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

Over the past month, a lot has been in the local and national news regarding the Patient Protection and Affordable Care Act or Obamacare. South Carolina remains in the headlines as Governor Haley has been vocal about her concerns of the sustainability of the program and its effect on the non-healthcare spending priorities of our state. I personally have made two trips to Columbia to discuss the effect of Medicaid expansion on perioperative services and my desire to be a resource and partner in restructuring how we care for patients from the time they are scheduled for surgery (preop evaluation) to the time they are discharged. The Governor and Tony Keck (SC DHHS Director) are interested in hearing creative solutions, and we are making headway in outlining how all of us can improve the care delivered during a patient’s surgical admission. As part of this dialog, Drs. Catherine Tobin, GJ Guldan and David Stoll represented the College of Medicine in South Carolina Physician White Coat Advocacy Day. It is critical that we make ourselves available to our legislators both at the state and national levels.

Care is not all about money but more importantly about quality. I am pleased that in this edition of Sleepy Times, the department is recognized for Frank McGowan’s ground breaking research in O2 delivery technology, our substantial contribution to the MUSC Children’s Heart Center and our OR efficiency efforts. Along those lines, it is with great anticipation that I announce that Dr. Tod Brown has agreed to lead the department’s efforts to expand our preoperative clinic with the move to the newly renovated Rutledge Tower 2nd Floor Preoperative Clinic on March 4. Our new clinic is the cornerstone of our future plans into perioperative care.

I hope you all have as much fun reading this month’s Sleepy Times as I did editing it.
On Tuesday, January 29, 2013, physicians from across the state traveled to the South Carolina State House to lobby for Medicaid Expansion. The South Carolina Physician White Coat Advocacy Day was organized by the SCHA (South Carolina Hospital Association). A total of 49 physicians from MUSC came. From our department, Drs. GJ Guldan, David Stoll and myself attended. It was an eye opening experience!

Here is some background information on the issue as I understand it. I realize that this is a highly political topic that provokes a lot of strong feelings. There will need to be a lot of give and take from all arenas as we strive to provide the best quality healthcare to all individuals while being fiscally responsible.

The Affordable Care Act (ACA) (also known as Patient Protection Affordable Care Act (PPACA) or Obamacare) was signed into law on March 23, 2010 and upheld by the US Supreme Court on June 28, 2012. As part of the ACA package, in order for a state to receive financial assistance from the Federal Government, the state must agree to expand Medicaid to include South Carolinians from age 18 to 64 with income up to 138% of the federal poverty level (FPL). The estimates vary but it seems to hover around 300,000 additional adults eligible for SC Medicaid.

In addition, as another agreement within the ACA, hospitals will lose a tremendous amount of revenue via a decrease in reimbursement from Medicare. Expanding Medicaid to cover the uninsured will help to offset some of this loss since hospitals could bill for what would otherwise be unbillable care. This “free” care has been offset in the past via Emergency Medical Treatment and Active Labor Act (EMTALA) as well as a loss to the hospital and/or transferred to higher premiums for those that are privately insured. The idea of Medicaid expansion is that by providing healthcare to this uninsured population (including preventative care), we as a society will cultivate a healthier population and cut down on the exceedingly expensive ER care administered when people arrive deathly ill. The expansion is projected to add several thousand jobs as well as create a tremendous amount of tax revenue for SC.

The Federal Government will fully subsidize this expansion from 2014 to 2016. After 2016, the amount of support will taper off until it reaches 90% in 2022. A lot of opponents fear that this amount of financial support from the government will result in even higher taxes (than those already enacted), and they also fear that the lower support limit to the states (90%) will drop even lower. The current federal assistance is 70%. Opponents do not feel this is the best way to cultivate a healthier society.

The Governor has to make the call, and so far she has stated that she will NOT expand Medicaid (we will still fund Medicaid expansion for every state that does accept it, and we will still bear the financial burden of the uninsured in our state that remain uninsured). It appears, that as of February 6, 2013, 11 states maintain that they do not plan to participate, and five other states are leaning towards not participating. You can follow each state’s stance on this website:


Now, to summarize the day:

We were briefed by Dr. Kris Crawford, an ER physician and state representative from Florence, SC. He understands the importance of Medicaid Expansion for the health of our patients in South Carolina. He supports Medicaid expansion, but few in our State House do.

After the briefing we were shuttled to the State House. We were introduced as a group to the House of Representatives by Kris Crawford, MD. We were then introduced to the South Carolina Senate by Senator Hugh Leatherman. In between these introductions, we stood in the lobby between the Senate and the House side and spoke with as many senators and representatives as we could. (Lobbyists really do spend a lot of time in the lobby, GO FIGURE!). It was an energetic, crowded, and fascinating space. MUSC physicians spoke with Senators George E. “Chip” Campsen, Lawrence “Larry” Grooms and representatives Harry C. “Chip” Limehouse and Paul Thurmond. Some lawmakers appeared frankly uninterested in our conversation.
Although many people are or were opposed to the ACA, it is here; and as health care professionals we have to work together to do what is best for our patients. As it currently stands, the ACA meets a lot of resistance from Republican lawmakers. Although the expansion may not occur immediately, it is felt that all states will accept the expansion once the financial burden is realized.

Key talking points were:

- Without insurance and access to preventative care, patients arrive in the ER with more severe conditions requiring more expensive care for which they cannot pay.
- Expanding Medicaid will provide many of our patients the preventative care they need so they will stay healthier.
- Medicaid Expansion will provide South Carolinians from age 18 to 64 with income up to 138% of the federal poverty level (FPL) health insurance. (138% FPL is about $15,000 per individual and $31,089 for a family of 4)
- On the brink of coverage, just in Charleston, Berkeley, and Charleston counties combined, Medicaid expansion would give approximately 37,000 people coverage.
- If SC rejects Medicaid expansion, we will forego $11.2 billion in federal funding from 2014 to 2020 to extend coverage to our most vulnerable poor population.
- Medicaid expansion will provide a positive economic impact by creating new jobs. (4,393 in just Berkeley, Charleston, and Dorchester counties alone). This will help us pay for the 10% of Medicaid that we will have to pay for after 2020.
- SC hospitals already agreed to federal cuts of $2.7 Billion dollars from 2014 to 2020. We have to find ways to offset these cuts with or without Medicaid expansion.

It is a myth that most uninsured patients do not work. In fact 7/10 of those without health insurance in SC live in a home with working family members.

It is important that MUSC faculty and staff educate themselves on this issue and contact your representatives! Feel free to contact us with questions.

Catherine Tobin   tobinc@musc.edu
David Stoll   stollwil@musc.edu

Dr. Allen, Dr. Guldan, and Dr. Tobin

Dean of MUSC College of Medicine
Dr. Etta Pisano at White Coat Ceremony

Dr. Stoll and Dr. Tobin
Recently the MUSC Children’s Hospital published its annual report on our Pediatric Cardi thoracic program entitled “Healing Young Hearts”

A portion of it has been included to highlight the substantial contribution our department gives to the overall success of the program. It starts with a two page description of Cardiothoracic surgery with Cardiothoracic anesthesia immediately following. This is an amazing recognition of our fine anesthesia care team model in this complex patient population.
Recently the MUSC Children’s Hospital published its annual report on our Pediatric CardiThoracic Program entitled “Healing Young Hearts” continued

Cardiothoracic Surgery

Under the leadership of Dr. Scott Bradley, surgeons at the MUSC Children’s Heart Center excel in the full range of pediatric surgical procedures for acquired and congenital cardiac disorders. More than 400 major operations are performed annually. Our specialists treat patients from birth, through adolescence and, in the case of congenital heart disease, into adulthood.

Our comprehensive surgery program is the only one in South Carolina, and, with an overall 30-day survival rate of 99%, ranks among the best in the world. The combination of specialized advanced technology and an individualized approach to each patient in an intimate, attentive environment ensures this continued success. The number of surgical procedures we perform has steadily increased every year since 1996 through ever growing regional, national and international referrals.

The high standard of care maintained by Children’s Heart Center surgical specialists is reflected in our achievements:

- A 99 percent 30-day survival rate for all surgical procedures from 2007-2012
- A 90 percent discharge survival rate for the Norwood procedure for hypoplastic left heart syndrome from 2007-2012
- Special expertise in reconstructive surgery for the correction and palliation of all forms of cardiac defects in infants, children and adolescents
- Emphasis and excellence in early complete repair during infancy
- Surgical management of patients with congenital heart disease from premature neonate to adult
- Innovative improvements in surgical techniques and operative strategies such as heart-lung bypass, blood preservation and minimally invasive surgery
- One of the country’s only dedicated Pediatric Cardiac Intensive Care Units (PCICUs), the 12-bed PCICU has the latest technology and is designed specifically for the critical care of all pediatric cardiac cases, including postoperative monitoring and management
- Ross repair for aortic valve replacement and valve-sparing aortic root replacement for Marfan Syndrome
- 24 hour Extracorporeal Membrane Oxygenator (ECMO) availability
- Biventricular pacemaker therapy and pediatric Automatic Implantable Cardioverter Defibrillator (AICD)
- The first implantation of the Berlin Heart Ventricular Assist Device in the Southeast
Recently the MUSC Children’s Hospital published its annual report on our pediatric cardiothoracic program entitled “Healing Young Hearts” continued

Cardiothoracic Anesthesia

State of the Art Technology and Care

Providing world-class surgery requires a team approach. An essential part of any surgery is managing pain. Children with congenital and acquired heart disease have special needs when it comes to anesthesia. Lead by the Chairman of Anesthesia Dr. Scott Reeves and Chief of the Division of Pediatric Anesthesia Dr. Frank McGowan our dedicated team of 7 specialized pediatric cardiothoracic anesthesiologist are best qualified to plan safe anesthesia for each child individualized based on age, weight, diagnosis, type of surgery/procedure and past history. Their services include:

• Evaluation of the child and discussion with parents prior to the procedure
• Individualized comprehensive management during surgery — including anesthetic drugs, management of cardiovascular drugs, and transfusion of blood products
• Anesthetic care of children undergoing cardiac catheterizations, electrophysiology studies and advanced cardiac imaging studies
• Anesthetic management of children with congenital heart defects undergoing noncardiac surgery — including the coordination of multidisciplinary providers
• Development and refinement of strategies, equipment, drugs and techniques to optimize outcomes

Tracheal Stenosis Program

Congenital tracheal stenosis due to complete tracheal rings is a life-threatening problem requiring surgical treatment in the great majority of cases. Approximately half of children with congenital tracheal stenosis have concomitant congenital heart anomalies. Surgical management generally includes slide tracheoplasty that is performed on cardiopulmonary bypass. Associated cardiovascular anomalies are addressed during the same procedure.

Successful treatment requires a team comprised of several pediatric subspecialists: cardiologists, cardiothoracic surgeons, otolaryngologists and anesthesiologists. With experienced specialists in all of these areas, MUSC Children’s Hospital has excelled in the treatment of these complex patients. To date, our one-year survival rate after slide tracheoplasty is 100%.
Research Selected as “World Changing Idea”  
By: Dawn Brazell/MUSC News Center

The parents he meets know him as their child’s anesthesiologist at MUSC Children’s Hospital. Others may recognize him from billboard and print ad campaigns where he’s dressed in a monkey cape blowing bubbles with children.

But there’s yet another side to Frank McGowan, M.D., who spends some of his research effort collaborating with researchers at Children’s Hospital Boston in Massachusetts on a new technique being heralded as a potential medical breakthrough. The team has developed a microparticle-based oxygen-delivery technology that oxygenates the blood and bypasses the lungs. It has the potential of saving lives for a wide array of patients and conditions, from wounded veterans in the field to premature babies in intensive care units.

The research landed on the cover of the December issue of Scientific American being chosen as one of 10 world changing ideas. It also was the cover of the journal Science Translational Medicine in June 2012 with its successful use in an animal model. McGowan said the possibilities of promising clinical applications will keep researchers busy for many years to come.

The idea first came up five years ago when McGowan worked at Children’s Hospital Boston and a doctor in residence, John Kheir, M.D., asked how he could have saved a patient he lost because of an inability to quickly oxygenate her blood. “We started thinking why don’t we have better ways to acutely deal with this while we’re trying to figure out what we’re going to do longer term.”

Then Kheir and McGowan began to do more than talk. The challenge was to devise some kind of shell to safely encase and deliver oxygen in the blood so that it could release the encapsulated oxygen to deoxygenated blood and then collapse in a non-toxic form to be eliminated.

“We found that there are materials that can do that with shells made of lipid or mixture of fats and other substances, many of which are normally found in the body. We found a number of really smart people who had spent their lives trying to figure out how to encase various substances, biologic drugs, viruses, genes and other things in lipids and other compounds. There’s always a whole world out there when you go looking.”

McGowan said the research is the perfect example of why basic science research is needed. “There was a tipping point. People had devoted careers doing fundamental work in related areas for many reasons and applications; we were able to study it and theorize based upon it. If we had to start completely from scratch, we would have spent five careers to be able to do this.”

Another advantage of having physician-scientists collaborate with basic scientists is that the former could understand and take advantage of the basic research and apply it to solve a clinical problem. Part of this was having the knowledge to construct the right paradigms and develop effective experimental models, he said. “It’s these interactions with people of widely disparate backgrounds and experiences that produce the best results sometimes.”

That’s not to say it was easy. McGowan said they had many failures until about three years ago when their persistence started to pay off. McGowan recalls he was just finishing a case in the operating room, and they decided it was time to test the latest shell version. They drew some of his blood and made it hypoxic, turning it dark red. When they injected the substance, his blood turned pink. It was a turning point. They then had a number of things to test, including defining the chemical and biologic characteristics of the microparticles shells before designing an animal model to test the further refined foam suspension.
The suspension contains lipid-based microparticles smaller than what would block the body’s tiniest capillaries that encapsulate a core of pure oxygen gas that can be delivered via intravenous injection. Once the shell delivers oxygen, it collapses to sub-micron size and is eliminated by normal body processes; the amount of lipid delivered is consistent with what can be tolerated in other medical applications, he said.

McGowan said the ability to administer oxygen and other gases directly to the bloodstream may represent a technique for short-term rescue of profoundly hypoxemic patients, to selectively augment oxygen delivery to at-risk patients or organs, or for novel diagnostic techniques. They will need further research to prove the lipid delivery system is safe and to find the optimum chemical formulation and delivery method.

One of the main advantages he foresees for when it’s ready to be used clinically is that it can buy time in situations with acute airway loss. “We’d be able to buy five or 10 minutes with someone who could pull up with a cart and inject you with oxygen as we are preparing more definitive, longer-term therapy to restore your ability to oxygenate.”

It will be 5-10 years before the research is ready for clinical applications, but a sampling of other possible uses that may prove successful are:

- As a bridge to ECMO (extracorporeal membrane oxygenation) or endotracheal intubation
- Short-term treatment by paramedics and emergency room physicians for those with airway loss until they can be stabilized
- Delivering oxygen intravenously may allow reduced mechanical ventilation in patients with various kinds of lung disease, perhaps reducing ventilator-related lung injury.
- As a treatment for diabetic wounds (either topically or intravenously), which are notoriously hard to heal
- Lower dosages for patients who only need partial oxygen replacement as might occur in situations such as lung injury or heart disease.
- For use in the battlefield for paramedics treating extreme blood loss or to improve the outcome of cardiopulmonary resuscitation (CPR).

“The toughest nut of all to crack and the one that is among the most interesting is the lower level, longer duration-needed application— the lung injury patient, or the cyanotic (blue) baby situation. Clinically, these may be some of the better applications, but experimentally, they’re also some of the toughest models.”

McGowan compares doing the research with his Boston and MUSC colleagues as similar to playing a team sport at a high level. It’s constantly challenging and stimulating (and fun).

“I’m certain that I’m better clinically because of what we’re doing in the lab and also think that I’m better in the lab because of what I do clinically. It really does inform in both directions.”

Though he doesn’t know what applications might pan out, McGowan said it’s worth all the extra work. He apologizes for tearing up as he explains what motivates him to do translational research.

“Parents hand me their child every day to take into the operating room. I still don’t know how they have the courage to do it. I usually have about 10 minutes to meet them and convince them to allow me to take care of their child and have them be OK with that. To continually try to be worthy of that trust and improve the outcome of what we do are the best parts of this.”

Courtesy: Office of Public Relations
**Rutledge Tower Preop Clinic Moves to 2nd Floor and Tod Brown, MD Becomes Department Preoperative Clinic Director**

After significant discussion, planning and renovation, the relocation of the RT preoperative clinic to the second floor has become a reality. It is scheduled to see its first patients on March 4th. The clinic is very convenient to patients as they have direct access to the parking garage through the second floor. The clinic will have 10 examination rooms as well as a central take in area where patients can get their registration, financial counseling, vital signs, and labs drawn all in one location.

Dr. Brown’s first order of business will be to organize the work flow within the clinic to allow us to see more ASA $\geq 3$ patients and at the same time phone screen more ASA 1 and 2s. An airline hub model will be utilized to send NPs and other personnel to areas such as ART to see patients, but the vast majority will be seen at RT. In addition, he will lead the out roll effort of our new lab testing guidelines to the department and our surgeons that Dr. Kelly Grogan worked so diligently to develop. Once we get through these initial updates, it is expected that patients will be able to schedule appointments with the clinic for evaluation. Starting out, the clinic will have consistent faculty staffing with Dr. Brown on Wednesday and Dr. Buddy Inabinet on Monday, Tuesday and Thursday.

**Perioperative Services: Six Strategic Big Bets**

This month’s edition of *Sleepy Times* has been focusing on the financial challenges that all healthcare facilities are facing moving into implementation of the Affordable Care Act in 2014. The department is a critical partner with Perioperative Services of the hospital. Probably the most profitable way to improve the financial state of the hospital is to first establish core strategic areas for growth within the operating room allowing for an improved payer mix and increased volume. With the arrival of our new chairman in orthopedic surgery on April 1, it is expected that orthopedics will see a substantial increase in case volume over the next two years. Also, one must become more efficient in how we handle daily work, hence the desire to shorten our turnover times, which will diminish the need for cases running late and the resulting staff overtime needs and decreased staff satisfaction.
PERIOPERATIVE SERVICES: SIX STRATEGIC BIG BETS CONTINUED

**What do we propose to do with turnover?** A working group from the OR has been attempting to answer that question.

- **OR nurses**
  - Monica Dunn, RN; Paige Fowler, RN; Rob Fedorchak, RN; Karen McGee, RN; Christy Mims, RN; Espie Melling, RN; Pam Nevill, RN; Cheri Wade, RN; Kim Wesley, RN

- **Anesthesiologist**
  - Grayce Davis, MD

- **CRNA**
  - Dennis McKenna, CRNA

- **Anesthesia Technician**
  - John McNiece

- **Environmental Services Technician**
  - Cynthia Holmes

- **Patient Care Assistant (PCA) or OR Assistant (ORA)**
  - Rosie Olatunji

- **Analytics Manager**
  - Jeff Fuller, MBA
**Perioperative Services: Six Strategic Big Bets Continued**

What is the definition of turnover? Time from prior Patient Out of Room to succeeding Patient in Room for sequentially scheduled cases. The following few points summarize proposals to improve our processes.

**Paging for Turnover:**
- As patient is waking up, circulator sends group page to PCA/OR, anesthesia technician, and environmental services supervisor
- Environmental Services staff assignments made according to TURNOVER CATEGORIES
- New Turnover Categories include:
  - Simple, Moderate, Major, Complex

**Many have asked what is the appropriate amount of time allocated for turnover based on the case?**

**Simple Turnover**
- Minor procedures
- Room not visibly soiled
- No blood/body fluids on floor
- Mopping not required
- Examples: bronchoscopy, myringotomy
- GOAL ≤ 15 minutes

**Moderate Turnover**
- Room visibly soiled
- Droplets blood/body fluids on floor
- Examples: most ENT, laparoscopic, and pediatric procedures, cystoscopy, minor neuro and ortho procedures
- GOAL ≤ 20 minutes

**Major Turnover**
- Room extremely soiled
- Pooling of blood/body fluids on floor
- Following isolation/contact precautions
- Examples: craniotomy, spinal fusion, total joints, cardiac, major GU/GYN procedures
- GOAL ≤ 25 minutes

**Complex turnover**
- Massive pooling blood/body fluids on floor
- Examples: free flaps, liver transplants, major trauma
- GOAL ≤ 30+ minutes

**Turnover Goals:**
- Before patient rolls out of OR, the entire team will collaborate and determine the next patient’s arrival time
- Turnover categories should be used as guidelines, but time will vary with each patient
- Anesthesia will roll back next patient at predetermined time unless a call is made that a delay is required
PERIOPERATIVE SERVICES: SIX STRATEGIC BIG BETS CONTINUED

It is critical that each member of our department prepares in advance to meet the turnover goals. What should we each be doing?

**Anesthesiologist**
- Pre-op patients in holding
- Enter information in PICIS
- Inform resident/CRNA about any issues with the next patient
- Be present for patient emergence

**Resident/CRNA**
- Have drugs for next case drawn up
- ET tubes and blades ready
- Other equipment – a-line, blood warmer, extra IV sets
- Page anesthesiologist early for wake-up
- Agree with OR team on return time
- Take patient to PACU
- Pharmacy
- Holding
- Should be no need to return to OR between cases
- Room staff to page if delay

This will be a learning process as we continue to find ways to improve. Please keep in mind a few things we all learned in kindergarten. 1) Be positive! 2) Every

NEW BABIES IN THE DEPARTMENT

Eleanor “Ella” Suzanne Munday, Born on January 3, 2013, 7lbs, 2 oz, 20.5 in

Tate McAdams, Born on January 17, 2013, 9lbs, 4 oz
On behalf of the 2,258 children and families helped by Families Helping Families in 2012, we thank you for the role you played in bringing the joy of the holidays to so many in the Lowcountry.

Families Helping Families was a huge success because of the time and effort put forth by you:

- 25% more families were sponsored this year
- 418 sponsors donated gifts and the basics — laundry detergent, toilet paper, soap, etc. — at an estimated value of $112,900
- 4 new agencies joined our list of referral partners for a total of 28
- Nearly 200 volunteers (3 times more than last year) worked at the warehouse, entered family info into our database, and answered phones at ABC News 4

As we begin 2013, we are mindful of the continued needs of the families we serve and hope that we can count on your continued dedication and service to those in our community who need a helping hand. Follow us on Twitter or Like us on Facebook to find out what’s next for Families Helping Families this year.

With kind regards,

STEPHEN SKARDON, Executive Director
Palmetto Project

SUZANNE TEAGLE, President and Station Manager
ABC News 4

Celebrate the holidays by helping a family in need.
FACULTY EXCELLENCE AWARDS: RECOGNIZED BY COLLEGE OF MEDICINE

Ebony Hilton, MD  Carey Brewbaker, MD  Robert Christopher, MD

ANNUAL SERVICE AWARDS: GLENNDA ROSS

10 YEARS!
GRAND ROUNDS FOR THE MONTH OF MARCH

“Assessing B-type Natriuretic Peptide (BNP) in Adult Surgical Patients: Is It Useful?”
March 5, 2013
Amanda Fox, MD, MPH
Associate Professor Brigham and Women’s Hospital

“Perioperative Management of Pheochromocytoma”
March 12, 2013
Denise Carneiro-Pla, MD
Medical University of South Carolina
Associate Professor of Surgery

“Update on Thoracic Anesthesia”
March 19, 2013
Tim Heinke, MD
Medical University of South Carolina
Cardiothoracic Anesthesia Fellow

“Sun, Sand, and Sur...gery: Healthcare Globalization and the Emerging Challenge of Medical Tourism”
March 26, 2013
Thomas Slaughter, MD
Wake Forest Baptist Health
Section Head, Professor
I HUNG THE MOON
Don’t forget to nominate your co-workers for ‘Beyond the Call of Duty’. I Hung The Moon slips are available at the 3rd floor front desk, and may be turned in to Janine Sims or Kim Crisp. Thanks so much!!

Mike Wolfman, CRNA and Theresa Morgan, CRNA: Stepping up and helping me start my neonate case. Couldn’t have been so smooth without you! Real lifesaver!

Jennie Cannon, CRNA: Great help in clinics. Helped with a difficult patient from ER!

Shelley Richardson, CRNA: Assisting in starting a very busy case without being asked

Leslie Ancrum, CRNA: Going the extra mile and helping me with a trauma patient. Thank you!

Kim Saletan, CRNA: You are always going above and beyond with team work. You are the best sidekick in the MRI. Thank you!

Andra Oprisan, Anesthesia Tech: High performance on a busy Saturday, with two transplants and another trauma. Great job covering all needs.

Dorothea Rosenberger, MD: Stellar care of critical patient and putting together a plan to get patient to the OR.

Save the Date!

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

March 2013

Standard of the Month

Maintain a safe environment for our patients, their families and our employees by:
- understanding all safety codes and knowing how to respond to them
- using security measures when appropriate
- understanding and following the National Patient Safety goals

We Would Love to Hear From You!
If you have ideas or would like to contribute to Sleepy Times, the deadline for the April edition will be March 25, 2013.

Future Events/Lectures

INTERNS
14/March—Skin and Musculoskeletal Diseases, Dr. Hand
28/March—Infectious Disease, Dr. Rieke

CA-1s
6/March—Postanesthesia Care, Dr. Roberts
13/March—Anesthetic Complications, Dr. Freely
27/March—Geriatric Anesthesia, Dr. Skorke

CA-2/3s
4/March—Advances in Aortic Repairs: Highlights for the Cardiovascular Anesthesiologist—All Residents, Dr. Fox (Brigham)
5/March—Assessing B-Type Natriuretic Peptide (BNP) in Adult Surgical Patients: Is It Useful?—Grand Rounds, Dr. Fox (Brigham)
11/March—Adrenal Dysfunction PBLD “Stoelting Chapter 16,” Dr. Sabbag
12/March—Perioperative Management of Pheochromocytoma—Grand Rounds, Dr. Carneiro-Pla
18/March—Acid/Base PBLD, Dr. Roberts
19/March—Update on Thoracic Anesthesia—Grand Rounds, Dr. Heinke
25/March—Preoperative Assessment of Hemostasis: A Practical Approach, Dr. Slaughter (Wake Forest)
26/March—Sun, Sand, and Surgery: Health Care Globalization and the Emerging Challenge of Medical Tourism, Grand Rounds, Dr. Slaughter