative Fluid and Vasopressor Use in Head and Neck Free Tissue Transfers

Introduction/Background

A retrospective review of patients who underwent a head and neck surgical free tissue transfer was performed to evaluate the impact of intraoperative fluid and vasopressor use on flap complication and failure rates.

Method

We identified 235 consecutive patients over a period of 34 months. Demographic, patient characteristic and intraoperative data regarding fluid and vasopressor administration were extracted from medical records. Flap complication and failure rates within the first 30 days were recorded.

Results

Flap complications were significantly associated with transfusion of packed red blood cells, total amount of fluid received, net fluid balance, and the rate at which fluids were given. Patients that received packed red blood cells had 1.83 times the odds of flap complications.

In addition, a 1 ml·kg⁻¹·hr⁻¹ increase in the rate of fluid administration was associated with 16.5% higher odds of a flap complication, and a one liter increase in the total fluids received was associated with an 11% increase in the odds of a flap complication.

Flap failure was significantly associated with reason for surgery (OR 5.40) and preoperative diagnosis of coronary artery disease (OR 3.60). Intraoperative vasopressor administration was not associated with either flap complication or failure rate.

Conclusion

The type and rate of intraoperative fluids given as well as net fluid balance are significantly associated with flap complications, but the use of vasoactive drugs is not. It may be that more judicious use of vasopressors could lead to better outcomes during head and neck free flap surgery.

Validation of ACRM Checklists Comparing Novice and Expert Graders Using Video Recordings of Simulated ACLS Mega Code Events

Project Summary

This project was a continuation of ongoing simulation research regarding ACRM checklists and ACLS Mega code events. The goal of this project was to validate a set of ACRM checklists that had been developed for the following events: STEMI, MH, CVA, Anaphylaxis, and Hyperkalemic Arrest. A group of four medical students acted as novice graders to view and grade a set of videos on each scenario. Each individual video (two videos for each scenario) was reviewed and graded twice continuously and twice with pauses by each student using the previously developed ACRM checklists. A group of faculty graders also evaluated the same scenario videos as a group to act as a gold standard in order to validate the novice graders’ use of these checklists. This validation process was designed with the goal of having checklists for novice graders to use to accurately evaluate high-fidelity ACRM simulations in the future. This project is nearing completion and a manuscript submission will be forthcoming.

Experience

During my summer research fellowship, I had the opportunity to work on both a retrospective study using charted information as well as an ongoing project that aims to eventually perform high-fidelity in situ simulations for ACRM checklist validation. Through this experience I gained a much greater appreciation for the amount of work it takes to plan, carry out, and publish a research study. I enjoyed learning from mentors that were willing to share their wisdom about how to ask pertinent clinical questions and seek to answer those questions with strong evidence, and want to thank the Department of Anesthesia, Dr. Matthew McEvoy, and Dr. Julie McSwain for the opportunity this summer. I look forward to continuing to develop the skills required for clinical research that have begun to develop as a result of this summer research fellowship in the near future.
Effect of a Designated Reader and Cognitive Aid on the Resident Performance During Simulation of Perioperative Emergencies

Introduction/Background

Use of cognitive aids by a team leader has improved performance during high-fidelity simulations of in-hospital cardiac arrest.1 One previous study reported that the use of a designated reader of patient management protocols may increase guideline adherence during perioperative emergencies.2 Accordingly, we conducted a randomized, controlled trial to test whether the addition of a ‘Reader’ plus electronic cognitive aid (‘App’) was superior for managing multiple perioperative emergencies when compared to management from memory alone.

Methods:

After IRB approval and informed consent, 27 anesthesiology residents ranging from PGY1 to PGY4 were enrolled and randomized into two groups: Reader+App (N=14) and Control (N=13). Each resident managed four high-fidelity simulations of perioperative emergencies, which were video recorded for later scoring. The scenarios were Anaphylaxis, ST Elevation Myocardial Infarction (STEMI), Malignant Hyperthermia (MH), and Hyperkalemia (HYPERK). In all cases SimMan3G® (Laerdal Inc.) and trained confederates were used to simulate the patient and clinical staff, respectively. At a standardized point in the scenarios, the Reader prompted the participant for a diagnosis, and the Reader offered to read protocol steps of that diagnosis for those in the Reader+App group. For the Control group, this person made themselves available to assist in any way needed. In the Reader+App Group, an anesthesia technician was trained and equipped with a novel iOS-based App containing management protocols for numerous perioperative emergencies. The Control group had an equivalent number of confederates present and were available to assist with any task. Performance was assessed using a grading checklist that was developed through a modified Delphi technique and based upon published best-practice guidelines, with certain items deemed to be ‘critical’ actions (e.g. beta-blockers in STEMI scenario). Performance was recorded as the percentage of overall and of critical items performed during the scenarios.

Results:

The Reader+App group performed significantly better in all four scenarios in overall performance (% of steps correctly done) and in 3 of the scenarios in percentage of critical steps performed (see Figure 1). The percentage of overall correct steps in Anaphylaxis increased from 62±15% in the Control group to 75±17% in the Reader+App group [p<0.04], in STEMI this increased from 50±8% in the Control group to 81±11% [p<0.0001], in MH this increased from 43±12% in the Control group to 61±10% [p=0.0006], and in HYPERK this increased from 66±8% in the Control group to 79±8% [p=.0008].

Conclusion:

Our results demonstrate that the implementation of a Reader with a novel decision support tool markedly improves adherence to published guidelines for patient management during a variety of simulated perioperative emergencies. Although participants in the Reader+App group performed remarkably better than the control group, the critical averages still fell below 100% compliance. Future studies are needed to elucidate a) how to improve adherence to 100% of published guidelines, b) whether these findings are reproducible during in-situ simulation using real clinical teams, and c) who is the most appropriate personnel for the Reader role.

Experience

I had the opportunity to do research in the department since year one, originally helping to develop ACRM scenarios in the Sim Center. That exposure allowed me to continue work with various Sim related projects with a numerous different faculty. I'm very grateful for the opportunities to learn about best practices, emergency related protocols and airway management. Additionally, and the access researching gave me to the thoughts and expertise of faculty was an elemental part of my decision to pursue Anesthesia.
Simulated Arterial Blood Pressure Feedback Improves Chest Compression Quality

Introduction/Background
Quality chest compressions (CC) are the most important factor for success of cardio-pulmonary resuscitation (CPR) during cardiac arrest. While it is known that the quality could be improved, the exact method for maximizing quality for the individual patient is not known. Adjustment of CC based upon an invasive arterial blood pressure (ABP) display theoretically would be beneficial. Such feedback could be established in the perioperative setting and possibly could improve patient outcomes. Additionally, having one compressor present for longer than a 2-minute cycle with an ABP display may allow for a learning process during which CC could be further maximized, assuming fatigue did not ensue. Accordingly, this prospective simulation study was done to test the hypothesis that CC can be improved with a real-time ABP display of invasively measured blood pressure and with an unchanged, physically-fit compressor.

Methods
An endotracheally intubated Laerdal® manikin was equipped with a linear potentiometer and a programmed microprocessor unit to allow quantitative analysis of CC and display of simulated achieved ABP. This display was derived from a hemodynamic model responding to the CC concerning the parameters of CC rate, depth, and compression-decompression ratio. The area under blood pressure curve over time (AUC) was used as the target parameter for data analysis.

After IRB approval, written consent was obtained from all participants (N=20). Participants had to self-report at least 5 hours of aerobic exercise per week. Each participant performed 4 CPR sessions, with each session having five 2-minute cycles of continuous CC with 10-second pauses between cycles for a simulated pulse check. The 4 CPR sessions were: a) No ABP display, exchange of compressor every 2 min; b) ABP display, exchange of compressor every 2 min; c) no ABP display, no exchange of the compressor; d) ABP display, no exchange of the compressor. Data were analyzed by ANOVA and non-linear multi-effects modeling. Significance was defined as p<0.05.

Results
Enrollment included 5 females and 15 males; age 25±2.7 years, weight 76.9±13.4 kg, and height 178±11.6 cm. The average of the achieved simulated mean ABP (MAP) was 43.3±8.7 mmHg for runs without ABP display and MAP of 50.9±6.1 mmHg for runs with ABP display (p<0.01). The average AUC for runs without ABP display was 5201 mmHg*s (95% confidence interval (CI) of 4804 to 5597 mmHg*s), and for runs with ABP display 6110 mmHg*s (95% CI of 5715-6507 mmHg*s) (Figure 1, p<0.01). The average increases from runs without to runs with ABP display for each participant was 20.2±17.4%.

Conclusions
Our study confirms the hypothesis that a real-time display of simulated ABP during CPR that responds to participant performance improves the achieved and sustained ABP. Compressors performing CC for more than 2 min could have opportunity to optimize CC, but would be at risk of fatigue even with good physical condition. However, in the high-tech environment of perioperative medicine, where an arterial line could be placed by a skilled provider in the setting of cardiac arrest, measures beyond current ACLS guidelines for CPR could be beneficial. Further studies using hemodynamic models in a modified manikin need to be performed in order to confirm our findings.
Effect of a Novel Cognitive Aid on Adherence to Guidelines in the Management of Medically-Unstable Patients

Introduction/Background

Each year in the United States, 500,000 people have a myocardial infarction (MI), 634,000 people are hospitalized for a Chronic Obstructive Pulmonary Disease (COPD) exacerbation, and 11-42% of medical in-patients have delirium. (1,2,5) Each of these unstable conditions have best-practice guidelines that are published for proper patient assessment and management. Interns are frequently the first-line of assessment and care in these situations. However, little training is given for the assessment and management of unstable patients in most medical school curricula (3). One study has shown that cognitive aids can improve adherence to guidelines in simulations of cardiac arrest. (4) However, this has not been evaluated in medically-unstable patients. As such, we performed a pilot study to test the hypothesis that the use of an iOS-based cognitive aid application (APP) will improve adherence to published guidelines for the management of a variety of unstable patient conditions by 4th year medical students and interns.

Method

After IRB approval and informed consent, four interns and twelve 4th year medical students were enrolled and randomized into two groups: No APP (N=8) and APP (N=8). All participants had been given an orientation to the simulation setting prior to involvement with this study. Each participant managed 3 unstable patient scenarios: ST-Elevation MI (STEMI), COPD Exacerbation, and Delirium. Two actors trained as standardized patients portrayed a patient and nurse in each station. The APP group was given a brief orientation to the iOS-based APP containing management protocols. Performance was assessed through a grading checklist that was based upon published management guidelines and finalized through a modified Delphi technique. Overall scores and critical item scores were recorded as a percent (%) of total items completed. To compare the effect of APP v. No APP, data were analyzed via a general linear mixed model with random participant effects to account for multiple measurements recorded on individual participants and are reported as Mean±95%CI.

Results

Compared to no APP use, APP use was associated with significantly higher scores for each individual scenario and overall for both overall correct (%) and critical actions correct (%) (p<0.001 for all comparisons, see Figure 1). On average, the APP group performed 30.2 percentage points higher on the overall % correct than the No APP group, and 26.9 percentage points higher on the critical items % correct (p<0.0001 for both). Interaction terms involving scenario and APP use were also assessed, and they were not significant, meaning that the APP did not differentially help in one scenario versus another. This is true for overall scores and for critical scores.

Conclusion

This pilot study tested the effects of a novel electronic cognitive aid (APP) on the assessment and management of medically-unstable patients. Three important findings emerged. First, the APP significantly improved performance across scenarios involving cardiac, pulmonary, and neurologic/psychiatric instability. Second, senior medical students and interns managing these conditions from memory alone had a very poor adherence to published guidelines. Third, even with the APP, students failed to reach a score of 100%. Thus, future research needs a) investigate the best pedagogical approach for training medical students and interns to manage medically-unstable patients and b) perform human factors analysis on the cognitive aid in order to determine the barriers to 100% adherence to published best-practice management guidelines.
Faculty Mentoring
By: Fred Guidry, MD

Going forward, both the Department and the College of Medicine would like for all younger faculty to have a mentor. After extensive discussion at the Executive Committee, it was felt that the best initial step would be for each individual to suggest their own mentor. The overall goal of the mentor-mentee relationship is to maximize the mentee's career potential.

That encompasses several aspects, including advice in area of focus (e.g., research, teaching, clinical care); professional development, which should include an active role for the mentor in promoting the career of the mentee (e.g., suggesting role for mentee at meetings or committees, introducing the mentee to leading experts, etc.); monitoring the progress of the mentee; helping to ensure academic promotion of the mentee at MUSC; academic career guidance; and psychosocial support.

In general, you should look for a mentor that has a similar career focus (clinical or research for example), is in a similar clinical subspecialty, and with whom you have a good working and personal relationship. It is acceptable to select a mentor outside the department.

If you are a Professor or Associate Professor, we would welcome your suggestions about who you would prefer to mentor.

If possible, make more than one request so that the assignments can be evenly divided among the available mentors.

It is likely that the department will adopt part of the E-Value system to guide you in implementing a career development plan and to assist you and your mentor in tracking your progress.

While it is optimum for all Assistant and Associate Professors to have a mentor, it may be that a mentor is not appropriate for your situation. If that is the case, please let me know that you would prefer not to have a mentor. All suggestions will be kept confidential.

Please note that The College of Medicine Faculty Affairs Team is presenting a new series of Faculty Affairs Roundtables. The goal of these sessions is to provide faculty with an understanding of departmental mentoring plans and to provide an overview of the APT process.
MUSC Gloving Up: Breast Cancer Awareness

From pink feathers flying around Ashley River Tower to water splashing past dragon boats in Charleston Harbor, the filming of MUSC’s Pink Glove Video brought out people’s passion to support a good cause. Anyone can go online to vote and help MUSC win $10,000 in Medline’s Pink Glove Dance Contest.

The video helps to raise awareness of breast cancer. About 200 employees participated in the filming that used more than 10 locations, including MUSC Health East Cooper.

Thank you to all who participated from our department in the MUSC Gloving Up video. Pictured are a few of our department participants, Dr. Eric Nelson and Dr. Susan Harvey.
“Post-Operative Cognitive Dysfunction”
November 6, 2012
Kenneth Hiller, MD
University of Texas
Assistant Professor

“Optimization of the Cardiac Patient for Surgery”
November 13, 2012
William Bradford, MD
Medical University of South Carolina
Cardiothoracic Fellow

“Perioperative Management of Sickle Cell and Thalassemia”
November 20, 2012
Scott Walton, MD
Medical University of South Carolina
Associate Professor

“Perioperative Cardiac Guidelines and Risk Stratification”
November 27, 2012
Eric Nelson, DO
Medical University of South Carolina
Assistant Professor
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 receptionist or Kim. Thanks so much!!

Young Choi, MD, Chief Resident— In recognition of your support during an un-posted emergency.

Holiday Party: December 1, 2012
Location: Carolina Yacht Club.

Resident Graduation: June 21, 2013
Location: Francis Marion Hotel

November 2012
Standard of the Month

Answer questions posed by patients, students or staff to ensure understanding and facilitate learning.

We Would Love to Hear From You!
If you have ideas or would like to contribute to Sleepy Times, the deadline for the December edition will be November 21, 2012.