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

Because I’m Happy

In April, the Society of Cardiovascular Anesthesiologists held its 36th annual meeting and workshops in New Orleans. This meeting had a special meaning for me on multiple fronts, hence the title of this month’s Sleepy Times, “Because I’m Happy.”

The faculty did a remarkable job participating by presenting lectures, original research, and leading committees (See meeting summary later in Sleepy Times). The adult and pediatric CT divisions were truly an integral part of the meeting. The meeting also highlighted the high level of patient care and education that occurs at MUSC. We should all be proud.

As the catchy tune, Happy, sung by Pharrell Williams goes…

(Watch Video) If you do not know the tune, please click on the you tube link before reading on.

It might seem crazy what I’m about to say…

Because I’m happy, Clap along if you feel like happiness is the truth
Because I’m happy, Clap along if you know what happiness is to you
Because I’m happy, Clap along if you feel like that’s what you wanna do

The annual meeting also featured one of our past chairs of the department, Dr. Joanne Conroy, Chief Medical Officer of the Association of Academic Medical Centers, who gave the keynote address entitled; “Turbulent Times for Academic Medicine: Evolution of the Clinical Enterprise.”

Dr. John Ikonomidis was one of several surgeons invited to update the society on advancements in cardiothoracic surgery. He gave an excellent lecture entitled “Aortic Valve and Aorta. How Big is Too Big? When to Repair an Ascending Aortic Aneurysm.”

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Finally, this is the first of two annual meetings where I have the honor to be the SCA President presiding at the meeting. I now know how proud and humble Jerry Reves and John Waller must have been as they served their terms as president and were able to steer the direction of the society.

Because I’m happy, Clap along if you feel like happiness is the truth
Because I’m happy, Clap along if you know what happiness is to you
Because I’m happy, Clap along if you feel like that’s what you wanna do
MEET OUR NEW RESEARCH NURSE STUDY COORDINATOR: WANDA JONES, RN

Wanda Jones is very excited to join the department in the area of research at MUSC. She has been an employee of MUSC since 2000 and an RN at MUSC since 2005. She has spent the past four years on various research grant projects. Wanda is a lifetime resident of Charleston. Outside of work she enjoys outdoor activities such as boating, hiking, hunting and gardening.

MEET OUR NEW ADMINISTRATIVE ASSISTANT, ALEXANDRA POOLE

Allie Poole is excited about joining the Anesthesia team as an administrative assistant at ART. She graduated from the College of Agricultural and Environmental Sciences at UC Davis where she earned a Bachelor of Science in Regional Development. After graduation she moved to the San Francisco Bay Area where she interned for a green energy company. Allie decided to move to the beautiful city of Charleston in the fall of 2011. Prior to joining MUSC she worked in the Reservations Department at Wild Dunes Resort.

When she is not at work Allie enjoys going to concerts, traveling, hiking, snowboarding and reading. She is looking forward to transitioning into her new role at MUSC and helping the Anesthesia Department as much as she can.
NEW MUSC PRESIDENT– DR. DAVID COLE

David Cole: Man of vision and integrity set to lead MUSC

By Mische Hayes
Public Relations

A search of global proportions resulted in finding a star in our very own backyard. After nearly a year, not only is the uncertainty over, there is an unmistakable air of excitement on campus.

David Cole, M.D., the A. McKee Rose, Jr. M.D. Endowed Chair, chairman of the Department of Surgery and president of MUSC Physicians, will soon shoulder the highest mantle of leadership at MUSC and colleagues and staff alike speak enthusiastically about his vision and ability to relate personally to all with whom he comes into contact.

Tom Stephenson, chairman of the MUSC Board of Trustees, expressed confidence in the board’s selection and noted that Cole’s experience and strategic vision will help the Medical University achieve the institutional goal of being one of the nation’s top 25 academic medical centers.

Mark Rothmann, Ph.D., interim president, shares the board’s conviction. “In my conversations with David, I have been struck not just by his intelligence, thoughtfulness, and diplomacy, but by how much he cares about MUSC. David has been extraordinarily successful in whatever he has chosen to do and I am confident that this pattern will continue with him.”

Cole’s assistant of seven years could not agree more. “MUSC simply could not have chosen a better leader than David Cole,” said Dawn Hartnell, administrative coordinator and assistant to the chairman. “He is a leader with vision who genuinely cares about people.”

Many of her colleagues feel the same way. Beloved, respected, honorable and kind were just a handful of the superlatives used to describe the president-elect by those who work with him in the Department of Surgery. In fact, while they can’t begin to imagine the department without him, according to Hartnell, faculty and staff were wildly excited when they received news that their chairman had been offered the position.

Following the announcement of his selection April 17, Ettie Pizzo, M.D., dean of the College of Medicine, addressed the faculty and staff of the Department of Surgery at a meeting Friday morning.

She spoke of Cole’s great character and integrity and said, “Of the 70 national and international candidates, David Cole was ultimately chosen because of his patient-first attitude which is the basis of this entire institution."

As a result of his work ethic and the reputation he has earned over the past 20 years, Cole is proud of the fact he has built institutional trust. “It was meaningful to me when Tom Stephenson described me as a person of integrity. I believe that’s an important quality. I’ve

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
Please RSVP to Kelly Landers
at landers@musc.edu
CONGRATULATIONS TO DR. CHRISTOPHER HACKNEY FOR BEING SELECTED PHYSICIAN OF THE MONTH

Dr. Hackney had 4 nominations! All listed below:

“Dr. Hackney is greatly appreciated in MSICU. He takes time to explain situations to patients and families so that they have clear information to make the best decision for the patient. Even when he does not necessarily agree with that decision he is kind and patient. On one occasion a patient without an advance directive was unresponsive on the floor. He called the family, who was not happy to be called, to be sure the patient wanted to be intubated and apprise them of the situation. Once the patient was transferred to the MSICU, she woke and stated she did not want to be intubated. She had end stage breast cancer with a very poor prognosis. However since she was not fully cognizant the family was again contacted to confirm that intubation was in fact what the patient would want. Dr. Hackney remained extremely professional throughout this difficult conversation with the family. He in no way stated his personal views or beliefs, but explained in a professional manner the issues and concerns involved with intubation in this very ill woman. The family was quite indignant and rude throughout the conversation and he conducted himself very well throughout. The nurses on MSICU always look forward to his rotation and value the time he spends here.”

Above, Nominated by: Susan Davis

“I would like to nominate Dr. Hackney as Physician of the Month. I have worked with him in the MSICU and he is absolutely one of the most empathetic physicians that I have ever worked with in my 20 year career. He is a patient advocate and goes out of his way to spend time explaining complex medical situations and status changes to families. Many of these discussions occur late at night over a long distance phone call, nonetheless he is relentless in his desire to do what is right for the patient. I have seen various physician styles but I am absolutely in awe of his caring attitude and the grace by which he guides his practice.”

Above, Nominated by: Persephone Redden

“Dr. Hackney is an exceptional resident in the MSICU. He is always calm in stressful situations and his ability to make quick decisions has saved lives. One example was when there was a MET on 5W on a patient in respiratory distress. He quickly took charge, the patient was rapidly intubated, and then immediately rushed to MSICU. In route, she lost a pulse in the elevator, and he quickly initiated ACLS protocol. Once the patient arrived in the ICU, without hesitation, he placed a central line while running the code. The patient was revived but remained very critical. He was very diligent in contacting the family for the patient once she was more stable. Dr. Hackney is always a team player, communicates and collaborates well with others, and sets a great example for lower level residents on how to be an excellent doctor here at MUSC. As a nurse, it is refreshing to see a resident with such a positive attitude and his enthusiasm and eagerness to learn is contagious. Thank you for all that you do!”

Above, Nominated by: Emily Brunner

“Dr. Hackney is every bit of what MUSC stands for... "Service Excellence, and Changing What's Possible". He has really made a difference on my nursing unit in the MSICU. I really enjoy working with him, as he's culturally sensitive to both patients and staff members, he treats everyone with total respect. He's also very compassionate, as he engages and reaches out to both patient and family. There's never a dull moment working with Dr. Hackney, very professional and easy going. He works very well under stress. I can recall a time, a patient went into AFIB with RVR, the nurse caring for the patient started to panic just a little. As Dr. Hackney so calmly, and professionally approached the situation, he reinforced that same behavior to that nurse as demonstrated through his positive attitude and graceful demeanor. PHENOMENAL I tell ya!! I am just calling it how I see it, he's truly, truly a positive asset to MUSC Hospital. Keep doing what you do Dr. Hackney, you're a shining star!!”

Above, Nominated by: Ivory Fripp
CONGRATULATIONS TO DR. CHRISTOPHER HACKNEY FOR BEING SELECTED PHYSICIAN OF THE MONTH

ADMINISTRATIVE PROFESSIONALS’ DAY AT SAFFRON CAFÉ AND BAKERY
The 2014 Society of Cardiovascular Anesthesiologists Annual Meeting marked another successful meeting for both our society and for our Department. Held in New Orleans, LA and comprised of great content and entertainment, a good time was had by all. A few highlights included the presentation of new data regarding how we care for patients with Left Ventricular Assist Devices by Drs. Eric Nelson and Kyle Branham. Fellows Kyle, Jeff and future fellow, Parker, all presented complex cases to expert anesthesiologists. Dr. Alan Finley shared with the membership his in-depth knowledge of heparin resistance in a prestigious refresher course delivered to a packed house. Dr. Reeves continues to provide excellent leadership to the society in his first year as President.

During the SCA-Foundation gala, monies were raised for “Fellows for the Future.” I am proud to announce that the MUSC faculty, current and former fellows received the award for the “Highest average gift.” My heartfelt thanks to each and every one of you who participated.

Most importantly, all of us who had the privilege of participating in the annual meeting owe a debt of gratitude to Dr. Tim Heinke who stayed behind to take care of our patients.

We all returned better educated and enthusiastic to continue our quest towards excellence in our tripartite mission of clinical care, education and research.
SCA ANNUAL MEETING UPDATE
BY: DR. JAKE ABERNATHY
LEAVING A LEGACY, FORTY YEARS OF CLINICAL PRACTICE
REFLECTIONS BY: FRED GUIDRY, 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.

Dr. Reeves asked me to write about the changes that I have seen in medicine and in anesthesiology in particular.

Some personal history will put these observations in context. I graduated medical school in 1970 and was a surgery resident for three years before transferring to anesthesiology, so I have seen things on both sides of the “ether screen.”

Medical school and surgery residency were at Charity Hospital, which was a most unusual institution. It was founded in 1736 using a bequest from a French sailor with the explicit purpose of serving the poor. A new building was built in 1939 that had 3300 beds and 40 operating rooms. Note that it had “beds” and not “rooms” because all patients were in 12-patient open wards. There were a number of smaller charity hospitals throughout the state so that it had a built-in referral system. It served as the primary teaching hospital for both Tulane and LSU. When I was there it literally was a charity hospital in that patients were not billed. That model changed with the rapid expansion in the cost of care and government funding.

Katrina flooded Charity Hospital’s basement. In spite of the building being cleaned by volunteer medical personnel and the military, the state refused to reoccupy the building. Critics contend that this refusal to use the building was an attempt (that was ultimately successful) to get a grant of $474,750,898 from FEMA to replace Charity with a new building. Charity Hospital now stands empty. A sad end for a historic structure.

The first anesthesiologist at Charity Hospital was John Adriani who was hired in 1941, and he quickly became the most powerful force in the institution. He was still there in the 1970’s. The history is unclear but he likely started both a nurse anesthesia school and anesthesiology residency in the 1940s.

Adriani got crosswise with organized anesthesiology in the late 40’s because of his insistence on being involved in the education of nurse anesthetists. He ultimately got his way, as he did in most things.

Almost all anesthesia was administered by student nurse anesthetists. One of the tricks that we surgery residents knew was that first year students were required to use ether and second year students could use halothane. Therefore, we scheduled all cases with a Bovie whether or not we really needed it. That ensured a more experienced student, no ether, and a much smoother post operative course!

Many things were in their infancy such as arterial blood gasses, central lines, arterial lines and intensive care units. The first saphenous vein coronary artery bypass graft in the United States was in 1967. Angiocaths were kept in the narcotics box for special situations because routine IVs were started with steel needles.

In the LSU surgery program at that time, third year residents were primarily responsible for the service and did almost all of the major procedures. I realized when I was at that level that I did not have a surgeon’s mindset or personality. That was the push out of surgery. The pull into anesthesia was Jim Arens, MD. He had been chair at Ochsner and had a great local reputation. The beginning of my third year as a surgery resident was the beginning of his first year in Jackson, Mississippi. I visited there and was stunned. He had recruited an incredible group of young anesthesiologists as faculty. There was a strong emphasis on critical care. The department ran the ICU and the entire faculty made ICU rounds together before starting the OR. I was hooked.

In 1973 I moved to Jackson to begin an anesthesiology residency and a new life.

Anesthesia machines were mechanical rather than electronic. That meant Copper Kettles and Vernitrols rather than vaporizers, and one had to know the vapor pressure of an agent to calculate its inspired concentration. Gasses were measured with needle valves and flow meters, and there were no devices to prevent a hypoxic mixture. Oxygen analyzers were introduced during this time period, but capnographs were not in use.
LEAVING A LEGACY, FORTY YEARS OF CLINICAL PRACTICE
REFLECTIONS BY: FRED GUIDRY, MD

There were two pop off valves and they were mounted on the CO₂ absorber. That meant that they were at face level
when sitting by the machine. One was a pressure valve that functioned similarly to our current APLs. The other was
the Georgia valve that closed when the bag was squeezed. Both exhausted waste gas at face level because there was
no waste gas scavenging. Some spouses claimed that we reeked of halothane when we got home.

Before the NIBP there was a most clever way to measure the blood pressure. There was a rubber stethoscope
attached to the underside of the BP cuff with Velcro. Everyone wore an earpiece at all times during a case. It was
attached to a Ploss valve that was a pressure-activated, two-way valve that allowed for monitoring blood pressure,
pulse, and respiration. The valve communicated with the blood pressure acoustic pickup that was always open, but the
pressure-activated feature automatically closed off communication with another acoustic pickup (esophageal
stethoscope or chest piece) when the blood pressure cuff was inflated. The sound from the chest or esophageal
stethoscope was temporarily shut off while the cuff was inflated.

The blood pressure cuff was automatically inflated by a Side Kick which was a valve located at knee height on the
anesthesia machine.

During an anesthetic one would be continually monitor the heart and breath sounds with the esophageal
stethoscope through the Ploss valve to the earpiece. A blood pressure could be taken simply by hitting the Side Kick
with a knee. That would both inflate the cuff to a predetermined pressure as well as flip the Ploss valve from the
esophageal stethoscope to the blood pressure acoustic pickup. We could take a BP without using our hands, but we
would still have to chart it on paper!

It was a very clever work around to a problem but completely disappeared when NIBPs arrived.

There were no pulse oximeters, so we really paid attention when the surgeon said that the blood was dark.

Pre op clinics were unheard of because out patient surgery was in its infancy. The first freestanding out patient
surgery center in the US opened in 1970. We saw all patients the night before surgery because virtually all patients
were in the hospital. Going into the hospital every Sunday night was a real pain.

The procedures that were done were by and large quite different. Basically there was no procedure that had
“oscopy” or “scopic” in its name – laparoscopic cholecystectomy, arthrosopy, colonoscopy. Some of the most
common procedures then are rarely seen today such as vagotomy and pyloroplasty for peptic ulcer disease or radical
mastectomy taking the pectoralis muscle.

Forty years is long enough to fog my memory, but I honestly don’t remember anesthetic catastrophes in spite of
conditions that we would now consider third world. However, another aspect that is impossible to quantify is the
severity of the patients’ illnesses and co-morbid conditions. It is likely that our patient population then was somewhat
healthier and certainly less obese. There were no patients with LVADs for a gastric bypass in the 1970’s.

Many things have changed in the OR over the last 44 years. The one thing that has not changed is the simple
pleasure of working with wonderful people in the operating room.
After multiple plane changes and 60+ hours of total travel time, we landed safely in Mwanza late in the evening. We arrived to find that the Serengeti house, our intended destination, was “full” with other visiting residents and medical students, so we were placed in a nearby hotel just down the road from Bugando Medical Center. This was the first of many lessons on adaptability that I would come to learn during my time in Africa. Completely exhausted from travel, I was happy to settle into what would be my new home for the subsequent 4 weeks. I was excited and nervous to find what awaited us the next day.

After a much needed night’s rest, we arrived at Bugando early the next morning. We passed through several “security guards” with metal detectors that seemed to beep continuously without consequence. We were initially stopped at the gate because we didn’t have hospital badges. After stumbling through communication barriers with hand signals and broken Swahili, we finally made it into the hospital with a substantial amount of medical equipment donated from MUSC. We arrived in time for morning report. This lasts for several hours each morning, and is an opportunity for each of the anesthesia students to present the upcoming day’s cases along with their intended anesthetic plan. It is meant to be a learning opportunity for the students. The plans are directed to and critiqued by Dr. Matasha, the only permanent year-round Anesthesiologist at Bugando. They also discuss all of the emergent cases that were done overnight, in addition to a brief presentation of all of the current ICU patients. This was my first exposure to the program at Bugando, and despite what I thought was adequate preparation from my predecessors, it was quite an eye opening experience. The students’ lack of background medical knowledge was evident, and I quickly understood how large the task was that stood ahead of us. Dr. Selby, a visiting anesthesiologist from Australia, was present that morning. He sporadically devotes many months each year to teaching at Bugando, and became instrumental in orienting us to the hospital. He allowed for a seamless transition by introducing us to the right people and obtaining our hospital badges all within our first day (a task that had taken others weeks due to all of the “red tape” that existed in the hospital system). He was also able to give us an idea of where the students stood academically, and which topics to focus on during our time in Mwanza. Unfortunately, he had to leave shortly after our arrival, so it was our responsibility to pick up where he had left off.

After a day of “learning the ropes,” we quickly joined in on leading morning report, and formulated a lecture series that included 2-3 hours of lecture per day, supplemented with OR teaching in the afternoons.

The anesthesia program at Bugando has grown substantially over the last few years and currently has close to 50 students. They are divided into 3 groups based on their time of enrollment: the September intake, the Kigoma group (a group of midwives from the Kigoma area that joined the program in December), and the largest of the three, the January intake. All three groups rotate throughout the week and have 2-3 days of lectures. The other 2-3 days/week are spent in the operating theatre under the guidance of their practicing nurse anesthetists. Unfortunately, the knowledge base did not vary significantly amongst the three groups, and their understanding of basic physiology and pharmacology was minimal. This became one of the major focal points of my lectures throughout the month. I quickly learned that the traditional “African way” of teaching was one of intimidation and fear. Incorrect responses often resulted in belittlement and embarrassment in front of the group. As a result, the students were extremely timid. It took some time, but I feel that overcoming this obstacle was one of our greatest achievements throughout the month. This allowed us to eventually make significant progress in their knowledge base and level of understanding. As the students became more comfortable with me, I was able to pinpoint the disconnect that existed between book knowledge and clinical correlation. I finally began to see “light bulbs” going off as I attempted to correlate these textbook concepts to specific cases. It was encouraging to watch the students’ enthusiasm and progress over the subsequent 4 weeks.
The operating theatre was an entirely different experience. I was warned about the lack of monitors, drugs, and resources in general, but nothing really prepares you for these things until you see them first hand. I was extremely thankful for the presence of a pulse ox in each OR as well as the PACU (thanks to MUSC’s prior donations). However, when the power in the entire hospital goes out (which happens frequently), we are forced to rely on physical exam skills alone. On one of my first days in the operating theatre I walked into an OR mid-induction. As Ketamine and Suxamethonium were being administered, I noticed that there was no one at the head of the bed, no pre-oxygenation, and the pulse ox and BP cuff lie idle at the patient’s side. I scrambled to help attach monitors as one of the students began to mask the patient. The patient ended up intubated without complication, and sadly, there seemed to be little realization that anything should have been done differently with induction. I made it a point to focus on respiratory physiology and the importance of pre-oxygenation at my next lecture. I learned that I was not going to be able to change every little thing that I felt was done incorrectly, and I began to hone in on just a few key concepts that would hopefully improve overall patient safety. It was exciting for me to be able use medications such as Thiopental, Pancuronium, Atracurium, and Halothane, which I had only read about in the past. I also learned a lot about flexibility and adapting to my surroundings. One afternoon, just prior to induction for an exploratory laparotomy for a suspected small bowel obstruction, I learned that the last vial of Suxamethonium was used earlier that day and there would be no more available until the following Monday. The only neuromuscular blocker available through the weekend was Pancuronium. As I adapted, I learned to work with the few resources that were at our disposal.

Outside of the hospital, I enjoyed getting to know the city of Mwanza. Several other attendings and residents were staying at the G&G hotel with us. There was also a constant rotation of visiting physicians and students in the Serengeti House down the road. I enjoyed getting to know these people and hearing stories of how things were done in different areas of the hospital. Most stories were filled with frustration and fear for patient safety; however, it was encouraging to know that we were all there with a common goal—a hope that we would make some small impact on these providers and improve the medical care delivered in Tanzania. We enjoyed exploring the city of Mwanza together.

The hustle and bustle of the central market was exciting and a little overwhelming at times, but it was the natural untouched beauty of the surrounding landscape that really amazed me. The sunsets over Lake Victoria with its scenic mountainous backdrop were stunning. I was fortunate enough to go on a safari into the Serengeti and Ngoragora Crater one weekend during my stay. I was able to see practically every wild animal imaginable in their breathtakingly beautiful, natural habitat. Zebras, wildebeests, elephants, and giraffes were close enough to reach out and touch! It was an experience that will be difficult to match.

The people of Mwanza were friendly and welcoming. They were excited to share their language and culture with us. The hospital personnel were extremely grateful for our presence. Dr. Mtasha constantly stressed that “education is the most important thing.”
I was sad to learn that in our absence, the students simply do not have lectures or any formal didactics. They are lucky to have Dr. Selby sporadically throughout the year, and our presence certainly appears to make a difference. There was constant praise and gratitude at the end of each lecture, and the disappointment was evident when we had to announce our departure. I can only hope that our program and the presence of foreign educators continues to grow and prosper over the years as rapidly as their class size is increasing. Another contribution that was made by MUSC was approximately 100 pairs of scrubs for the anesthesia students. Despite the many sacrifices that most of the students had to make in order to come up with tuition for the anesthesia program, OR attire was not provided by the hospital. Most of the students had only one pair of OR appropriate scrubs that they wore every day. They were so excited and grateful to receive a pair of scrubs from MUSC. A contribution that seems so minimal made such a significant impact on these students.

Overall, the rotation in Tanzania was an amazing, life changing experience. It not only made me a better clinician and teacher, but also changed my perspective on the many things that we take for granted in the US. I am so grateful to the department and to Dr. Reeves for this wonderful opportunity, and I would encourage everyone to get involved in similar ventures if ever given the chance.
Dear anesthesiologists, residents, and nurse anesthetists:

It is time to sign up for Epic training in preparation for go-live with Epic enterprise to include inpatient hospital activities on July 1st. Please sign up early. Training slots will be difficult or impossible to find if you wait until the last minute. Only users who have completed training will be able to log into Epic inpatient on July 1st. An ambulatory login and experience will not allow your access to inpatient. Obtaining training immediately after July 1st will not be available as our training team will be assisting in the go-live process.

Please follow the directions below for BOTH eLearning and Classroom Training:

I. Steps To Register for Training eLearnings

1. Log into CATTs www.musc.edu/catts
2. Navigate to the Quick Links section in the middle of the screen.
3. Click the button next to Self-Enroll – eLearning
4. In the Module Name column, locate and select enroll for “Epic Enterprise Prereqs for Anesthesia Providers”

5. In the top left corner, click “Select All” and in the bottom left corner click “Add Lessons”. (All three lessons should be selected)
6. In the upper right corner, click “Close Window”

   This is also a good time to clear up those elearning the hospital assigns to us:
   Go to the eLearning tab at the top of CATTs
   Go to MY eLearning lessons
   Please at least do the one on ICD-10 if you have not already done so.

II. Steps To Register for Classroom Training

1. Using the course catalog located here: http://mcintranet.musc.edu/epic/training/Course%20Catalogv2.pdf

   (alternately you can go to epic.musc.edu, select Training Resources on the left then Course Catalog)
EPIC EDUCATION AND TRAINING
BY: DR. SUSAN HARVEY AND LARRY FIELD

2. We are required to complete both of these classes, which are 4 hours each:

3. Login to CATTS using your NETID here: www.musc.edu/catts

4. Scroll down to the Quick Links section in the middle of the screen.

5. Click the button next to Self-Enroll – Classes & Events

6. In the Search for courses like box, type Epic and the first word of the course you are looking for. For our example, you could type “Epic Anesthesia” to find both courses. Set the date range to 04/28/14 – 06/30/14. This will decrease the amount of time the search will take. Click “List Event”.

7. Select Enroll Now next to each class you would like to attend.

For help please:
call 792-9979
e-mail epicregassistance@musc.edu

Dr. Susan Harvey
Dr. Larry Field
“BEST OF CHARLESTON” ONCE AGAIN!
BY:  PAT CAWLEY, MD

CEO Message: MUSC - "Best of Charleston" Once Again!

March 27, 2014

Dear MUSC Medical Staff,

For 2014, the Charleston City Paper voting has ended and MUSC has come out on top in 3 categories!

Best Hospital
Best Health Club
Best Place to Work

Even though we are South Carolina's #1 hospital as noted by US News & World Report, it is just as important to be considered the best right here at home.

Each of you makes these awards possible by providing advance, coordinated health care while pioneering ways to treat and heal patients.

We are going to celebrate these awards by marketing them to the public and here is a preview of those efforts:

Best Hospital
Best Health Club
Best Place to Work

Leader Change
Melissa Martin, manager of Children's Hospital 8D and PCICU, is leaving MUSC to pursue other opportunities. I would like to thank Melissa for her leadership. We have accomplished many initiatives on these units and she is greatly appreciated for the many important things she has done for the Children's Hospital, as well as multiple adult units over the past 11 years. She has made a positive difference at MUSC. She will be missed and we wish her luck in her new adventure.

While a search is conducted for the permanent position as the Nurse Manager of PCICU and 8D, Amanda Schubert, Assistant Nurse Manager for 8D and PCICU, and Amelia Little, 7E Nurse Manager, will both assume additional duties as interim nurse managers of PCICU and 8D, respectively.

Thank you for the phenomenal care you provide every day!

Sincerely,

Patrick J. Cawley, M.D.
Executive Director/CEO, Medical Center
Vice President of Clinical Operations, University
GRAND ROUNDS FOR THE MONTH OF MAY

“Perioperative Outcomes”
May 6, 2014
Eric Wittkugel, MD, FAAP
Cincinnati Children’s Hospital
Associate Professor

“Perioperative Outcomes in Orthopedic Patients and the Role of Anesthesia”
May 13, 2014
Stavros Memtsoudis, MD, PhD, FCCP
Weill Cornell Medical College
Professor

“Epic Training– Entire Department”
May 20, 2014
Epic Team
Medical University of South Carolina

“Anesthesia Medically Challenging Case Conference”
May 27, 2014
George Guldan and Ryan Gunselman, MDs
Medical University of South Carolina
Assistant Professors
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 Kim Crisp. Thanks so much!!


Brystol Henderson, MD: Outstanding team-player! She helped taking care of a patient, placed a central line super fast! Awesome!

Robert Harvey, MD: Robert offered help to take care of a complex patient, despite his different assignment for the day. He organized to assist! Super Team Player!

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

May 2014

Support growth in others by providing direct constructive feedback when appropriate.

We Would Love to Hear From You!
If you have ideas or would like to contribute to Sleepy Times, the deadline for the June edition will be May 26, 2014.