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

The End is Near

Can you believe that another academic year is coming to a close? Our senior residents are now preparing to enter the workforce or do a fellowship. Our interns are now in the department and preparing to finally start training in their specialty, anesthesiology. The University just held graduation and our medical and nursing students are leaving to start their chosen fields of practice. What an exciting time!

This month is also an exciting time as several attending in our department are being recognized for their academic accomplishments. Alan Finley has been promoted by the College of Medicine and Board of Trustees to the rank of Associate Professor. Jake Abernathy has received the Liberty Mutual Research Institute for Safety and the Institute of Ergonomics and Human Factors Best Paper Award. Heather Highland have been selected the new Main Chief CRNA and Katie Smith the new Anesthesia Technician Supervisor. Congratulations to you all.

Finally, June is the last month before we implement our new hospital wide Electronic Medical Record (EMR), to EPIC. If you have not done so, now is the last chance to complete training before go live on July 1st. Without training, you will be unable to work starting July 1st. If you need assistance in scheduling training, please talk to Brenda Dorman.
Transition to a new or different electronic medical record is a period of high stress. The Department of Anesthesia will be particularly vulnerable to stress during the transition as the ORs will continue to operate a full schedule while also welcoming new anesthesia and surgical residents. Managing health information in this transitional environment carries the risk that quality of care may be adversely affected without the engagement and collaboration of all members of the health care team. Success during go-live will be highly dependent on team work, a supportive environment, and each individual’s commitment to learning the new system well in advance. Those that exceed the minimum training requirements by regularly working within the playground environment will be significantly less stressed and distracted from patient care responsibilities. Further, effective anesthesia care teams, characterized by shared responsibility and accountability for clinical care and documentation, are more likely to maintain quality care and suffer less stress than ineffective teams that lack sufficient engagement by one member.

Epic Enterprise go-live is rapidly approaching and interval go-live readiness assessments (GLRA) indicate there are currently no issues that will prevent go-live on July 1st. The Epic team has developed a watch list of outstanding items they are focused on resolving before June 16th and have engaged senior stakeholders to confirm application specific readiness. The OR/Anesthesia application, OpTime/Anesthesia (OpTesia), is on target and will undergo another go-live readiness assessment on June 3rd. There is a high degree of confidence that we are ready for launch!

Before the enterprise wide go-live, multiple other interval go-lives will begin in early June. Epic has designated June 16th as an internal “ready for go-live” date, meaning all tasks have been completed and the system is ready to implement. In the perioperative area, OpTime case conversion and scheduling will go-live on June 2nd. Cases scheduled on June 2nd or thereafter for July 1st and beyond will be entered and scheduled into Epic. Those cases that will be performed prior to the July 1st go-live date will continue to be scheduled in PICIS. The Pre-op Clinic will go-live with documentation in Epic on June 17th. Charging and orders will remain on paper until July 1st, however, documentation for the encounter by the provider will be in Epic. As of July 1st, the Pre-op Clinic will be fully integrated with all of OpTime/Anesthesia and capturing orders and charges. Advance go-live of the Pre-op Clinic allows all perioperative caregivers to view pre-operative documentation when patients arrive for their procedure on the day of go-live.

In the coming weeks, expect to see increasing email communications as we approach go-live and beyond the transitional period. These communications will be limited to important “need to know” information to avoid email fatigue. Stay tuned for “parking lot” updates to questions asked in the training sessions. Questions that you may have after completing training are also important and we would appreciate hearing from you! For questions regarding training, please contact Lisa Ihnken at ihnken@musc.edu. General questions about the application build, reporting, functionality, etc., should be directed to Brett Seyfried at seyfried@musc.edu, or Regan Allenspach at allenspa@musc.edu. Dr. Larry Field and I will also be happy to answer your questions.
RESIDENTS AS TEACHERS

ONE MINUTE PRECEPTOR:
1. Ask the Learner What is going on? (WHAT)
   a. What do you think is going on?
   b. What do you want to do next in the work up?
2. Probe for Reasoning (WHY)
   a. What led you to that conclusion?
   b. What else did you consider?
   c. Why did you rule out that choice?
   d. What are the major findings that led to that conclusion?
3. Teach: Teach general rules/principles and limit to 1-2 important points
4. Reinforcement: provide positive feedback about what the learner did right
5. Correction: correct any errors and make suggestions for improvements

Teaching Tips for Residents

GOOD TEACHERS:
- Ask Questions
- Are Enthusiastic
- Are Nonthreatening
- Are Knowledgeable
- Promote Self Learning
- Recognize the Needs of the Learner

REMINDERS:
- Be Professional
- Have a Good Attitude
- Treat Everyone With Respect
- Pitch in and Lead from the Front

RECOGNIZE THAT YOU LEARN BY TEACHING

PITFALLS IN CLINICAL TEACHING:
- Inappropriate Lecturing
- Taking Over the Case
- Insufficient “Wait Time” on Questions
- Leading Questions
- Pushing Past Ability

Elements of Effective Feedback

CREATING A SAFE ENVIRONMENT
- State the purpose of the interaction
- Check for time and place
- Make clear that not a punitive but an interactive process
- Focus on problem solving
- Be open and accepting of feedback yourself
- Accept receiver’s disagreement, i.e. agree to disagree

ARTICULATING COMMON GOALS AND OBJECTIVES
- Orient the learner to your expectations
- You can’t get to your target if you don’t know where you want to be

RECEIVING FEEDBACK
- Perceive feedback as learning tool, not a criticism or attack
- Create receptive body language
- Avoid defensive response, even if feedback is perceived as inappropriate
  - Ask for clarification or specific example
  - Ask for specific ideas about how issue can be resolved
  - Use active listening skills: rephrase, paraphrase
- Keep ego separate from behavior
- All feedback is a reflection of the sender’s mood, perceptions and personality
- Making mistakes is human
- Present perceptions and avoid excuses
- Focus on the issue at hand
RESIDENTS AS TEACHERS CONTINUED....

On April 10th, 14 members of the Anesthesia Interest Group met for a Regional Anesthesia workshop. They were given a short lecture by Abdu Algendy (CA-3) and Steven Aho (CA-2) then had some hands on experience working with a needle on a gel station and identifying anatomical structures on two standardized patients. Regional Anesthesia attending Dr. Wilson graciously coordinated the workshop and Dawn Leberknight arranged the models. John Fox (CA-1) also participated in setting up the workshop as well as assisting with the gel station.

CA-3 Abdu Algendy teaching a medical student the anatomy of the popliteal block.

Medical student working on needle visualization with the gel model.

CA-2 Steven Aho teaching the anatomy of the interscalene block.

IARS ANNUAL MEETING UPDATE

MUSC was well represented at this year's annual meeting of the International Anesthesia Research Society in Montreal, Canada.

Our presence was notable at many of the workshops throughout the conference. Drs. Larry Field and Carlee Clark served as instructors for the Perioperative ACLS Simulation workshop. Dr. Sylvia Wilson served as an instructor for the Ultrasound, Simulation and Stimulation for Peripheral Nerve Blocks workshop. Additionally, Dr. Wilson served as both a lecturer and instructor for the Advanced Ultrasound Guided Nerve Block workshop.

Faculty also presented posters, PBLDs and lectures. Dr. Joe Whiteley presented a poster detailing research on the relationship between intravenous starch administration and acute kidney injury in orthotopic liver transplant patients. Dr. Larry Field presented another poster discussing work by Dr. Will Hand and colleagues on the use of electronic support tools in the management of simulated local anesthetic toxicity. Dr. Alan Finley participated in a panel regarding practice guidelines and presented the current guidelines for discussing a basic and comprehensive TTE examination. Additionally, Dr. Finley presented a PBLD discussing the role of factor concentrates during perioperative bleeding.
IARS ANNUAL MEETING UPDATE CONTINUED...
May 5, 2014

Joseph Whiteley, DO  
Medical University of South Carolina  
167 Ashley Avenue Suite 301  
Charleston, SC 29425  
United States

RE: IARS 2014 Annual Meeting and International Science Symposium  
Best of Category Abstract Award

Dear Dr. Whiteley,

Congratulations! Your abstract, "Hydroxyethyl Starch And Acute Kidney Injury In Orthotopic Liver Transplantation: A Single Center Retrospective Review," Control ID: 4b, has been selected for the distinction of "Best of Category" for the Liver category from over 512 abstracts submitted for the IARS 2014 Annual Meeting and International Science Symposium, May 17-20, 2014 in Montréal, Canada. At the Annual Meeting in Montréal, your poster board will receive a "Best of Category" award ribbon to indicate its prestige as the best abstract submission in your category.

As a Best of Category winner, your abstract poster will be recognized during the onsite poster presentations. It will also be one of 17 abstracts highlighted digitally online during and following the Annual Meeting. For instructions on how to submit a digital file for this abstract recognition, please click here. This will be in addition to your scheduled poster presentation.

Your abstract has now been entered for the distinction of "Best of Meeting." A panel of judges is currently reviewing all of the "Best of Category" submissions and will select the top finalists from the 17 "Best of Category" submissions.

You will be notified by Monday, May 12 if your abstract has been selected as one of the finalists to present and be judged for additional recognition at the Best of Meeting Awards Session on Monday, May 15, 1:30 pm to 2:30 pm.

For questions regarding poster presentations, please contact Laura Kuhar at abstracts@iars.org or 415-296-6911.

For questions regarding digital posters, please click here.

We look forward to seeing you at the IARS 2014 Annual Meeting and International Science Symposium in Montréal!

Sincerely,

Keith A. (Tony) Jones, MD  
IARS 2014 Annual Meeting  
Program Co-Chair

Santhanam Suresh, MD, FAAP  
IARS 2014 Annual Meeting  
Program Co-Chair
CONGRATS TO ALAN FINLEY FOR BEING PROMOTED TO ASSOCIATE PROFESSOR

CRNA EPIC SUPER USERS

It truly takes a talented team to develop our new EPIC anesthesia electronic medical record. Our CRNA super users are pictured below. Thank you all for your dedication to making EPIC possible.

Top Row (L to R): Sam Tripp, Erin Straughan, Alyssa Cleveland, Deb Feller, Jean Day, Margaret Stark, Candace Jaruzel, Jane Swig, and Susan Groome
Bottom Row (L to R): Ray White, Robin Buchanan, Melissa Paladino, and Jodi Weber
Not pictured: Kate Wendorf
DEPARTMENT CELEBRATION AND NEW RESIDENT WELCOME
JUNE 27, 2014

Please join us for the Department Celebration & New Resident Welcome

Friday, June 27th at 7:00 p.m.
Blackbaud Stadium
1990 Daniel Island Drive Charleston, SC 29492

Charleston Battery Soccer Game
Charleston Battery
vs.
Richmond Kickers

Please RSVP by June 6th to Kelly Landers (landers@musc.edu)

Sticky Fingers BBQ and beer will be provided.
Families and kids are welcome to attend.
MEET THE NEW CA1S

Thomas Brinkley, UNC Chapel Hill
Jay Chan, University of Florida
Jackson Condrey, MUSC
Loren Francis, New York Medical College
Jordan Friel, Ohio State University
Ben Jones, Ohio State University
Tyler Keena, Indiana University
Tony Lawson, University of Florida
Jared McKinnon, Medical College of Georgia
Sam McLaurin, Mercer University
Jeff McMurray, Indiana University
Julie Owen, George Washington University
Stefanie Robinson, MUSC
Kevin Shamburg, Wake Forest
Matt Zachary, University of Tennessee
LIBERTY MUTUAL RESEARCH INSTITUTE FOR SAFETY AND THE INSTITUTE OF ERGONOMICS AND HUMAN FACTORS BEST PAPER AWARD; JAKE ABERNATHY, MD

A team of nine researchers including our own Jake Abernathy received the 2014 Liberty Mutual Award for the scientific paper, Technologies in the wild (TiW): human factor implications for safety in the cardiovascular operating room. Ergonomics 2013;56:205-219. Click Here to read article. The paper provides a richer and more realistic understanding of the potential risks to patient safety introduced by multitudes of technologies in a complex health care work system, specifically a cardiovascular operating room.

The best paper award promotes excellence in safety and health research and recognizes the manuscript that best contributes to the advancement of ergonomics. Congratulations to Jake and our adult cardiothoracic team at MUSC.

MEET THE NEW ANESTHESIA TECHS

Hercules Brown and Allie Greer

Shelley Martin
HEALING YOUNG HEARTS; THE CHILDREN’S HEART PROGRAM OF SOUTH CAROLINA

The Children’s Hospital sends out a very nice weekly report, Progress Notes. I would encourage all of us to subscribe to it. Recently our congenital cardiac program was featured. To view on the web Click Here.

NEW BABY IN THE DEPARTMENT

Congrats Tim Heinke, MD
Everett Lee Heinke
Born: May 7, 2014
RESIDENT IN TRAINING EXAMINATION (ITE) SCORES

Congratulations to our CA3 residents who have demonstrated exceptional improvement in their fund of anesthesiology knowledge as reported on their scores on the ABA ITE examination. This is a tribute to our faculty teaching, lecture series and the residents commitment to their education.

CONGRATULATIONS TO TIM FLETCHER FOR GETTING ACCEPTED TO USC MEDICAL SCHOOL OF GREENVILLE
NEW MAIN CHIEF CRNA: HEATHER HIGHLAND, CRNA

“I am happy to announce we have selected Heather Highland as the new Chief CRNA at the Main. Heather has been a valuable member of the pediatric heart team and daily CRNA coordinator group. We are very excited to have Heather stepping into this roll as Wendy prepares for her retirement. I would like to thank Wendy Ewing, Jodi Weber and Robin Buchanan for their assistance in the selection process.”

- Carlee Clark, MD

“I am very excited about transitioning into my new role as Chief Nurse Anesthetist at the Main hospital as Wendy Ewing prepares for retirement! I graduated from MUSC’s Anesthesia for Nurses Program in December 2007 and have been a CRNA in the Main hospital since January 2008. I am a member of the pediatric cardiac anesthesia team and the general pediatric anesthesia team. As a member of the communication committee, I plan to continue working to improve communication and working relationships within the department. With the recent restructuring of the department, I look forward to being part of the changes that are in the future. I’m optimistic about the direction of our department under the new leadership of Dr. Clark and I will do everything I can in my new leadership role to make it successful.”

- Heather Highland, CRNA

NEW ANESTHESIA TECH SUPERVISOR: KATIE SMITH

“I am happy to announce that Katie Smith has been selected as our first department-wide Anesthesia Technician Supervisor. Katie has been an anesthesia tech in the main OR for many years and has most recently been the daily tech coordinator. We are very excited about her taking on this new position. She will be working with Jodi Weber, Robin Buchanan and Wendy Ewing to transition into her new role.”

- Carlee Clark, MD

“I am beyond thrilled about being chosen for the Anesthesia Tech Supervisor position. I have worked in the main OR for four and half years and have been certified for two and half of those. I am looking forward to getting familiar with the techs and staff at ART and Rutledge Tower. We have a great team of anesthesia techs, and I am very proud to lead and support them. I know great things are ahead for us.”

- Katie Smith
UNDER AFRICAN SKIES
BY: DR. EBONY HILTON

My favorite line from Paul Simon’s “Under African Skies” is, “This is the story of how we begin to remember.” This perfectly describes how I felt once we arrived in Mwanza. The scenery I swore I would never forget, the tastes of the amazing foods, the feelings of gratitude when entering the hospital, and seeing old friends all felt like completely new experiences. I couldn’t keep myself from wanting to relive everything over again because my memories didn’t seem to do justice to what I now saw. So after settling in, I again tackled my fears of animals by visiting a private island converted into a national park, Saanane Island National Park. This may be the smallest national park in Tanzania and all of east Africa, but trust me when I say it was not void of wild beasts! There were zebras, gazelles, monkeys, and as our guide so kindly pointed out… black mambas. Did I mention this was a walking safari tour… and that our guide was a woman who was smaller than me… and without weapons? Needless to say I came prepared with my mace and a good pair of running shoes.

I wish I could describe just how beautiful this place was, but that’s impossible. Words are too few and cameras can’t truly capture the colors, sounds, and feeling you get from just standing still on the cliff of these huge boulders overlooking Lake Victoria. The only thing more incredible than that was to see old friends and meet new ones. I had kept in touch with many of the previous students and a few were now working on staff. It was good to see them teaching some of the very lectures we had provided them! Given the large class sizes, I was at first intimidated on how we would be able to connect to them on a personal level, to gain an understanding of their knowledge base, and to see what we could offer them to be a better provider. I quickly found that this fear was unnecessary. The students proved just as eager as those before to improve on their skill set.

Despite the overly crowded ORs, they gathered around to hear tips, practice safer procedure techniques, and learn from each other. The staff was greatly appreciative of the equipment that we brought, courtesy of the gigantic suitcases Dr. Reeves so kindly gave to us. It may have been a hassle to get through security (hard to explain pulse oximetry to a person who only speaks Swahili), but luckily I did not get tased. The most coveted piece we offered was that created by our own MacGyver himself, CRNA Ray White. A little oxygen tubing, esophageal temp probe, disposable stethoscope ear piece and voila! We are ready for some level one type cases… because unfortunately many of the operating rooms were still void of what we would consider mandatory monitors.

Again, despite the limited resources I was amazed at the surgical case load and success. It really makes you appreciate the human body. Before I knew it my time to leave Africa had come and I again promised myself to never forget, to remember the sounds, colors, smiles, faces, and love that I felt. I guess I will try to hold on to this until the day I can return and again “begin to remember.”
UNDER AFRICAN SKIES
BY: DR. EBONY HILTON

RETIREMENT LUNCH FOR CINDY FITZGERALD, RN
AFTER 17 YEARS IN THE PAIN MANAGEMENT CLINIC
LEGACY OR RAMBLINGS OF AN OLD CODGER  
REFLECTIONS BY: CHARLES WALLACE, MD

Over the next several months Sleepy Times will be featuring articles on the concept of leaving a legacy. Drs. Guidry, Wallace, and Reeves will be presenting materials.

I have been blessed in my formative years with good role models and mentors. I hope you have also. First, there was my scoutmaster when I was a youngster, then several biology professors at The Citadel, and then Drs. John Mahaffey and Will Middleton in medical school.

I met Dr. John Mahaffey, the chairman of the department of anesthesiology, 48 years ago as a 23-year-old freshman medical student at MUSC. (It was the Medical College of SC then.). He hired me for a part-time job in the department of anesthesia providing N₂O-O₂ analgesia to OB patients in labor. (OB epidurals had not evolved yet). There were four of us and the pay was $140/month. I was required to spend the first summer (between freshman and sophomore years) working in the Main OR, learning the basics of airway management and IV insertion. I was then on in-house call every 4th night for OB anesthesia and urgent respiratory care. (There were no respiratory therapists at night or on weekends.) Dr. Mahaffey had me spend the majority of the second summer (between sophomore and junior years) with Dr. Will Middleton at Roper Hospital to experience private practice anesthesia. Little did I know, but Dr. Mahaffey, who loved fishing, was slowly reeling me into the specialty of anesthesiology, and that my life would be changed forever. Dr. Middleton told me he was going to do three things: convince me to become an anesthesiologist, teach me the art of sailing, and convince me to become a republican. (My family had a long history of being yellow-dog democrats.) Dr. Middleton succeeded in all three.

Dr. Layton McCurdy, Dean Emeritus of MUSC, also had the OB anesthesia job in medical school. Dr. Joanne Conroy, a former chair of our anesthesiology department, did not have the OB anesthesia job, but did rotate through anesthesia with Dr. Middleton.

Few American medical students were choosing anesthesiology as a specialty in the 1960s. The ASA created a special internship (PGY 1) known as a Rotating-8 to expose more graduates to anesthesia. It required 6 months of anesthesia training during the intern year.

Following internship, anesthesiology was a 2-year residency; but if you had completed the Rotating-8 internship, you could get 6 months credit on a fellowship. Dr. Mahaffey saved this internship for me and a slot in the residency. We had four faculty anesthesiologists and seven O.R.s at that time.

I had always planned to go into private practice at Roper Hospital upon completion of the residency, but early in my last year Dr. Mahaffey asked me to join the faculty. Since all my training had been at MUSC for both medical school and residency, I wanted to complete a fellowship in either cardiac or pediatric anesthesia prior to joining the faculty. I interviewed at UAB for cardiac and Children's Hospital of Philadelphia for pediatric. I finally decided on CHOP and completed a fellowship in pediatric anesthesia in December of 1972 and returned to MUSC as the 5th faculty member in January 1973.

Anesthesia in the late 60s and 70s was what we might best describe today as 3rd World. Monitoring was basic -- manual BP cuffs, a finger on the pulse or pre-cordial esophageal stethoscopes, and ECG. One of our anesthetics, cyclopropane, was explosive. When using cyclopropane, the electric cautery (Bovie) and static electricity had to be avoided. Our O.R. shoes and booties had to have conductive strips grounding us to the floor. There were no ventilators in the O.R. other than in the heart room. A few pressure transducers were available for the heart room monitor, but they had to be individually cleaned, sterilized, and calibrated for each case. CVP was done with water manometers. We had no way to take manual blood pressures in infants until the Doppler became available, and then only obtained the systolic blood pressure.

Volatile anesthetics available were PenthraneÔ (methoxyflurane), Fluothane (halothane), and FluomarÔ (isopropyl vinyl ether), also called Fluobarf because of the high incidence of postoperative nausea and vomiting. Methoxyflurane metabolism produced small amounts of fluoride ions, which could cause high output renal failure. Halothane eventually became suspect for any hepatitis, which developed post-operatively.
LEGACY OR RAMBLINGS OF AN OLD CODGER
REFLECTIONS BY: CHARLES WALLACE, MD

We had a few of the early temperature-compensated Fluotec vaporizers, but most of the volatile anesthetics were administered through a Kopper Kettle or Vernitrol vaporizer. The concentration had to be calculated based on room temperature and the vapor pressure of the anesthetic. The vaporizers produced approximately 45 ml of halothane for every 100 ml of oxygen bubbled through the vaporizer at normal room temperature. A short-cut method to calculate halothane concentration was to run a total gas flow of 4.5 liters so that the 100 ml could be viewed as 1% (45 ml halothane/4.5 L total gas flow = 1%). 200 ml of oxygen through the vaporizer would produce approximately 90 ml halothane, or 2% and so on. Newer temperature-compensated vaporizers became available and were a great improvement.

The only muscle relaxants that were available were succinylcholine, curare, and gallamine (Flaxedil Ò). We would administer 30-40 mg of curare for long-acting relaxation. (And to think that we worry about histamine release today.) There were no safety devices on the anesthesia gas machines other than the “pin index system”--no oxygen analyzer or internal mechanisms to prevent a hypoxic mixture from being delivered. Halothane was well known to produce cardiac arrhythmias. We could often abolish “halothane” arrhythmias by adding a small concentration of methoxyflurane to the anesthetic. (Yes, 2 vaporizers in use at the same time.)

Ketamine and InnovarÒ (a fentanyl/droperidol combination) became available as intravenous anesthetics in the late 60s and early 70s. Innovar-N2O-O2 was known as neuroleptic anesthesia—the precursor to TIVA. Ethrane and isoflurane also emerged in the 70s with sevoflurane coming in 1990 and desflurane in 1992. Newer non-depolarizing muscle relaxants (pancuronium, vecuronium, and rocuronium) were also developed.

Children and adults were administered IM pre-meds. Demerol 50 mg, VistarilÒ 50mg, and atropine 0.4 mg IM on call to the O.R. were a commonly used pre-medication in adults. Children received IM secobarbital, morphine, and atropine in varying doses. VersedÒ was a welcome advance when it became available in the early 80s. (Our Jerry Reves was involved in a number of the initial VersedÒ studies.)

Monitoring began to improve and safer anesthesia machines were developed. The Swan-Ganz PA catheter became available in the early 70s. It was not until 1983 that pulse oximetry became available and shortly thereafter end-tidal CO2 monitoring. Prior to the invention of the LMA in 1982, all inhalation anesthesia was administered via mask or endotracheal tubes. In my view, these three—pulse oximetry, ETCO2, and the LMA—are the three most important improvements to occur during my career.

All of us have a few cases that affect our careers and are burned into our memories:

Back when I was doing pediatric hearts, I provided anesthesia for a child. He was having surgical correction for TOF just before Christmas. As we were putting him to sleep I asked him what Santa was going to bring him. He looked down, shook his head sadly, and would not talk to me. I asked again and again with the same results. I finally convinced him that he could tell his friend Dr. Charlie what Santa was going to bring. He looked up, and told me with the saddest expression that Santa did not come to his house. "Well," I said," he is coming this year; so what do you want him to bring?" With a big grin, he told me a gumball machine. And off to sleep he went dreaming of gum ball machines and being able to run and play like all his friends now that his heart was going to be fixed. I asked several of the O.R. nurses if they knew where we could find one, and they did. We arranged to get one that afternoon so it would be in his ICU room. Unfortunately, he died in the O.R. I know in my heart he met the real Santa Claus in heaven and is running and playing like all the other kids today.
LEGACY OR RAMBLINGS OF AN OLD CODGER
REFLECTIONS BY:  CHARLES WALLACE, MD

On a lighter subject:

Do you know what the difference between major and minor surgery is? When it is being done to you, it is Major. Funny, but true --- Where do surgeons buy their watches? I have tried to find this top-secret store my entire career. It seems their watches only work between cases, never intraoperatively.

It is a special privilege and responsibility for us as physicians to walk just a few steps with patients in their journey through life. I urge you to set aside all the issues competing for your time as you enter the holding room and be there for your patients. Don’t just stand at the bedside; sit down with them, hold their hands, and let them know you care. We may never see or care for them again. This may be the only opportunity you have to make a difference. If you are not already doing this, you will be amazed!

Thank you for the opportunity to share a little about the good old days. I only regret that as we have grown in numbers of faculty, residents, CRNAs, and hospitals we cover, I do not know many of you as well as I did in the past. We are so fortunate to have so many talented individuals known nationally and internationally, as well as so many rising stars.  God Bless!
GRAND ROUNDS FOR THE MONTH OF JUNE

“Liposomal Bupivicaine”  
June 3, 2014  
Michael Anderson, MD  
Mount Sinai  
Associate Professor

“Anesthesia Medically Challenging Case Conference”  
June 10, 2014  
George Guldan and Ryan Gunselman, MDs  
Medical University of South Carolina  
Assistant Professors

“Epic Training– Entire Department”  
June 17, 2014  
Epic Team  
Medical University of South Carolina

“Subspecialty Team Meetings”  
June 24, 2014  
Medical University of South Carolina  
Division Chiefs
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 into Kim Crisp. Thanks so much!!

Don’t Forget to Recognize Someone Who is Going Above and Beyond!

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

June 2014

Standard of the Month

Keep all interactions positive by not engaging in negative behaviors such as gossiping, back-stabbing, non-verbal negative insinuations or arrogance.

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