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

Who Will Respond?

Recently, a co-pilot on Ethiopian Airways flight 702 from Addis Ababa to Rome locked himself in the cockpit while the pilot went to the bathroom. The hijacked plane was then flown to Geneva, Switzerland so that the co pilot could ask for political asylum. (Take a careful look at the fighter jets above).

Italian and French fighter jets were scrambled to escort the plane to the Geneva airport. Switzerland's fleet of F-18s and F-5 Tigers remained on the ground. Swiss air force spokesman, Laurent Savary, explained it was because the Swiss air force is only available during office hours (from 8am until noon, then 1:30 to 5pm). Laurent further explained, "Switzerland cannot intervene because its airbases are closed at night and on the weekend."

After hearing about that event, it really got me thinking. What was the Swiss air force’s duty to protect their citizens and country? Medicine, unfortunately, is facing a similar crisis as we move to a shift work mentality. Try to find a primary care physician who will see you at night, on weekends, or holidays. Recently, while responding to the recent weather storm emergency in Charleston, our department gave exemplary service to our community. Some of us worked for 30 straight hours. Many walked from home or left significantly early to be available to relieve those that were on call and to care for our patients. I pray that we all never get the mentality of working only during office hours from 8am until noon, then 1:30 to 5pm and are closed at night and on the weekends. Our patients deserve better from us!
ACADEMY OF MEDICAL EDUCATORS- NEW MEMBER: DR. ERIC NELSON

“The Academy of Medical Educators (AME) recently announced a new member, Dr. Eric Nelson (Anesthesia and Perioperative Medicine) – Mentored Teaching Fellow.

Please join me in congratulating Dr. Nelson on his selection and in thanking him for his commitment to our educational mission.”

-Etta Pisano, MD Dean, College of Medicine

The Academy of Medical Educators was established in June 2012 to provide a forum for higher levels of participation, training and recognition of faculty educators. Our membership is an interdisciplinary group of educators who are dedicated to promoting excellence, innovation and scholarship in teaching and education.

The Academy is supported by the Dean's Office of the College of Medicine. Debra Hazen-Martin, Ph.D., Leonie L. Gordon, M.D. and Paul J. McDermott, Ph.D. serve as Co-directors and work closely with the Academy’s Executive Council and Committees.

MEET THE NEW RESIDENCY/FELLOWSHIP PROGRAM COORDINATOR: KELLY LANDERS, MT

Kelly Landers is excited to join the Anesthesia Department at MUSC. As a graduate of the Curry School of Education at the University of Virginia, Kelly earned a Bachelor of Arts in Spanish and a Masters in Teaching. After college, she moved back to her hometown of Arlington, Virginia, where she spent five years as an elementary school teacher. Kelly moved to Charleston in November 2013 and began working at the Children’s Museum of the Lowcountry.

As a new Residency Program Coordinator, Kelly now looks forward to working within graduate medical education. Outside of work, Kelly enjoys concerts, sports, traveling, and exploring the beautiful city of Charleston.
Dear Department,

This year we interviewed 146 extremely qualified candidates from every region in the U.S. over the course of two months. It was not uncommon to see USMLE score in the 250 + range in our candidates as well as excellent research and clinical performance. I can honestly say this was the most qualified group of applicants from top to bottom we have ever had at MUSC.

At the end of the match process we have 15 outstanding residents entering the department in June. I would like to thank all of the residents, faculty and support staff that made this year’s match a success, and I would like to give special thanks to Dawn who made everything run like clockwork. Please join me in welcoming these new residents into the MUSC Anesthesia family!

Sincerely,

GJ

Another Successful Match

by: Dr. Guldan

Department Celebration and New Resident Welcome
JUNE 27, 2014

Charleston Battery Soccer Game at Blackbaud Stadium
Charleston Battery vs. Richmond Kickers

Blackbaud Stadium
1990 Daniel Island Drive
Charleston, SC 29492
@ 7:00 PM
MEET OUR NEW RESIDENTS

Welcome to the Department: 2014-2015 Intern Class

Joseph Abro  
MUSC

Mark Glentzer  
University of Texas Galveston

Janus Patel  
Eastern Virginia Medical

Patrick Bise  
MUSC

Sergey Gukasov  
Michigan State University

Adam Rhodes  
University of Texas Galveston

Ashley Feeman  
University of South Carolina

Stephanie Henning  
Lake Erie College

Joel Sirianni  
Drexel University

Adam Frank  
East Carolina University

Jocelyn Koppelman  
MUSC

Tim Stooksberry  
University of Alabama

Eric Gelman  
University of Central Florida

Andrew Klein  
Medical College of Georgia

Ryan Wilson  
University of South Carolina
Tanzania Experience
By: Dr. Will Hand

My return to Weill-Bugando Medical Center in Mwanza, Tanzania was filled with anticipation and optimism. Three years ago I spent a month working with the Madaktari Project educating the anesthesia students and learning the logistics of healthcare delivery in sub-Saharan Africa. Since my visit, several groups of anesthesiologists and residents have invested time and resources with the hopes of progressing toward a population of providers capable of managing neurosurgical patients. There is a contemporary surgical wing to the project.

Departing for the trip with Abdu, I knew much of what was ahead and tried to prepare him for the eye-opening condition of the operating rooms. I need to recalibrate his educational expectations to best suit the audience, but I could tell from our conversation he’d need to get there to really understand. We settled into the seats on our first (of four) flight, both looking forward to doing exactly what calls so many physicians to practice—help improve the lives of others.

After a circuitous route through Dallas, Dubai, and Dar es Salaam, we arrived to the Serengeti House (medical compound hostel) at 10pm local time—60 hours after we departed Charleston. I was not surprised to find that there was no room for us, despite confirming our reservation three times including 48 hours before departing. Hezron, a taxi-driver I met last trip and am Facebook friends with, waited for us and took us to a hotel in town—what’s 12 more hours of transience.

The following day we made it to Bugando—sitting atop the highest point of Mwanza, this concrete monolith was built in four stages starting in 1968 through combined efforts of the Catholic Church and Weill-Cornell University. The hospital has a stated capacity of 900 patients, but reportedly had 1400 patients and 400 parents (pediatric patients) as tenants. The open-air design (architectural protection for tuberculosis) causes an olfactory-induced flashback to my previous work here instantly—I recall the layout and we make our way to the executive suite for “orientation.”
After sitting in a dilapidated loveseat for 25 minutes, Abdu and I grow restless of waiting for the volunteer secretary to see us, and I recall the system of reciprocal politeness doesn’t apply in Africa exactly the way it does back home. We walked back into the office and found Ms. Josephine speaking with a student. Noticing us, she dismisses the students (likely headed to our hallway couch) and welcomes us to Bugando.

Part of the reality of our presence is exposed in the following interaction. While the students we will teach (and I taught before) appreciate the knowledge and experience we will impart to them, the executive suite associates all foreign presence with, well, foreign presents. Our face-to-face discussion begins a bit slowly with a faux apology regarding the room and assurance that beds will be made available shortly, but the hostel-manager was ultimately to blame. She does, almost immediately, state the cost of the rooms and explains that we are to pay up-front and ideally today, before we can get hospital badges. At this point I reference my happiness in returning to Bugando and how things look remarkably similar to three years ago, when I stayed at the Serengeti House, but recall the rate being 50% lower then. After a lost-in-translation rationale for the inflation, I point to the red suitcase we brought with us containing 5 Nellcor Pulse Oximeters (certainly worth a few thousand dollars) that will continue to expand the monitoring capability for perioperative patients and her stance softens. We immediately become old friends of the hospital and are provided a 40% discount to the rooms with some flexibility in payment. This was the first, not last, time I acknowledge the hospital sees our presence as a means to financial/technological survival as much as the students see us as teachers.

After recollecting our bags and meeting the roommates at the Serengeti House, Abdu and I walk back to the hospital. As described above, the hospital sits atop a hill. The most eerie part of visiting the medical center is the drive (or walk—for most) up the hill. Flanking your ascent on both sides are small businesses selling their wares. The majority of these vendors sell the same thing. Decorated with brilliant colors: purple, gold, white, and marigold, these hand crafted items honestly are more impressive than their American counterparts. It is, however, the demand for them than makes my hair stand on end—all the way up the hill you can shop for your loved-one’s casket.

The operating theater is one floor below the entryway and abuts the ICU and obstetric ward. Through a wide and creaky aluminum door await 5 operating theaters and approximately 25 patients per day. The OT’s, like the rest of the hospital, are open-air and nearly wretched for a new-comer with the impossible-to-describe combination of surgical body odor and sterilizing bleach. The men’s locker room is smaller than any faculty’s office but shared by all 40 male employees. There is a commode, or rather, hole in the floor where the broken commode used to sit and a shower I pray no one uses. After dressing in scrubs I show Abdu the schedule—mostly Ortho, ENT, and GYN our first day.

Next to the daily schedule is the PACU. This room has five patient bays, an oxygen canister and mask (for post-extubation hypoxia) and five pulse ox monitors adorned with tiny silver MUSC stickers. It brings an immediate rush of excitement to realize how many patients will avoid morbidity and mortality due to these little boxes with blue numbers. Dr. Reeves acquired an impressive amount of hardware MUSC determined was surplus or required replacement two years ago. He managed to convince the manufacturers to provide missing pieces and non-disposable peripherals for the devices and sent two shipping containers across the Atlantic bound for Madaktari. The contents that arrived, enough to fill one container after the “tariff” of medical philanthropic donation, was scattered throughout the hospital we would come to find.

Back to the PACU. Much is different in Africa, but more is the same… we all need oxygen more than anything on Earth. Patients are not extubated (routinely) in the OT, instead transported to PACU breathing spontaneously through the 7.0 ETT that all non-pediatric patients receive. In PACU the tube is removed after an assessment by the Associate Medical Officer (AMO—think PCA) observes them forcefully breathing through the tube. There they lay, until transported to the floor or discharged “home”. Now, however, they are actually monitored for the duration of their stay. If our work accomplishes nothing more than this, we will have been successful. Three years ago we watched at least one patient per day struggle in PACU and had no way to assess them other than physical exam and evaluation. I told Abdu we’d see a patient’s life saved by those boxes before we left—I was right.
After changing back to our street clothes, we met with Dr. Matasha, a 65 year old German-trained anesthesiologist, one of only seven in the country. He’s been running the training program as long as anyone can recall and shook my hand enthusiastically as he recognized me, the “acacia mzungi” (rough translation: foreigner as tall as a tree). We briefly exchange and agree to meet in the morning for report.

Morning report is worse (for Abdu and I) than internal-medicine rounds as an intern, if that’s possible. Every single case to be done is presented by one of the anesthesia students. They are provided a template for their presentation: name, age, ailment, procedure, history, past surgical history, ASA classification, anesthesia risks, and anesthesia plan. 30 patients per day, hot classroom with little air circulating all presented in Swahili-english accent making 30% of the words unrecognizable. The process is well intended—to allow everyone to learn from each other’s cases, but the execution is terrible. Abdu and I could interrupt every single presentation to add or ask a relevant question, but the students can’t go to the OT until we’re through, so we reserve our commentary for the most egregious missed precautions or teaching points. The students are mostly AMOs, meaning, basically, they’ve worked in a hospital in some capacity before but have little-to-no formal education even in the basics of medical care delivery. This is made most apparent during morning report because 98% of cases are presented with “no medical problem other than (insert surgical indication)” and have a binary set of anesthesia plans. The anesthesia plans are two-fold: if surgery is mid abdomen or below it is a SAB, above gets GETA: thiopental, sux, ETT, Iso, O2. That’s really it—almost no one is given more than an NSAID for pa in, long-acting paralytic, or any other adjunct. Little if any consideration is given to starting vital signs, so why would they consider how to keep them within the bounds of auto-regulation. Abdu and I have our work cut out for us.

Back at the house we get to know our roommates. There are six of them. Julie, Tracie, and Sarah are peds residents who have been here for a few weeks. They’re a little fed up with the lack of a real shower, minimal food, and the frequency with which their patients die from preventable causes and greet us with a “don’t judge us at our worst” affect since there was just rice and cabbage for lunch that day, again. They split their time between the Bugando wards (split into three teams with 60 patients). They work as attendings and there is one peds-hospitalist who is permanent but uses the American presence to provide time off. When no Americans are present, the three teams of 60 patients are rounded on in daily sequence—yes, that means every third day. (Please close your mouth and continue reading.)
Tanzania Experience
By: Dr. Will Hand

There is an aloof guy headed out who works primarily at the other peds hospital “Secratory”, a smaller AIDS hospital across town caring for more chronic than acute disorders. He’s a crass New Yorker but very efficient, we can tell. He’s finishing in two days and headed on a brief vacation into the Serengeti with his college roommate who is studying the Lions near the Seronera Plains (central Serengeti). He actually moved out of his room for Abdu and I to have. We thank him on his way out.

Next are two long-term residents: Vladimir is the unspoken tyrant of the upper house. He has been a tenant for six months as he awaits his operating privileges from the Tanzanian government. He was apparently hired to be the new Cardiothoracic surgeon, but as yet to cut skin due to all the “red tape” he has to cut through first. He’s mad at the world, but mostly the cooks. We are told by the others he’s practically a carnivore and thus despises the rice and (something not meat) we have most days. The other long-term tenant is a third year medical student from Cornell-Qatar named Reim. She is young, optimistic and happy—destined for pediatrics, I assume. She shows us around a bit and departs for Swahili class. “Tall” Sarah rounds out the bunch. She is a 4th year student from Cornell-NYC planning to pursue dermatology. Far more ambitious than I, she has taken a year off and paired with a Cornell attending to pilot tele-dermatology consult service at Bugando. They obtained funding for several iTouch devices capable of capturing high-resolution photos and created an app that requires relevant history to be sent with the tele-consult photos back to NYC. From there diagnosis and treatment recommendations can be made. Brilliant!!! Like a commercial for what technology can do. The 8 of us make a motley group and will struggle through the coming weeks together.

Abdu is already awake and waiting for me (the norm I will find out) when my alarm sounds the next morning. I grab a Cliff Bar and head out the door to the hospital. Dawn brings respite from the heat, and the streets are active with people headed, well, wherever they’re going (unemployment rate ~40% in Mwanza). We make our way to the classroom we’ll inhabit every morning for morning report 5 minutes early—almost no one is there. The American custom of being on time I fail to abandon even by the end of my stay. Eventually the room is packed beyond the capacity of the desks. This brings up the second example of misguided priorities, in my assessment. Dr. Matasha et al have advertised the anesthesia training program appropriately as having expert teaching (from the US and Australia), likely superior to any other in Tanzania. The result (intended, I presume) is that the class size has tripled since my last visit. The students have to pay (or be sponsored) a tuition that is undoubtedly lining the pockets of a few individuals, at least to some extent. It’s impossible, and perhaps inappropriate, for me to judge the class size decision because he could easily (and honestly?) defend the decision explaining that 80% of anesthetics are currently provided WITHOUT ANY FORMAL TRAINING. (I take no responsibility for anything that takes residence inside your permanently gaping mouth.)
So there ended up being between 40-55 students expected to learn anesthesia from 25-30 cases per day, occurring in 5 operating theaters. The math precludes daily participation so Dr. Matasha has created a rotating schedule where one third of the students are assigned to the OT each day, one having a “study day,” the last a day for “relaxation.” We are asked to teach the “study day” students, and decide the most they can possibly retain is a morning and afternoon lecture. There exists a syllabus (another major improvement from 3 years ago!!!) and we pick up where they claim to be.

Lecturing at Bugando is easy for me. I’ve done this before, giving lectures all the time at MUSC, and in self-reflection, appear to like to hear myself talk. I speak painfully slowly and in the most general terms. Everyone reading this has a terrific medical vocabulary and understanding of physiology. Imagine trying to teach about blood pressure management without using the words (or really concepts) of arteries, vasoconstriction, cardiac output, or heck, even ohm’s law (V=IR). I remember one lecture where I had to back track from blood vessels, to blood flow, to the idea of preload, to the chambers of the heart and finally said in a long drawl, “ok, there is a HEART.”

Education there is a unique challenge. I realized last time that practical knowledge is actually more important than the theory. Patient outcomes will be more affected by teaching pattern recognition and decision making than understanding with the current students because, literally, there are years of background understanding that are missing from the foundation, and we don’t have years to teach them! Abdu and I reconsider our lectures (countless ppt slides go to waste) as we look at each topic for the coming weeks and assess them in three ways: how do they currently interact with the topic, what risks to patients come from the topic, and what is the bare minimum understanding they need to manage the risks of each topic. For example more than half of cases are completed under spinal. For SAB: what drugs do they use and how do they do the block, sympathectomy associated hypotension has end-organ risk and “total”-spinal needs to be recognized and treated immediately, and finally a basic understanding of onset, duration, and mechanism for spinal anesthesia needs to be covered. Confidence renewed, the lectures quickly reformed and appeared well received.

A week into the trip Abdu and I are increasingly comfortable and effective. One of the best students, Erasto, asks for private tutoring and visits our house at 9PM for his supplement. Abdu looks toward a small group as it’s too inefficient to teach just one student with so much need.

I spend more time in the OTs with Abdu lecturing daily. Intraoperative teaching is a distinct challenge. There are often 4-5 anesthesia students (and the one salaried anesthetist) at the head of each bed. Their mechanical skills are impressive. Intubations generally go well, IV cannulation is almost perfect, and they now are using pulse ox and BP cuffs on every case. I have opportunities to subtly improve techniques, but realize the vast majority of our effect will be in planning and reacting to physiologic management deficiencies.
TANZANIA EXPERIENCE
BY: DR. WILL HAND

One afternoon, while lecturing, I hear that Abdu is “rescuing” a patient. We finish lecture a bit early and by the time I visit the OT, Abdu and the patient are headed to the ICU. He debriefs me: the power was out (it’s Wednesday, so that is to be expected) in the PACU. He casually walked past and saw an extubated patient lying, as they generally do with the appearance of the standard recovering patient. He paused to watch her breathing and quickly observed her respiratory efforts were minimal to non-existent. The details were a bit hazy, but she’d had a very brief esophagoscopy and didn’t do well in the OR. She was extubated and brought to PACU where she was “recovering” sadly without a functional pulse ox. Due to his appreciation of apnea/hyopopnea, he immediately requested the ambu and asked for monitors. He was informed the power was out (remember… its Wednesday…) and showed great adaptability by ordering the patient moved back to the OR. Nevermind there was another esophagoscopy started in the OR, he placed the pulse ox on his new patient (deciding she was more urgent) and found her sat to be 55% and falling into the high 40s. He immediately reintubated her and watched her immediate recovery. Due to the “event” the Bugando staff requested she be moved to the ICU for recovery and Abdu assisted in her transport. The following day she had recovered fully and debriefing revealed a perilous sequence of failed intubation, excessive thiopental administration, and the aforementioned power outage consummating the oft-cited “swiss cheese” model of risk-event overlaps causing the near-death. I, silently recalled my first clinical comment to Abdu, that those pulse ox boxes would save someone’s life before we left.

I’ve waxed poetic for too long already—the 17 days were filled to the brim. We were often self-critical due to the vast difference between care at Bugando and that at MUSC; the inequity that country-of-residence causes in terms of outcomes is something we discussed daily because our best effort appeared inconsequential for the population of Mwanza. Despite this, several individuals are alive and “well” today because of our presence. We hope (and expect) that morbidity will be decreased because of some of the knowledge we imparted—to think one month will serve as panacea is foolish, but Brystol and Ebony depart soon as well as resources from other locations. In time perhaps the goals of the Madaktari Project will be realized—I truly hope they are, but if not, I feel justified in the experience based on the limited impact we have made and the opportunity to show people we’ll never see again that they have value and potential. Perhaps the latter is the most important because once they start to change the expectations for their care, they can start to put the casket-makers out of business. Who knows, those crasftmen may be the next class of anesthetists…

We want to thank the considerable efforts of our colleagues to allow us the opportunity to work with the Madaktari Project. Many of you covered call shifts and clinical duties that allowed our absence. The kind words of encouragement sent via email were greatly appreciated during our trip. Finally, due to the hospital and department support of the project, we continue to make a dramatic impact on the patients at Weill-Bugando Medical Center.

Also: a few pictures from a one night safari into the Serengeti—the abundance of natural beauty stands in stark contrast to the paucity of hope in the hospital.
TANZANIA EXPERIENCE
BY: DR. WILL HAND

ANESTHESIA TECH DAY: MARCH 31, 2014
The Pediatric Critical Events Checklists have been placed in the following locations:

Main OR locations: 2, 4, 5, 9, 11, 16, 17, 18, 19, 20.

Outside OR locations: MRI, Peds Cath labs, IR room 5, Peds GI rooms, Neuro angio, the periphery spare ventilator, radiation overflow room (room of requirement), radiation oncology

The booklets are attached to the anesthesia machine by a wire on the right side of the machine. If you have other locations that you feel the booklet should be kept, please let me know and we will put it there. Below is a picture of where the booklet is attached to the anesthesia machine. Please let me know if you have any questions or concerns.

Thank you very much.

Michelle Rovner, MD
NEW WINDOWS 7 COMPUTERS
BY: DR. LARRY FIELD

Dear all,

You should have seen the multiple email notices by now:

Windows XP End of Life Notice

Microsoft has announced the “End-of-life” for Windows XP. As of April 8, 2014, Microsoft will no longer provide any security patches, updates, or support for this 12 year-old operating system. This will significantly increase the vulnerability of any device still running Windows XP at that time. Cyber-criminals are poised to attack any Windows XP systems they can still get to after April 1st, especially through the external Internet.

Due to the risks involved, many higher education and healthcare organizations are blocking external and internal network access to Windows XP devices. At MUSC, we will be blocking only external Internet access to these devices. Windows XP devices will still be able to access resources on the internal MUSC network. This change will occur on April 1, 2014.

In order to meet MUSC's legal and compliance requirements, there will be no exceptions: general external Internet access can no longer be permitted from Windows XP systems on MUSC's network after April 1st.

What does this mean for us and our Picis Windows XP machines?

The computers physically attached to anesthesia monitors and machines in order to allow automated data capture into Anesthesia Manager and PACU Manager must remain running Windows XP until after the conversion to Epic on July 1. For these machines, rather than completely blocking any mechanism for internet access, internet access will be restricted via routing all internet access through safe virtual servers hosted elsewhere. All of the Picis machines should have a new virtual internet access icon (instead of the usual internet explorer icon) installed for use during this April 1 – July 1 transition period. Technically, this means users may still view anesthesia educational resources on the internet via this creative portal system that has been set up for us. However, please continue to keep internet usage from perioperative computers limited to those activities related to the perioperative care and education.

All other departmental computers are being upgraded to Windows 7 as soon as possible. Access to Picis applications from Windows 7 machines is then accomplished via Webapps/Citrix, which can be accessed at http://webapps.musc.edu. The Picis applications can be found and launched from the Webapps Picis folder. For Picis access problems, please continue to use the Picis Support Team pager (17348). While the Picis team has been generous enough to also help with other issues, most other computer problems related to the Windows 7 upgrade should be referred to the HelpDesk (792-9700). The Webapps access is confirmed to work from Internet Explorer on Windows 7 machines and Safari on Mac computers provided that Java is also installed and up-to-date.

Once our operating systems have been upgraded, most faculty will initially have to re-enter their user ID and password for the Outlook mail application to setup your specific mailboxes again. Please include the clinlan domain name along with your user name to log back into your Outlook mailbox. The format for the user field will be: clinlan\user_ID. If you utilize the O: drive, re-mapping to that virtual drive will require personal help by an IT admin while you are logged into your computer (they can do this remotely while you are logged in). While this may be a bit of a painful process, it probably is best to get the Windows 7 conversion under our belt before the Epic conversion, which is now <90 days away.

Everyone recognizes that many of our computers are older models, however they all appear to support our immediate Windows 7 upgrade needs. As many of our computers are reaching the end of their useful life cycle, the department will be replacing our oldest computers first over the next few months.

Larry Field, MD
FACULTY EXCELLENCE AWARD: DR. DAVID WARTERS

Congrats Katie Bridges, MD:
Jackson Harter Bridges,
Born February 27, 2014,
7lbs 10oz., 20 in.
GRAND ROUNDS FOR THE MONTH OF APRIL

“Epic & Perioperative QAPI”  
April 8, 2014  
Epic Team and Drs. Robert Cina & Joseph Sakran  
Medical University of South Carolina  
Assistant Professors

“Update on Neurointerventional Procedures”  
April 15, 2014  
Aquilla Turk, DO  
Medical University of South Carolina  
Professor

“Residents as Teachers”  
April 22, 2014  
Mary Mauldin  
Medical University of South Carolina  
Professor

“Role of Adenosine in Cerebral Aneurysm Surgery”  
April 29, 2014  
David McDonagh, MD  
Duke University  
Associate Professor & Neurology Division Chief  
Duke University
Future Events/Lectures

Intern
3/April—OB, Dr. Hebhar
17/April—Infectious Diseases, Dr. Ricke

CA-1
2/April—Anesthesia for Cardiovascular Surgery, Dr. Grogan
9/April—Obstetric Anesthesia PBL, Dr. Tobin
23/April—Anesthesia for the Trauma Patient, Dr. Skorke
30/April—Pediatric Anesthesia PBL, Dr. Redding

CA-2/3s
1/April—Subspecialty Meetings, Division Chiefs
7/April—Neurophysiology, Cerebral Protection and Monitoring (Barash Ch. 39), Dr. Skorke
8/April—Epic & Perioperative QAPI, Epic Team and Drs. Cina and Sakran, Grand Rounds
14/April—Neurosurgical ICU PBLD, Dr. Rosenberger
15/April—Update on Neurointerventional Procedures, Dr. Turk, Grand Rounds
21/April—Anesthesia for Spine Complex Spine Surgery and Trauma PBLD (Barash Ch. 39), Dr. McSwain
22/April—Residents as Teachers, Mary Mauldin, Grand Rounds
28/April—Anesthesia for Neurointerventional Procedures, Dr. McDonagh (Duke), All Residents
29/April—Role of Adenosine in Cerebral Aneurysm Surgery, Dr. McDonagh (Duke), Grand Rounds

Department Celebration and Resident Welcome:
June 27, 2014, Blackbaud Stadium at 7:00pm

Resident and Fellow Graduation: June 20, 2014
Mills House Hotel at 6:00pm

Christmas Party: Friday, December 12, 2014
Carolina Yacht Club at 7:00pm

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 Kim Crisp. Thanks so much!!

D.J. Beckman, Anesthesia Tech: Your work in the Main OR and your willingness to help everyone!

D.J. Beckman, Anesthesia Tech: Your work in the Main OR and your willingness to help everyone!

Hold myself and staff accountable for providing professional and reliable service in a consistent manner.

We Would Love to Hear From You!
If you have ideas or would like to contribute to Sleepy Times, the deadline for the May edition will be April 24, 2014.