



SLEEPY TIMES



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December

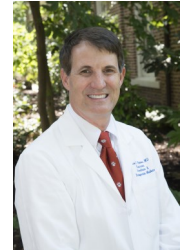
Inside This Issue:

-Message from Chairman	1-2
-Research Corner	3
-Dr. Catchpole's Teamwork App	4-5
-Halloween Fun	5
-Women in Anesthesia	6-7
-OB Bundles Part II	8-12
-Pre-Op Clinic Award	12
-West Ashley Expansion	13
-Department Events	14-15
-Grand Rounds	16
-Future Events/Lectures	17

MESSAGE FROM THE CHAIRMAN: IT IS ALL ABOUT TEAMWORK

-SCOTT T. REEVES, MD, MBA

Recently, I was invited to be the 10th J. Earl Wynands endowed lecturer in Cardiac Anesthesiology at the University of Ottawa Heart Institute. Dr. Wynands is widely regarded as the father of cardiac anesthesiology in Canada. He published a seminal article entitled "Coronary Artery Disease" in the *Canadian Journal of Anesthesiology* in 1967. In 1996, he received the Order of Canada, the highest civilian award given to a Canadian citizen, for his life achievements and dedication to our field. He was awarded the Gold Medal from the Canadian Society of Anesthesiologists and the first Distinguished Service Award for the Society of Cardiovascular Anesthesiologists.



It was a huge personal honor to be invited by Dr. Stephane Lambert to give the Wynands address. My only charge was to give a lecture that would be of interest to the cardiothoracic surgeons, cardiologists and anesthesiologists that would be in attendance. The endowed lectureships at the Ottawa Heart Institute are truly multidisciplinary.

I titled my presentation, *Physician Report Cards: Do They Affect the Outcome?* Much has been made recently of individual physician report cards through organizations such as Rate MDs, Consumer Reports and Medicare.gov Physician Compare. These grading services typically use patient satisfaction data along with other data sets to give physicians an individual health grade. The question has become, can you therefore identify poorly performing physicians and affect change to increase quality and improve outcomes?



Drs. Scott Reeves, Earl Wynands and Stephane Lambert



OPENING STATEMENT CONTINUED...

The lecture focused on what we have been learning in our human factors research: an individual's competency is important but the system and teams that one works within are equally important. Clemson's national title game against Alabama allows me to use a college football analogy. With only seconds remaining, the five-star college recruit, Deshaun Watson, threw the game-winning touchdown pass to the walk-on player, Hunter Renfrow. No matter how good your A-team may be (cardiac surgeons, etc.) it is the whole team (anesthesiologists, CRNAs, residents, anesthesia techs, OR/ICU nurses) that will ultimately contribute to the patient's outcome. I plan to give this presentation at an upcoming Grand Rounds lecture.



Hunter Renfrow catching the winning touchdown from Deshaun Watson.

As we enter into the heart of the holiday season, take a minute to celebrate the team atmosphere we have within the department. We have a lot for which to give thanks.



RESEARCH CORNER

It Is Not Always the Epidural: A Case Report of Anterior Spinal Artery Ischemia in a Trauma Patient

Matos, Jennifer R., MD; George, Renuka M., MD; Wilson, Sylvia H., MD

A&A Practice: September 15, 2018 - Volume 11 - Issue 6 - p 148-150
doi: 10.1213/XAA.0000000000000764
Case Reports



Dr. Matos



Dr. George



Dr. Wilson

DR. SCOFIELD'S RESEARCH ON THE COVER OF BIOLOGICAL PSYCHIATRY!



Dr. Scofield

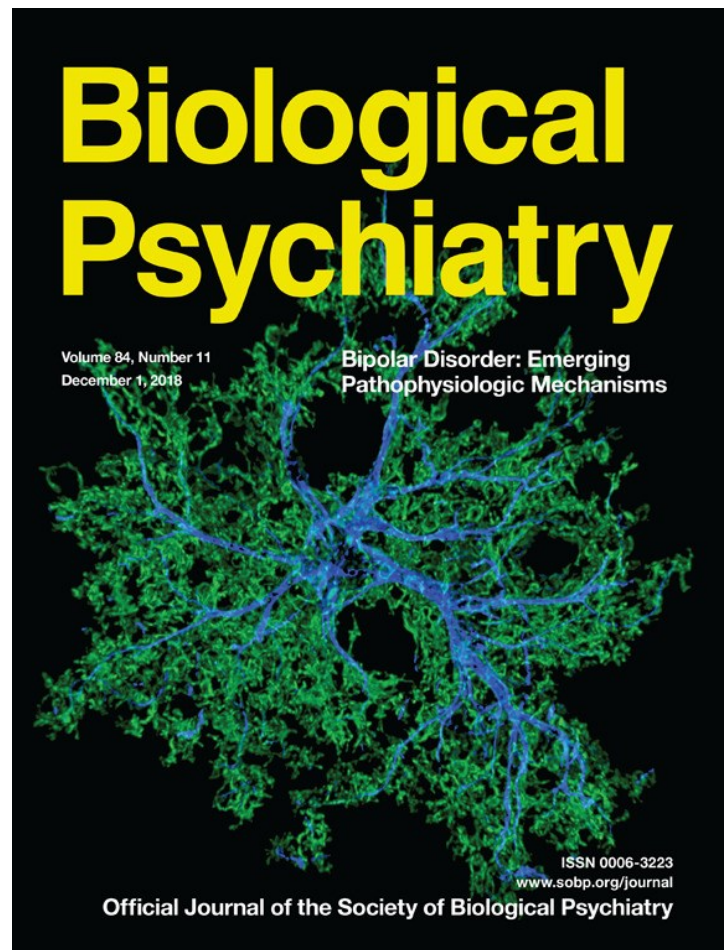
Congratulations to Dr. Michael Scofield! His work entitled "Exploring the Role of Astroglial Glutamate Release and Association With Synapses in Neuronal Function and Behavior" was featured on the December 2018 cover of *Biological Psychiatry*!

Exploring the Role of Astroglial Glutamate Release and Association With Synapses in Neuronal Function and Behavior

[Michael D. Scofield](#)

Department of Anesthesiology and Perioperative Medicine, Medical University of South Carolina, Charleston, South Carolina

Department of Neuroscience, Medical University of South Carolina, Charleston, South Carolina



THE SCIENCE OF TEAMWORK BY KIMBERLY MCGHEE FOR THE CATALYST

Can technology be used to improve teamwork in health care?

The answer is yes, according to Ken Catchpole, Ph.D., S.C. SmartState Endowed Chair in Clinical Practice and Human Factors at the Medical University of South Carolina. But only if the technology has been developed with the needs of the team in mind.

People should come first when designing technologies for health care, according to Catchpole. If technologies are not designed with users in mind, they are unlikely to be effective.

“A lot of health care IT falls down either because it wasn’t designed with people in mind in the first place or, when it was implemented, not enough attention is given to integrating the device into the rest of the work,” said Catchpole.

As a human factors specialist, Catchpole looks at how technologies can be adapted to providers’ needs instead of asking providers to adapt to the technology. “Instead of saying what can the technology do, we say how can this technology help providers do their job and how can we fit this technology to the provider.”

Adopting this user-centered design approach and using funding from a pilot grant from the South Carolina Clinical and Translational Research Institute, Catchpole and MUSC Health trauma surgeon Alicia R. Privette, M.D., designed a smartphone app to improve teamwork and communication in trauma care. Their app took top honors for Innovation in the Great Team Science Contest sponsored by the National Center for Advancing Translational Sciences. Winners of the contest were announced at the Fall CTSA Program Director’s meeting in Washington, D.C.

Catchpole had already spent time watching trauma care in action in his previous position at Cedars Sinai. He noted that the reliance on phone-based communication made it difficult for the trauma care team to efficiently share needed information, prepare for the patient’s arrival or plan a treatment strategy. When the emergency department is notified that a trauma patient is en route, an emergency department resident or other provider pages the trauma team as well as the operating room and specialist surgery teams.

However, that page includes very little information about the patient, making it difficult for the trauma team to prepare for the patient’s arrival or for the operating room and specialty surgery teams to assess whether, and when, their services are likely to be needed. Follow-up calls to the emergency department seeking more information about the patient disrupt care.



Dr. Ken Catchpole looks at how technology can be adapted to meet doctors' needs. Photo by Sarah

Pack

THE SCIENCE OF TEAMWORK CONTINUED...

While at Cedars Sinai, Catchpole had suggested that the emergency department resident write down details about the patient on a whiteboard to better inform the care team. That greatly helped the trauma team prepare for the patient but did little to serve the operating room team or specialty service teams located elsewhere in the hospital. At MUSC, Catchpole and Privette first considered an electronic whiteboard but finally settled on an app to improve teamwork and communication.

Using the app, the emergency department resident sends out information about the incoming trauma patient, including age, condition, and mechanism of injury to all members of the team. This helps, for example, the operating room team to assess, based on the severity of the injury, whether it should begin readying a room. The app also enables all members of the trauma care team to send HIPAA-compliant text messages to one another. The app arranges these messages by patient, enabling team members to “brief” one another on each stage of the patient’s care and to better judge when they are needed in the emergency department. They can also post photographs of the patient’s medical imaging to better inform those further down the care pathway.

A three-month trial of the app at MUSC, a Level I trauma center, enhanced teamwork, streamlined workflows and reduced patients’ stays in the emergency department. That data has not yet been published. Providers also found the app useful, particularly the operating room and specialty surgery teams that would otherwise have little ability to track the patient through the care pathway.

For Catchpole, the success of the app shows that technology designed with a user-centered approach can enhance teamwork in health care. “Teamwork is not just about training people about how to interact with one another,” said Catchpole. “It’s about how we can use technologies to improve how they communicate remotely.”

HALLOWEEN FUN



Several members of the Administrative Staff dressed up in their favorite 70’s clothes for Halloween this year. Groovy, baby!



WOMEN IN ANESTHESIOLOGY BY CATHERINE TOBIN, MD

Our department has 62 attending anesthesiologists: 24 female, 38%; 38 male, 62%. This female:male ratio correlates with the national average for female anesthesiologists. We have 60 residents: 14 female, 23%; 46 male, 73%. Thus, the female:male ratio for our residents is less than the national average.

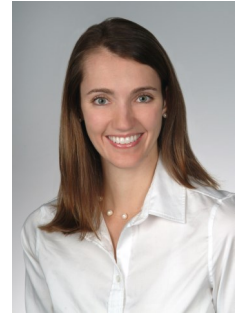
In the American Society of Anesthesiologists (ASA), women are starting to really lead the group! The current President is Dr. Linda J Mason, the President-Elect is Dr. Mary Dale Peterson, and the First Vice President is Dr. Beverly K Philip. In 2014, the ASA's first female president was Dr. Jane C.K. Fitch. At the recent 2018 ASA meeting, I met these women in a small ad-hoc committee, Women in Anesthesiology. After meeting with them, I returned to MUSC impressed, inspired, and refreshed.

Nationally, there is a Women in Anesthesiology Organization meeting held each year in October. The meeting is open to both men and women. I have attended the meeting for the last two years and learned about women in medicine, gender bias, pay gaps, mentoring, diversity and inclusion, #MeToo stories, and Imposter Syndrome.

I will say that women need the support of men for things to change and improve. For example, our department's own Dr. David Gutman recently spoke on "Opportunity Justice" for the Women's Scholar Initiative, an organization that helps promote and advocate on behalf of women within MUSC. I commend him for his talk on a somewhat difficult discussion!

At MUSC, I formed a Women in Anesthesiology group supported by Dr. Scott Reeves and the department to encourage more women faculty and residents to join our team. Our goal is to support one another, promote female resident and faculty job retention and satisfaction, and career advancement. Through casual off-campus events, we informally discuss work-life balance, pregnancy, and other issues to support one another.

Our event on October 19 was a painting class at Wine and Design in Mt. Pleasant. We all painted an abstract woman with rainbow hair (see photos below). It was fun to be together and see everyone's artistic talent.



Residents: Drs.
Andreea Lazar,
Sherry Zhou, and
Eugenia Pugach



WOMEN IN ANESTHESIOLOGY CONTINUED...
BY CATHERINE TOBIN, MD



OB SAFETY BUNDLES PART II BY LATHA HEBBAR, MD

National Partnership for Maternal Safety: Bundles of Maternal Care: Venous Thromboembolism Bundle (VTE) 2017



This is the 2nd of the 3 part series on Maternal Safety Bundles. Safety bundles, organized into four R domains: Readiness, Recognition and Prevention, Response, and Reporting and Systems Learning, outline critical clinical practices that should be implemented in every maternity unit. The importance of VTE prophylaxis in the parturient is reflected in two 2018 publications from National society's. The 4th Edition of ASRA Guidelines on Regional Anesthesia in the Patient Receiving Antithrombotic or Thrombolytic Therapy emphasizes the altered physiology and pharmacokinetics in the parturient necessitating higher dosing requirements of these drugs and the consensus statement from SOAP addresses the anesthetic implications of the higher doses of antithrombotics in parturients. The Bundle supports *routine thromboembolism risk assessment* for obstetric patients, with appropriate *use of pharmacologic and mechanical thromboprophylaxis*.

Background: Obstetric VTE, one of the most common causes of maternal morbidity and mortality, can be prevented, and thromboprophylaxis is the most readily implementable means of systematically reducing the maternal death rate.

Obstetric VTE prevention strategies in the United States have focused on 1) providing pharmacologic prophylaxis for women with risk factors such as prior thromboembolism events, thrombophilias, and family history of thromboembolism and 2) perioperative mechanical prophylaxis for cesarean birth. Despite increasing use of mechanical prophylaxis during cesarean birth data from the Nationwide Inpatient Sample have demonstrated that obstetric VTE increased 72% during hospitalizations for childbirth between 1998 and 2009 and remained relatively constant proportionately as a cause of maternal mortality. The prevalence of risk factors for VTE is also rising with obesity, advanced maternal age, and major medical comorbidities becoming increasingly common.

READINESS:

- Use a standardized thromboembolism risk assessment tool for VTE during: Outpatient prenatal care; Antepartum hospitalization; Hospitalization after cesarean or vaginal deliveries; Postpartum period (up to 6 weeks after delivery)
- Apply standardized tool to all patients to assess VTE risk at time points designated under “Readiness”
- Apply standardized tool to identify appropriate patients for VTE prophylaxis

Risk assessment is key to reducing the incidence of VTE. **It should be standardized and occur at four time points in pregnancy: 1) during the first prenatal visit, 2) during all antepartum admissions, 3) immediately postpartum during a hospitalization for childbirth, and 4) on discharge home after a birth.**

Assessment of hospitalized patients for VTE risk both after admission and after surgery is a JCAHO requirement but excludes pregnant patients. The NPMS working group recommends that this measure be extended to pregnant and postpartum patients. ACOG recommends 2 modified risk assessment systems: Caprini and Padua. In surgical patients with the Caprini system, risk of venous thromboembolism after surgery was 0.0% for a score of 0–1, 0.7% for a score of 2, 1.0% for a score of 3–4, and 1.9% for a score of 5 or higher.

OB SAFETY BUNDLES PART II CONTINUED...
BY LATHA HEBBAR, MD

Appendix 1. Modified Caprini Risk Assessment Model for Pregnancy*

Risk factors	Points
Age 41-60	1
Minor surgery (less than 45 minutes)	1
Visible varicose veins	1
Swollen legs (current)	1
Overweight or obese (body mass index above 25kg/m ²)	1
Currently on bed rest	1
Serious lung disease including pneumonia (<1 month)	1
Pregnancy or postpartum (<1 month)	1
History of unexplained stillborn infant, recurrent spontaneous abortion (≥ 3), premature birth with toxemia or growth-restricted infant	1
Other risk factors (smoking, diabetes, BMI >40kg/m ² , blood transfusions)	1
Central venous access	2
Major surgery (>45 minutes)	2
Patient confined to bed (>72 hours)	2
Family history of thrombosis	3
History of DVT/PE	3
Prothrombin 20210A or factor V Leiden	3
Lupus anticoagulant or elevated anticardiolipin antibodies	3
Elevated serum homocysteine	3
Other congenital or acquired thrombophilia	3

* Original Caprini scoring system condensed to include conditions commonly encountered in obstetric patients. Source: Steven L. Clark

RECOGNITION and PREVENTION:

- Provide patient education
- Provide all healthcare providers education regarding risk assessment tools and recommended thromboprophylaxis

The emphasis is on the recognition of maternal risk and routine screening of obstetric patients for VTE risk factors and who therefore might benefit from pharmacologic or mechanical thromboprophylaxis or both. There is controversy among ACOG, RCOG and ACCP regarding prophylaxis of high risk parturients: Mechanical vs Pharmacological and if pharmacological, the optimum dose.

Long-term compliance with pneumatic compression device is limited and may contribute to mechanical thromboprophylaxis being less effective – hence the emphasis to use LMW heparin or unfractionated heparin. So more patients will be receiving pharmacological prophylaxis.

RESPONSE:

- Use standardized recommendations for mechanical thromboprophylaxis
- Use standardized recommendations for dosing of prophylactic and therapeutic pharmacologic anticoagulation
- Use standardized recommendations for appropriate timing of pharmacologic prophylaxis with neuraxial anesthesia

OB SAFETY BUNDLES PART II CONTINUED...
BY LATHA HEBBAR, MD

Table 1. National Partnership for Maternal Safety Recommendations for Antepartum Outpatient Prophylaxis

Clinical History	Anticoagulation
Multiple prior venous thromboembolism episodes	Treatment-dose LMW heparin or UFH
Prior venous thromboembolism with high-risk thrombophilia	
Prior venous thromboembolism with acquired thrombophilia	
Idiopathic prior venous thromboembolism	Prophylactic-dose LMW heparin or UFH
Prior venous thromboembolism with pregnancy or oral contraceptive	
Prior venous thromboembolism with low-risk thrombophilia	
Family history of venous thromboembolism with high-risk thrombophilia	
High-risk thrombophilia (including acquired)	
Low-risk thrombophilia	No treatment
Prior venous thromboembolism provoked	
Low-risk thrombophilia and family history of venous thromboembolism	

A) Outpatient Antepartum Thromboprophylaxis
 Table 1

High-risk thrombophilias include:

- 1) factor V Leiden homozygosity
- 2) prothrombin gene mutation homozygosity
- 3) factor V Leiden, prothrombin gene mutation compound heterozygosity
- 4) antithrombin III deficiency

Low-risk thrombophilias include:

- 1) factor V Leiden or prothrombin gene mutation heterozygosity
- 2) protein C or S deficiency; the primary acquired thrombophilia is antiphospholipid antibody syndrome

B) Inpatient Antepartum thromboprophylaxis **The selective use of unfractionated heparin rather than LMW heparin may facilitate intrapartum neuraxial anesthesia**

- i. Daily LMW heparin or twice-daily unfractionated heparin for all antepartum patients hospitalized for at least 72 hours who are not at high risk for bleeding or imminent childbirth.
- ii. For women at high risk for childbirth or bleeding, mechanical thromboprophylaxis or a prophylactic dose of unfractionated heparin (5,000 units every 12 hours) should be used.

C) Vaginal Birth

- i. Low risk: Intrapartum use of pneumatic compression while in bed and postpartum administration of LMW heparin or unfractionated heparin.
- ii. High risk: pharmacologic prophylaxis with LMW heparin or unfractionated.
- iii. Heparin may be considered.

D) Cesarean Delivery

- i. All women undergoing cesarean birth who are not receiving pharmacologic prophylaxis receive perioperative mechanical thromboprophylaxis with pneumatic compression devices, which should be continued until the patient is fully ambulatory
- ii. Hospitals may choose a strategy in which all women undergoing cesarean birth receive postoperative thromboprophylaxis with unfractionated or low-molecular-weight heparin unless there is a specific contraindication when postcesarean patients otherwise meet criteria for postanesthesia care unit discharge.

Extended pharmacologic thromboprophylaxis for high risk patients for up to 6 weeks is recommended.

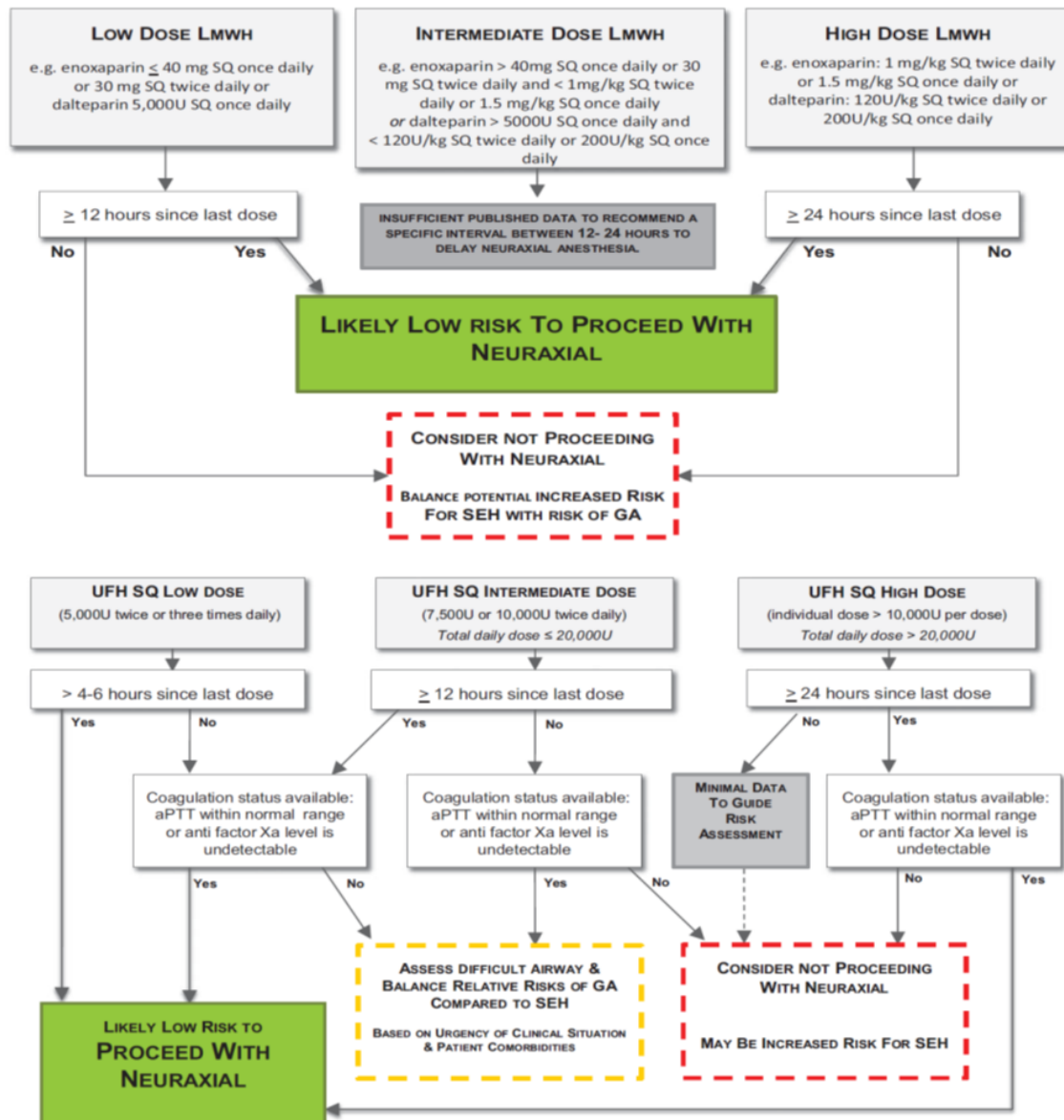
**OB SAFETY BUNDLES PART II CONTINUED...
BY LATHA HEBBAR, MD**

REPORTING:

- Review all VTE events for systems issues and compliance with protocols
- Monitor process metrics and outcomes in a standardized fashion
- Assess for complications of pharmacologic thromboprophylaxis

MUSC has most of the VTE bundle in place. The Anesthesia and OB team are working together to have the standardized MUSC bundle in place by the end of this fiscal year.

Anesthetic Implication of the VTE Bundle: a) *increase in number of patients* receiving thromboprophylaxis and b) *patients receiving higher doses* due to changes of pregnancy altering the pharmacokinetics of thromboprophylactic medication. SOAP/ASRA published a consensus statement for neuraxial placement in this patient population in 2018. (Decision aids - see below.)



OB SAFETY BUNDLES PART II CONTINUED...

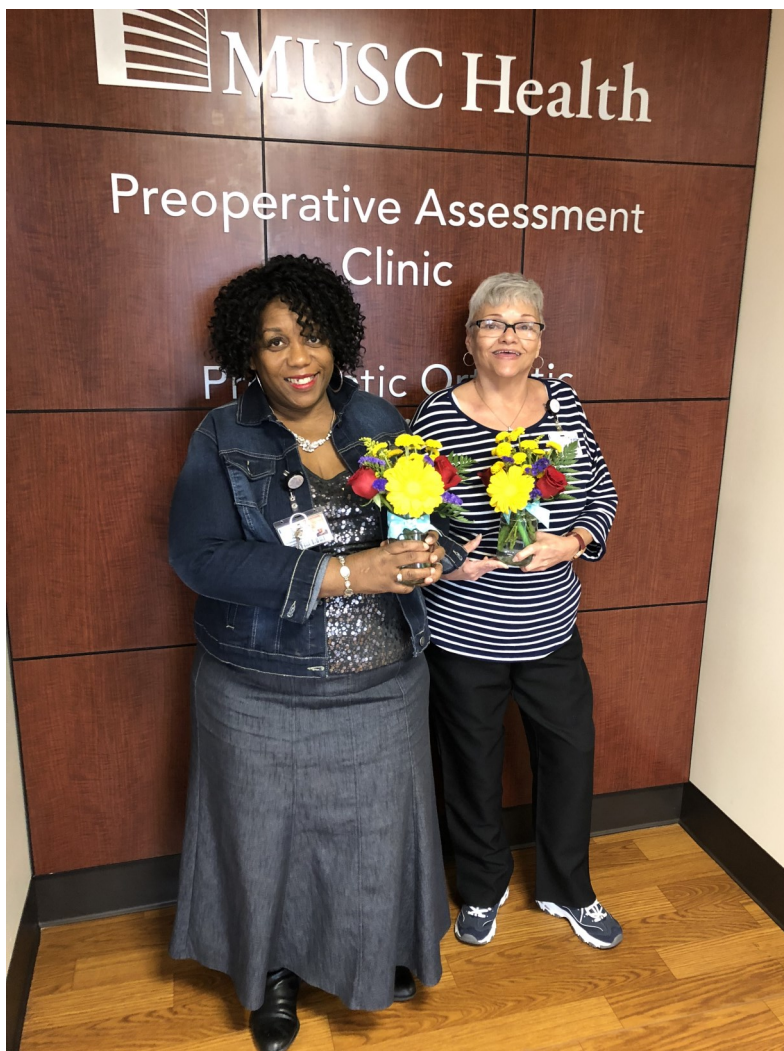
BY LATHA HEBBAR, MD

References:

National Partnership for Maternal Safety: Consensus Bundle on Venous Thromboembolism. Mary E. D'Alton, MD, Alexander M. Friedman, MD, Richard M. Smiley, MD, PhD, Douglas M. Montgomery, MD, Michael J. Paidas, MD, Robyn D'Oria, MA, RNC, APN, Jennifer L. Frost, MD, MPH, Afshan B. Hameed, MD, Deborah Karsnitz, CNM, DNP, Barbara S. Levy, MD, and Steven L. Clark, MD. (*Anesth Analg* 2016;123:942-9)

The Society for Obstetric Anesthesia and Perinatology Consensus Statement on the Anesthetic Management of Pregnant and Postpartum Women Receiving Thromboprophylaxis or Higher Dose Anticoagulants. Lisa Leffert, MD,* Alexander Butwick, MBBS, FRCA, MS,†Brendan Carvalho, MBBS, FRCA, MDCh,† Katherine Arendt, MD,‡Shannon M. Bates, MDCM, MSc,§ Alex Friedman, MD,□ Terese Horlocker, MD,‡ Timothy Houle, PhD,* and Ruth Landau, MD,¶ the members of the SOAP VTE Taskforce. [Anesth Analg](#). 2018 Mar;126(3):928-944

CONGRATULATIONS TO PREOPERATIVE ASSESSMENT CLINIC STAFF



Pam Harris and Judy McCombs, Patient Access Representatives (Registration) for Preoperative Assessment Clinic, received the Top Patient Satisfaction Scores for all of Rutledge Tower in October! Congratulations, ladies!

Congratulations!

MUSC OPENING \$16 MILLION SITE IN CITADEL MALL BY MARY KATHERINE WILDEMAN FOR THE POST & COURIER

Soon, patients of the Medical University of South Carolina will be able to get their health care at a former J.C. Penney department store.

MUSC is opening a roughly 128,000 square-foot facility at the retailer's old Citadel Mall location that will offer a range of health services, from ambulatory surgery to musculoskeletal care and ophthalmology. Announced last year, the new suburban medical outpost will open in late 2019.

If a shopping mall and a hospital seem like a mismatched pairing, proponents say they share many of the same basic requirements, such as ample parking, a central location in a growing area and easy accessibility.

Other hospital systems have had success with the same approach, said Dr. Patrick Cawley, CEO of MUSC Health. He cited Vanderbilt Health's move into a Nashville mall as one example. "We feel pretty good that the concept is a solid one," Cawley said.

Cawley, Mayor John Tecklenburg and representative of the property owner spoke Tuesday in front of a white banner that, when dropped, revealed a banner for the "MUSC Health West Campus" and a map pinpointing its location.

The announcement comes as little surprise as MUSC aims to expand off the peninsula. The hospital system's planned sites include a children's hospital downtown, a children's ambulatory campus in North Charleston, a community hospital in Summerville and a distribution center in North Charleston.

MUSC's board of trustees signed off on the idea of beginning to move some of the system's services off the traffic-clogged peninsula several years ago, Cawley said. They approved the roughly \$2 million a year lease for the vacant Penney space last October.

Like the former department store, the MUSC Health West campus will be two stories tall. Blueprints on display showed planned patient and provider rooms, operating rooms, a pharmacy and a check-in on the second floor.

\$16.4 million is MUSC's share of the project, the total cost of which was about \$32.9 million. The developer kicked in the rest. Richard C. Davis, who leads a group that owns most of the mall site, called MUSC the "five-star recruit in this area." He said he hopes the partnership helps to breathe new life into the property, which has endured a rash of vacancies from conventional retail tenants.

Tecklenburg said redeveloping the mall site is an important piece in the city's goal to revitalize West Ashley. The new MUSC center could offer new employment opportunities for nearby residents and reduce traffic, he said. "It's just going to lead to a real fruition of this vision for West Ashley and its revitalization that we've all been talking about for years," Tecklenburg said.



A rendering shows the lobby of MUSC's future West Ashley Campus in the former JC Penney store.



Mayor John Tecklenburg (center) greets Dr. Patrick Cawley of MUSC Health at the unveiling of the new MUSC campus that will occupy the former JC Penney store.

TOYS FOR TOTS HOLIDAY DRIVE

It's that time of the year again! The department will collect unwrapped toys for the Marine Corps Toys for Tots Foundation, as we did last year. We have a large box for unwrapped toys set up in the copier area of SEI 301. If you would prefer to donate cash, we will be happy to do the shopping for you! Simply give your donation to Jackie Fisher (SEI 315) or Sarah Hameedi (SEI 302) or to the Administrative Assistant in your area and we'll take care of the rest. The last day to donate toys is **Friday, December 14, 2018**. Thank you in advance for your kindness and generosity!



HOLIDAY DOOR DECORATING CONTEST

Dr. Reeves would like to invite the department to participate in the annual Holiday Door Decorating Contest! While in the holiday spirit, you can decorate your office door or a shared door (ex: resident library door, on-call rooms, etc.) in any fashion you'd like. The doors will be judged on **Thursday, December 20, 2018**. There will be a prize for the winning door! We hope to get a lot of participation this year! Please [email Jackie Fisher](#) if you plan to participate in the contest so that we have a list of doors for judging. Here are the 1st and 2nd place winners from 2017!



Research Office, 1st Place Winner



Heather Highland & Rhi Davis, 2nd Place

TRIDENT UNITED WAY DAY OF CARING: LET'S CARE ABOUT SOCKS & UNDERWEAR!

Thank you to all those who participated in our department's Trident United Way Day of Caring event! Vicky Ingalls, the Director of Programs for Charleston Promise Neighborhood, was very appreciative of the undergarments that we gathered and she will distribute them to our community's children in need.

Thanks again, everyone!



NEW BABIES IN THE DEPARTMENT



Congratulations to Ali Lataille and family as they welcome new baby Emma Kate. She was born on October 10, 2018 weighing in at 6 lbs 12 oz and 20.5 inches long!



Congratulations to Adrienne West and Tom Todoran as they welcome new baby Luca James. He was born on October 20, 2018 weighing in at 9 lbs, 10 oz!



Congratulations to Gabe Hillegass and family as they welcome new baby Jack Edward! He was born on October 31, 2018 weighing in at 8 lbs, 6 oz and 20.5 inches long.



GRAND ROUNDS FOR THE MONTH OF DECEMBER



**“Investigating the Cellular and Molecular Correlates of Addiction”
December 4, 2018
Michael Scofield, PhD, Assistant Professor
Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina**

**“Mission Trips”
December 11, 2018
Eric Nelson, DO, Associate Professor
Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina**



**“Morbidity & Mortality Conference”
December 18, 2018
Renuka George, MD, Assistant Professor
George Guldán, MD, Associate Professor
Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina**

**December 25, 2018
No Lecture—Happy Holidays!**





DEPARTMENT OF ANESTHESIA AND PERIOPERATIVE MEDICINE

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CHECK OUT OUR WEBSITE AT:
[HTTP://WWW.MUSC.EDU/ANESTHESIA](http://www.musc.edu/anesthesia)

Future Events/Lectures

Intern Lecture Series

December 13th—GI Morbidity (Liver, Pancreas), Dr. Stoll, SEI 314

CA 1 Lecture Series

December 5th—Acid-Base Balance; Renal Physiology & Anesthesia, Dr. Field, CSB 429

December 12th—Anesthesia for the Trauma Patient, Dr. Ellis, CSB 429

CA 2/3 Lecture Series

December 3rd—Post Anesthesia Recovery, Dr. Romeo, Moodle

December 10th—Finances of Medicine, Dr. Gutman, CSB 429

December 17th—Management of Patients with Psychiatric/Substance Abuse, Dr. Skorke, Moodle

December 24th—Happy Holidays—No Lecture

December 31st—Happy Holidays—No Lecture

Grand Rounds

December 4th—Addiction, Dr. Scofield

December 11th—Mission Trips, Dr. Nelson

December 18th—Morbidity & Mortality Conference, Drs. George & Guldán

December 25th—Happy Holidays—No Lecture



I HUNG THE MOON

Please 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 Tammie Matusik. Thank you!

"Chris Amoroso went above and beyond in helping to provide care for a patient with mental challenges. Chris provided stickers for the patient and was a huge help in getting the patient ready for surgery with his ever-present calm and professional manner. He was able to develop a trusting environment for this patient, which made his mother happy and over-joyed knowing that her son was in good hands! Awesome job!" (Dianne Liebrader, ART Holding, November, 2018)



Holiday Party 2018
 Saturday, December 1, 2018
 Carolina Yacht Club



MUSC Leading Health Innovation for the Lives We Touch

[Imagine 2020 Strategic Plan](#)

We Would Love to Hear From You!

If you have ideas or would like to contribute to *Sleepy Times*, the deadline for the January edition will be December 14, 2018.