Welcome to our first annual Snooze Newz ASA Supplement! Thanks are in order to the Poster Masters (Resident Physicians) Drs. Crowe, Kuebler, Luu, and Sweet! Thank you for your hard work in getting this year’s posters ready for presentation. Thanks as well to Dr. Gibson for soliciting and collecting summaries of the sessions attended by our residents and medical students at the meeting. It’s a busy 4.5 days and we can’t all be there for the entire duration or attend every worthwhile presentation, so we hope that putting together this supplemental issue of our departmental newsletter will allow us all to share what we learned now that we’re back home. For information on the presenters from each summarized session and their affiliations, please refer to the ASA website.

Congratulations to our Education Section! Our Anesthesiology Interest Group (AIG) has been honored as the finest in the country! The future of the specialty depends on the kinds of efforts this group makes to familiarize medical students with anesthesiology and to recruit students to continue their education with us. Thanks for everyone’s hard work to help us represent OU and the department at the highest level on a national stage!

This year we continued our tradition of bringing the innovative work we do here at OU to national attention by exhibiting 31 posters, giving two talks and serving as moderators for 10 different sessions. The ASA meeting is essential to furthering the specialty and continuing to challenge ourselves and our colleagues to raise the level of medicine practiced here in Oklahoma and around the country.

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OU Anesthesiology Wins AIG Award!

The OU Department of Anesthesiology was recognized with the

Outstanding Anesthesiology Interest Group Award

at the 2017 American Society of Anesthesiologists Annual Meeting
Ultrasound in Perioperative Medicine

DAVID FISH / CA-2 Resident

A team of lecturers gave an overview of a wide range of ultrasound uses in perioperative medicine. Topics included the use of rapid ultrasound assessment during CPR, assessment of pulmonary edema, confirmation of ventilation, and assessment of the lungs in postoperative acute respiratory failure. One speaker discussed current integration of ultrasound use as early as the first year of medical school at West Virginia University. Their students are now using ultrasound regularly as part of their anatomy course and are then able to translate these skills into their clinical exam and procedural skills. With the increasing availability of ultrasonography, this lecture highlighted the importance of being able to use the exam tools we already have in new ways to provide our patients with the best care.

Quality Anesthesia: Medicine Measures—Patients Decide

TRUNG PHAM / PGY-I Resident

I had the opportunity to attend the Emery A. Rovenstine Memorial Lecture: Quality Anesthesia: Medicine Measures—Patients Decide, presented by Dr. Lee A. Fleisher. He talked about the importance of patient-centered care and discussed how the rise of consumerism in medicine has influenced the way medicine is practiced. The quality of healthcare delivered in today’s society is often measured by patient satisfaction. There are six major domains of quality care: effective, timely, efficient, equitable, safe, and patient-centered. Dr. Fleisher brought up important topics about anesthesiologists’ roles as perioperative physicians and how we can positively impact patient experiences prior to surgery, in operating rooms, and even throughout the recovery process. Measuring the quality of our work, being accountable for providing good care, taking ownership of what we do as providers, and listening to patients’ feedback were four major themes in his presentation. After listening to this talk, I gained more insight into our roles as anesthesiologists and a deeper understanding of what it means to be a perioperative physician who is dedicated to improving health outcomes for the people that matter most: our patients.
Just a Fancy Name? The Quadratus Lumborum Block Explained

ASHLEY MOORE / CA-2 Resident

The quadratus lumborum (QL) block is a posterior abdominal wall nerve block which distributes local anesthetic around the QL muscle. This provides postoperative pain relief for patients undergoing certain abdominal surgeries. The greatest pain relief is concentrated in the middle and lower thoracic regions. Dermatomes covered include T6 to T12-L1. Compared to a transversus abdominis plane (TAP) block, the QL block has greater sensory spread for analgesia and also has the potential for visceral analgesia. This is due to close proximity to the paravertebral and epidural spaces. QL blocks also tend to have a longer duration of effect compared to TAP blocks. When compared to an epidural, QL blocks have the advantage of maintenance of bladder and lower limb function as well as avoiding a sympathectomy. Many different approaches to performing the QL block have been described including anterolateral, posterior, and transmuscular approaches. These approaches were demonstrated during the lecture. For midline surgical incisions, bilateral QL blocks should be performed. Catheters may also be left in place for continuous delivery of analgesia when desired.

Safety and Efficacy of Regional Anesthesia in Infants, Children, and Adolescents

JAMES PAUL / Medical Student

On Saturday, October 21, I attended a lecture by Santhanam Suresh MD, FAAP on the “Safety and Efficacy of Regional Anesthesia in Infants, Children, and Adolescents.” Dr. Suresh shared that his team has been accumulating data on regional anesthesia cases since April 2007, and now have >135,000 blocks in the database. Ultrasound use increased dramatically from 2007-2010, and complication rates have dropped inversely proportional to the rise in ultrasound use. The greatest improvement has been seen in supraclavicular blocks. With ultrasound use, there is a decrease in both failure rate and the need for additional analgesia at 1 hour post-block. Dr. Suresh recommends caudal, brachial plexus, femoral, sciatic, TAP, spinal, and epidural blocks as safe regional anesthesia techniques in the pediatric population. Interestingly, their data has also shown that with 20,000 caudal blocks there has not been a single occurrence of paraplegia, indicating that overall, it is an extremely safe procedure. He also mentioned that when treating a fractured limb, there has been concern for the ability to accurately assess nerve damage while under regional anesthesia, for which they have begun putting a catheter in place and only give the medications after the nerves are assessed in the post-operative period.
Anesthesia Drug Shortages: Can Capitalism and a Lack of Price Controls Improve Patient Safety?

BRADLEY GOODSELL / CA-3 Resident

Anesthesia related medications can all of a sudden be in short supply for a variety of reasons. Most recently, hurricane Maria is to blame. Why? 10% of medications are made in Puerto Rico which was devastated by the hurricane. 50 production plants were left without power and workers. Situations such as this result in price fluctuations which lead to an increase in the use of other less effective agents or the same medication but in different packaging with a potentially different concentration from what the physician is used to. This can lead to medication errors. Currently in short supply are Rocuronium, Fentanyl, Vecuronium, Dilaudid (the plant was ordered to shut down for 4 months in order to make updates to the factory), Morphine, Lidocaine and Bupivacaine. Also, most shortages are of the generic forms of drugs, as they are less profitable for the companies.

Free Markets

Pricing of drugs is largely based on research and development (R&D). In 2011 pharmaceutical R&D was a $26 billion dollar industry. Only 3 of 10 drugs that make it to market will recover their cost of R&D and make a profit. One study showed that price control would have a negative effect on new drug development by de-incentivizing R&D due to the excessive regulatory burdens and difficulty recovering costs if the drug makes it to market. For example, the price of Neostigmine increased from $5 to $90/vial after Suggamadex arrived on the market. The increased price was to recoup the R&D that went into the development of the drug. Even the possibility of regulation can have an impact on innovation and pricing. President Trump said recently that “drug prices are out of control.” Shortly thereafter the pharmaceutical stock prices dropped.

Keynote Address-- Atul Gawande

JOHN CROWE / CA-3 Co-Chief Resident

There are ideas that spread quickly, and those that don’t. Many good ideas are held up because the effect is delayed, such as hand washing. It’s important to look at what effect is good for the patient, versus what is convenient for the doctor. There are a lot of different ways to improve patient safety. First, you can tell people "You should do X." Better yet, you can tell people "You must do X", and have a system of punishments or rewards. The best, however, is to systematize X using checklists, defaults, and data feedback loops to improve performance (i.e., using the Diameter Index Safety System to make sure nobody can hook up the wrong gas line). The way we approach care should be in the best interest of the patient.
Chronic Pain Management in Hospitalized Patients

TYLER PHILLIPS / Medical Student

This presentation was conducted by a panel consisting of Dr. Robert Bolash (Cleveland Clinic), Dr. Richard Rosenquist (Cleveland Clinic), and Dr. Reda Tolba (Oschner). Anesthesiologists are often consulted on chronic pain management in hospitalized patients. The presentation showed how effective an inpatient chronic pain management team can be. Each physician discussed a challenging case that their team faced. For example, Dr. Rosenquist discussed his team’s approach to a sickle cell patient who was pregnant and an active heroin user. He discussed their multimodal analgesic approach which sought to maintain the patient’s baseline opioid level (prevent withdrawal), while still providing adequate pain relief using long acting, slow onset medication. At the end of the presentation, Dr. Bolash discussed very briefly how his institution incorporates a chronic pain management inpatient service. He talked about the DuPont shift scheduling model which involves a four-member team working 12 hour shifts. The team is composed of 4 physicians, a mid-level, and house officer.

Current Concepts and Controversies in Acute Pain Management

MICHAEL TAYLOR / CA-2 Resident

This presentation was a refresher course lecture with focus on acute pain management and how the perioperative surgical home can provide additional and alternative options for pain management. The presenter initially discussed the growing opioid epidemic and shared data showing that the use of opioids in the perioperative and postoperative period increased long term opioid use while doing little for chronic pain management following surgery. The presenter then went on to discuss multimodal pain management as a part of the perioperative surgical home to decrease opioid usage and requirements. He presented data supporting the use of multimodal strategies to improve both acute and chronic pain management postoperatively. An example that he presented included recent studies in the use of perioperative intravenous local anesthetic infusions for pain management. The data suggested that in addition to improving pain control in the immediate postoperative period, it also improved long term pain management 6 month out from surgery. I found this to be a very interesting discussion considering the growing national attention on the opioid epidemic in our country along with the growing interest in the preoperative surgical home.
This lecture was a Point-Counterpoint discussion about whether “failure to rescue” is a real phenomenon in hospitals. “Failure to rescue” is based on the premise that healthcare systems should be able to prevent most complications and identify and treat the ones that do occur in a timely manner to prevent death. Complications that develop and lead to significant morbidity/mortality are seen as “failure to rescue.” Higher rates of failure were correlated with higher hospital volume, communication failures, and lower nurse staffing. The counterpoint of this argument stated that “failure to rescue” should be considered “could not be rescued.” This idea focuses on the fact that not all patients are able to be “rescued,” and that focusing on multi-step treatment guidelines and protocols is not practical for all cases. The speaker argued that as we let protocols and guidelines make clinical decisions for us, providers are not utilizing their medical knowledge and patients are worse off.

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**Failure to Rescue in 2017**

**JACLYN IRWIN / CA-2 Resident**

This lecture was a Point-Counterpoint discussion about whether “failure to rescue” is a real phenomenon in hospitals. “Failure to rescue” is based on the premise that healthcare systems should be able to prevent most complications and identify and treat the ones that do occur in a timely manner to prevent death. Complications that develop and lead to significant morbidity/mortality are seen as “failure to rescue.” Higher rates of failure were correlated with higher hospital volume, communication failures, and lower nurse staffing. The counterpoint of this argument stated that “failure to rescue” should be considered “could not be rescued.” This idea focuses on the fact that not all patients are able to be “rescued,” and that focusing on multi-step treatment guidelines and protocols is not practical for all cases. The speaker argued that as we let protocols and guidelines make clinical decisions for us, providers are not utilizing their medical knowledge and patients are worse off.

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**CSE vs Epidural: What do we really know in 2017? Point-Counterpoint**

**JAMES SWEET / CA-2 Resident**

The Case for Combined Spinal Epidural (CSE) and Dural Puncture Epidural (DPE): studies consistently show decreased time to pain relief for CSE vs Epidural. They range from 5 min to 10 min. For both CSE and DPE, there is no evidence of increased risk of infection or dural puncture headache when the needle is 25 gauge or smaller. Concerning the increased risk of pruritis and nausea/vomiting, most studies use relatively high doses of opioids and a ceiling effect exists with 15 mcg of fentanyl with minimal side effects. Lastly, there is a small, yet statistically significant decreased fail rate with epidurals in which the dura is punctured, and no difference has been found in time to replacement when the epidural does fail. Summary: faster, more reliable, and no increased risk.

The Counterpoint: CSE and DPE are indeed faster by about 5 min. However, there is no difference in maternal satisfaction. And while the data does not show an increased risk of dural puncture headache, there may be risks associated with manipulation of the dura and cerebrospinal fluid that we are unaware of. The fetus must also be considered. While there is no evidence of increased morbidity/mortality to the unborn child, there is an increased risk of non-reassuring fetal heart rate after CSE which can cause significant distress to the parents. Summary: equal satisfaction, no CSF manipulation, and less anxiety for the patient.

My conclusion: CSEs and DPEs are safe and can be an excellent option for specific patients in significant pain. Due to the increased rate of non-reassuring fetal heart rate and resultant anxiety, I would not offer a dural puncture routinely for all patients.
Pain Medicine: Is There a Future to the Specialty?

JEFF FOSTER / CA-3 Chief Resident

This talk was given by three different practitioners of interventional pain management. It began by discussing growing concern surrounding the opioid crisis as well as the physical danger this has brought to individual providers (violence, death threats, etc). The rising costs of healthcare affect the field negatively, while reimbursements are declining simultaneously. The speakers discussed the need for improving pain training and reimbursement in multi-disciplinary pain therapies, not simply improving them for intervention. Board certification has evolved into MOCA training which will be better overall. The speakers discussed a recent article from JAMA that used a flawed trial to refute support for radio-frequency ablation for low back pain. Pain medicine practitioners need to embrace responsible evidence-based medicine and be innovators for the field. Digitalization of medicine offers some unique and exciting opportunities for pain practitioners to involve themselves in providing more effective pain evaluation and management.

ASA Point-Counterpoint: Should Elective Cases be Permitted to be Performed in the Evening?

IAN GRAY / CA-2 Resident

This Point-Counterpoint session featured doctors Heller and Weiner who examined the available evidence and expert opinion surrounding the safety of performing elective surgery after hours. Dr. Heller argued that such cases should be prohibited. He cited a series of articles which suggested that there is an elevated risk of morbidity in cases that start later in the day. Some patient populations may be more vulnerable than others to this risk of morbidity. For providers, operating at night leads to decreased sleep and increased fatigue. Fatigued providers have been shown to be slower to complete tasks and more likely to make errors. Systemically, there are fewer resources available in the evening, which helps make the case against attempting elective cases at that time. Finally, late starts inevitably result in increased provider handoffs which increase the risk of communication failures. Dr. Weiner argued that elective cases should be permitted to continue at night. He cited studies that showed no difference in mortality amongst patients having surgery during the day or at night receiving hip surgery at one center. He further pointed to a study that showed no difference among patients receiving elective cardiac surgeries at one center. The suggestion was made that the specialized cardiac teams available on call may protect these patients from the risks of a general call team performing surgeries at night that they do not typically perform during the day. Ultimately, neither Dr. Heller nor Dr. Weiner were unable to convince the other to abandon their argument. More studies are indicated.
For a lot of budding residents, the “real world” remains a fleeting notion viewed from on-call television screens, or a conversation topic to which we contribute little amongst our childhood friends (who had grown-up jobs before the age of 3D). ERAS standardized our CV structure and the modality in which we sell ourselves virtually to prospective employers/residency programs. I bear no shame in admitting I need some guidance on growing up and into a world outside of resident learning. So, I attended a lecture hosted by Mednax, advertising information specifically for this situation. On creating a proper CV, they brought up points one may consider common sense, but would never specifically pay attention to. First off, place your full legal name and contact information with a professional email (and really, sk8ter2@aol.com probably isn’t suitable beyond middle school). List your education, the states that you are licensed in, professional experiences, societies, awards, and bibliography (most recent events first). Do not list personal interests (that always has the potential to be an HR nightmare). Go ahead and account for gaps in employment/training. Don’t present everyone with your life novel; keep your CV at 2 pages. Write a cover letter summarizing your experience and why you want the position. On preparing for an interview, take a day or two to explore the location and really ask yourself if you could see yourself living there. On your initial interactions during the interview, try not to make salary your first question (you’re a physician, you most likely won’t starve). When discussing financial topics, one can be more tasteful and ask things like what the salary structure is, what benefits are available as far as relocation allowance, retirement planning, various insurance plans, etc. The moment that glorious job contract appears, consult a lawyer who has experience with medical practices, and don’t be afraid to ask for more time to make a decision. It’s your life; you can finally go and live somewhere without the instruction of a computer-generated match algorithm!
Evidence-based Guidelines in Acute Pediatric Pain Management

JOEY CARDA / CA-2 Resident

This lecture was densely packed with information and recommendations for pediatric pain management. Below are some quick facts from the presentation. Caudal blocks are the most common regional procedure in pediatrics; supraclavicular blocks are the second most common. Studies have shown that the use of ultrasound both increases the success rate and decreases the amount of medication used. Blocks done without neuromuscular blockade have been shown to have the fewest complications. Pediatric regional anesthesia performed under general anesthesia or deep sedation should be viewed as the standard of care. Most providers use saline for loss of resistance when performing pediatric epidurals, and the use of air increases with patient age. However, complications are largely due to operator error, so providers should use the method they are most comfortable with as the literature comparing air vs. saline is sparse. There were no specific recommendations regarding the type of opioid that should be used in Peds PCA management. Basal rates should be used on an individual case-by-case basis. PCA by proxy is acceptable as long and training and monitoring are appropriate. In patients with addiction issues, non-opioids should be maximized but opioids should not be withheld. Titration of opioid to pain score has been shown to cause excessive sedation, so global discomfort and functional outcome indicators should be utilized when assessing a child’s pain.

Periprocedural Fasting Guidelines in Infants and Children

CASEY BUTLER / PGY-1 Resident

This lecture discussed the pros and cons of periprocedural fasting and suggested that a closer examination of the guidelines is in order to improve several aspects of the perioperative experience. The main reason purpose of the guidelines as they are now is to prevent/minimize aspiration risk. However, research has shown that children and infants are fasting much longer than the guidelines recommend which has led to issues with patient satisfaction, patient energy, hemodynamic performance intraoperatively, and vascular access. In addition, the available data does not unequivocally support the current “2, 4, 6, 8” rule for preoperative fasting. There is data suggesting that the volume of gastric contents preoperatively does not necessarily correlate with a patient’s risk of aspiration. For the above reasons, there seems to be enough evidence to indicate that we should take a closer look at the current guidelines and work to decrease clear fluid fasting times in order to improve the perioperative and intraoperative experience for our pediatric patients.
Basic Transesophageal Echocardiography (TEE) Workshop: SOS Rescue Ultrasound

JORDAN PHILLIPS / Medical Student

This lecture was a condensed version of a larger presentation about how to approach rescue diagnostic echocardiography. One of the critical takeaways was to always perform your exam the same way. Every physician’s exam doesn’t have to move in the same order, but each person should have their own method that can be repeated. A second lesson is to not look at rescue ultrasound as a snapshot, but to view it as a process. Forming a differential diagnosis and seeing how your patient responds to a proposed treatment is the backbone of the process. One particular diagnosis that is commonly missed in the frenzy of the exam is a left ventricular outflow obstruction. The examiner needs to always be cognizant of the search satisfaction bias and not miss subsequent diagnosis after finding the initial problem. Approaching exams the same way every time can prevent physicians from missing critical patient issues.

Cardiac Anesthesia Outside the Cardiac ORs: Luxury or Necessity?

MATT MOORE / CA-I Resident

This session was a Point-Counter-point discussion of the pros and cons of cardiac anesthesiology in the setting of outpatient operating rooms, not in cardiac suites. The procedures discussed were non-cardiac procedures performed on cardiac patients. The first presenter shared the viewpoint that there was no need for cardiac trained anesthesiologists to leave the busy cardiac ORs for these patients. His main argument was that the experience of the anesthesia provider factors far less into adverse events than the experience of the surgeon and OR staff. He stated that with adequate planning a general anesthesiologist is more than capable of taking care of cardiac patients in an outpatient setting. The counterpoint was that patients continue to get sicker over time and there is a higher incidence of heart failure in elderly patients. There are also more pacemakers and AICDs to manage. Cardiac anesthesiologists think about patients differently and may be better equipped to treat these patients.
Currently, $560-635 is spent on treating chronic pain each year in the United States. In the late 1980s, pain was felt to be undertreated in the U.S. The shift to better pain control included adding questions on patient satisfaction surveys like the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Institutions would not receive the full potential of reimbursement if the patients’ satisfaction surveys did not reflect adequate pain control. This is when pain control began to be known as the “fifth vital sign.” Fast forward twenty years in 2013 and we are now dealing with 1.9 million people who are dependent on opioids and 16,000 deaths (four times that in 1999). Just one year later, there were 19,000 deaths. In 2015, drug overdose (prescription and illicit) accounted for 52,404 deaths of which 84.2% were unintentional. Prescription opioids were the second leading cause of these deaths second to heroin.

In 2012, the state of Oklahoma recorded 128 opioid prescriptions for every 100 people, one of nine states above 110 for that year. Also in Oklahoma, there was an increase in the supply of these medications. From 2006 to 2016, the rate for prescriptions of > 30 day supply of opioids went from 17.6 to 27.3% with a similar reflection in the decreased rate of < 30 day supply. A patient survey demonstrated that even when patients received a > 30 day supply of opioids, they will still only take about 3-5 days’ worth for acute pain control. However, 71% of the patients kept the leftover medications at their disposal for a different time.

The current goal for preventative measures is a multimodal approach to analgesia to decrease the amount of opioids. If opioids are prescribed, the CDC guidelines state to treat acute pain with immediate release opioids at the lowest effective dose with appropriate quantity. Prescription drug monitoring programs have also been implemented and can be accessed by health care providers and pharmacies. In 2017, the HCAHPS patient satisfaction survey delinked the patient’s pain control to reimbursements. In Arizona, physician report cards are sent quarterly stating their usage of opioid prescriptions. Within two years, opioid prescriptions in Arizona had decreased by 10% and there had been a decrease of 4% in opioid related deaths in the state. The pain control and opioid epidemic pendulum continues to swing and it is important to do what we can to help in the effort toward safer pain control practices.
I went to several presentations, but the one I felt was most beneficial to the group as a whole was the Mednax presentation on job search/applications that I attended with Clairese. The session was structured to detail the job application process from presenting your qualifications to negotiating and accepting a position. Highlights included what to include on your CV and, more importantly, what not to include. Do not include your social security number, photographs, date of birth, personal interests (these can actually potentially hurt you in the initial round), marital status/family, and religious affiliation. Of note, these are off limits for the CV, and for the job interview itself. If something comes up in conversation, walk a fine line in determining what you wish to share outside your professional life. The recruiter could not highlight this specific issue enough.

Sources for jobs were also discussed: Mednax is an in-house recruiter, but other sources, including recruitment firms, internet job boards (i.e. Gasworks), networking/referrals from peers/colleagues, national associations (ASA, etc.), medical meetings, and recruitment firms are all possibilities. In terms of recruitment firms, the presenter was adamant that they should not ask for payment of any kind. They are paid by the organization using them.

Timing is a source of angst for many job searchers. Your personal time frame for job searches will depend on where you want to end up. If you have a specific place in mind, you should start out a year to 18 months in advance, especially if you don’t have any contacts in the area; otherwise, 6 months to a year is usually plenty of time. Also, do not forget to consider the time frame for obtaining your state license, and personal time frames for moving, taking boards, family issues, etc. Specific things to keep in mind when job searching are varied. Professional interests such as type of practice, facility, teaching/research opportunities, your current needs, and where you possibly want to be 5-10 years from now. Research the practice/facility through the internet/word of mouth from colleagues in the area (if any), local Chamber of Commerce, and any published information about the facility/practice. Also, take into consideration your personal interests in the area—geography, family considerations, and what type of lifestyle you are looking for in a work/personal life balance.

When you wish to apply, make certain you submit a brief (1 page) cover letter. In the cover letter, give a brief summary of the following: your experience, reason(s) position is desirable, how you learned about the position, special areas of interest to you/the position, your availability to work, and the best way to contact you. Do not include a repetition of your CV or any personal information unrelated to the position. After the initial submission, expect a phone call and then determine if there is a mutual interest between you and the group/facility. Never burn bridges, and always attempt to build relationships for the future, regardless of whether you accept the position.
What They Didn’t Teach You in Medical School: A Guide to Starting a Successful Career

Cont’d

In terms of the actual interview process, things to remember include: actively showing your interest, taking notes on people, places, asking about on-call schedule, and being very circumspect in terms of asking about compensation. Always send thank you notes, and follow-up as requested. Do not leave the employer waiting on you without telling them honestly that either you are not interested, or waiting on another interview. Again, don’t burn bridges. In the same vein, communicate honestly about your intentions, any reservations, or if you are looking at other opportunities.

After accepting a position, make certain you have time to deal with all the logistics involved with moving and new state/institutional requirements. These include licensure, any practice specific credentialing, plan enrollment, relocation time frame, and contracts and their specifics. With regard to contracts, most of them are full of standard terms. Some of these terms are negotiable, others are not. Feel free to contact the employer or recruitment firm and ask about what specifically is negotiable. Also, feel free to utilize a medical contract lawyer, as much of the terminology is going to be confusing to non-judicial types. If interested, I have the contact info for Mednax recruiter for anyone interested in the areas in which they work.

Pain Medicine and the Opioid Epidemic

RYAN VINCENT / CA-3 Resident

The current epidemic of opioid use has put the field of pain medicine under scrutiny. The number of deaths from overdoses has increased to the point that regulations are now being put in place to limit the amount of narcotics that patients can receive. These guidelines were meant for primary care physicians, but have spread to pain management specialists. While this is good for the overall safety of the general population, there are some people that need high amounts of narcotics to live with their constant pain, especially with reimbursement declining for interventional procedures. Another problem with this is that insurance companies are unwilling to reimburse for a holistic approach including long-term physical therapy, psychiatric evaluation and care, acupuncture or massage therapy. Insurance companies incentivized narcotic use, which in turn increased its prescription and changes are going to have to be made going forward to balance this back out. Treatment of pain requires multimodal therapy including holistic approaches. The VA has already mandated that one alternative therapy be offered to chronic pain patients, and insurance companies are going to have to increase coverage so that patients can be treated appropriately.
Reversing Irreversible – Perioperative Management of Direct Oral Anticoagulants (DOACs)

CHRIS CHEANEY / Medical Student

The session I attended covered the perioperative management of direct oral anticoagulants (DOACs), also known as novel oral anticoagulants. The first panelist gave a brief introduction on the structure and mechanisms of the various novel oral anticoagulants, specifically Factor Xa inhibitors and direct thrombin inhibitors. The names can be distinguished easily as factor Xa inhibitors all contain an Xa in their name (apixaban, rivaroxaban, etc). The second panelist spoke on the issues surrounding anticoagulation monitoring of DOACs. In the ambulatory setting, monitoring is often unnecessary, however good options for monitoring are not available in the inpatient setting. Traditional clotting tests (PT, INR, aPTT) are not reliable with these medications. Ecarin clotting time and calibrated anti-Xa activity are reliable, but are expensive and rarely available. The best method of determining anticoagulation at this time is to determine when the last dose was taken. The PAUSE trial is currently in progress with a completion date in 2018 which measures anticoagulation at various times after taking DOACs to help guide reversal decision making. The third panelist spoke about reversal strategies for patients on DOACs. Currently dabigatran is the only DOAC to have a reversal agent, idarucizumab. This is a direct antibody to dabigatran, which provides acute reversal for up to 24 hours. The factor Xa inhibitors do not have a reversal agent yet, but Andexanet is in Phase III trials. If a patient is bleeding or needs an emergent high risk surgery on Xa inhibitors, the current recommendation is to use prothrombin complex concentrates off-label to attempt to reverse the anticoagulation until Andexanet becomes available as a true reversal agent.

Care Team Model/Scope of Practice in Anesthesiology Summary

CIERA WARD / PGY-1 Resident

As physicians, it is our duty to promote patient safety and quality of care both inside and outside of our clinical work. Who else is better suited to be the leaders in patient safety than anesthesiologists, who deal with the sickest of patients in the most critical of circumstances? Our sphere of influence should not be limited to the four sterile walls of the ORs, ICU units, or any other area of our practice. The securement of our specialty’s future and the outcomes of our patients lie within our willingness to step up and speak out on the issues physician anesthesiologists are facing today. Some of these issues, being debated on both state and national levels, include the following: the APRN Consensus Model, balance billing, reduced reimbursements, and dental anesthesia, among many others. There are several ways to become involved in advocating for the rights of your patients. The American Society of Anesthesiologists encourages donating to the ASAPAC, and I am proud to say that this year, 100% of our Anesthesiology Residency Program donated to ASAPAC.
Enhanced recovery after surgery (ERAS) programs are examples of clinical pathways which serve to improve both surgical outcomes and efficiency of care in the perioperative period. The key elements of ERAS protocols include preoperative counseling, optimization of nutrition, standardized analgesic and anesthetic regimens and early mobilization. However, these programs have not yet been widely adapted for surgery in children. In the pediatric population, initial trials of ERAS protocols have been implemented for spine, colorectal, urology and pectus excavatum surgeries. The initial focus has been on length of stay, surgical site infections, nutrition, pain reduction, and early removal of lines, tubes and drains. Several recent studies were highlighted throughout the lecture. The anesthesiologist’s contribution and focus in the ERAS protocols for pediatric patients emphasizes regional anesthesia and an opioid-sparing multimodal analgesic regimen for postoperative pain control.
Hope For The Warriors—Run For The Warriors 5k!

Hope For The Warriors was founded in 2006 aboard Marine Corps Base Camp Lejeune, in North Carolina. For the past 10 years Hope For The Warriors has been dedicated to serving those who have served. The organization provides a full cycle of care to restore self, family and hope to post-9/11 service members, their families, and families of the fallen.

*Drs. Gibson, Ozcan & Malach represented OU Anesthesiology at this year’s run*

*Drs. Ozcan and Gibson finished 3rd and 4th in their respective age groups!!*
"It became at once apparent to all the world that surgical anesthesia had become a reality and that pain was no longer a master but a servant of the body."

J. Collins Warren, M.D. in a 1921 speech on the impact of the historic surgery at the Ether Dome
Celebrate!

Thanks to Dr. Kosik for hosting and Dr. Gibson, the best Dirty Santa in Medicine!
Williams Pavilion Holiday Doors!