

A return visit is nice for programs you are very interested in. Although you cannot ask directly about your ranking, many programs will send letters showing interest in late January. For example, some programs send out letters to the top 30 to 40 applicants on their rank list. Don't forget to continue to interact with your advisor at your home institution.

References:

1. <http://anes.anesthes.sunysb.edu/Residency/Education.html>
2. www.emra.org; Med Student Survival Guide, Chapter 13
3. <http://www.ama-assn.org/ama/pub/category/7475.html#Anesthesiology>
4. <http://www.umassmed.edu/anes/residency/interview.cfm>
5. First Aid for the Match; Le, Bhushan



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CHAPTER 13

Osteopathic Student Guide to Applying to Anesthesiology Residency

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Osteopathic students are in a unique situation as they apply for anesthesiology residency. Important considerations must be made before beginning the process. One of the issues of prime importance is deciding between osteopathic or allopathic anesthesiology residencies. This is a difficult decision and is based on multiple factors including geographic location, size of residency desired, career plans, separate residency match programs, board certification, approval of allopathic internship and residency, licensing exams, and relating with separate professional organizations. All of which can be daunting but well worth the effort.

Geographic location is an important decision based on family, cost of living, or metropolitan versus rural location. There are 11 osteopathic anesthesiology programs located in seven states, including California, Florida, Missouri, Michigan, Ohio, Oklahoma and Pennsylvania.¹ As there are 23 osteopathic schools (soon to be 29) with approximately 3,000 graduates per year, this leaves relatively few osteopathic anesthesiology residencies to

meet the demand by osteopathic students.^{1,2} It is a challenging dilemma for osteopathic students when looking for an osteopathic anesthesiology residency because of the limited geographic locations and the limited number of positions at each site. Due to the small number of osteopathic anesthesiology slots, it is likely that an interested applicant seeking an osteopathic anesthesiology residency may not be granted the opportunity nor be willing to relocate for such an opportunity. There are 129 allopathic anesthesiology programs that exist throughout the United States today, in every state but Hawaii, Alaska, Idaho, Rhode Island, Wyoming, Delaware, Montana and South Dakota.³

Size of anesthesiology residency is important to many osteopathic student applicants. The benefits of small and large programs must be weighed. The largest osteopathic anesthesiology programs have a total of 12 residents compared to allopathic programs that can carry over 100 anesthesiology residents.^{1,3} Possible benefits of training at a smaller osteopathic or allopathic program include greater personal attention by instructors, greater investment in each resident as a reflection of the program, greater emphasis on private practice anesthesiology, and the programs are usually community hospital-based. Potential benefits of larger allopathic programs include larger number of faculty, a greater emphasis on didactics, exposure in training to a vast diversity of pathology accompanied by a higher complexity of clinical cases, more research opportunities, and less need to move to affiliated hospitals to gain subspecialty training.

The data to support what the typical D.O. does after osteopathic anesthesiology residency versus allopathic anesthesiology residency is difficult to gather (academic versus private practice). In general, it is assumed he or she would follow the trend of M.D. residents and enter into private practice at a greater rate. It is important for the osteopathic student to know in general for an osteopathic physician to become a program director or director of medical education at an osteopathic

institution, he or she must have completed an osteopathic anesthesiology residency.¹ It is also important for osteopathic anesthesiology students to know that they are not eligible for dual board certification (ABA/AOBA) unless they complete both residencies. In addition, there are no dually accredited (AOA/ACGME) anesthesiology residency programs like those that exist in primary care specialties.

The American Board of Anesthesiology (ABA) is the certification organization for physicians, both M.D. and D.O., who have completed ACGME-approved anesthesiology residency training. ABA certification requires passing both a written and oral examination. The ABA written examination is administered in July, after graduation from residency. The oral examination requires passing the written exam, and is administered in April or October of the year subsequent to graduation from residency.

The primary certification organization for osteopathic physicians who have completed an AOA-approved anesthesiology residency is the American Osteopathic Board of Anesthesiology (AOBA). The certification process requires completion of a written, oral and clinical examination. The clinical examination requires submission of case totals and medical record numbers for a specific period of time, and involves a board-certified osteopathic anesthesiologist reviewing selected patient charts, and observing one or two anesthetics during a visit to the applicant's clinical practice.

If one matches into an allopathic anesthesiology residency, it is advisable to either complete an AOA internship, or ensure that the AOA will recognize and credit training completed at the intended ACGME internship. Start by contacting the AOA and informing them of the intended institution and the internship rotations it provides. The reason to go through this process is osteopathic physicians are required to have completed an AOA-approved internship in order to receive a medical license in the states of Florida, Michigan, Oklahoma, Pennsylvania and West Virginia. Sometimes there are ways around this stipulation, i.e., practicing at a Veterans Affairs Hospital. An AOA-approved internship is required for application to an AOA-approved anesthesiology residency, and for entrance into the AOBA board eligibility and certification process. AOBA board certification is required to become a director of medical education (DME) or a program director in AOA-approved postdoctoral programs. Since the passage of AOA Resolution 42, a total of 1,241 osteopathic physicians petitioned the AOA for approval of their first year of ACGME postgraduate training. Seven hundred and seventy-four (62 percent) of these applications have been approved and 455 (37 percent) approved pending completion of residency training requirements and 12 (<1 percent) were denied between July 2001 and October 2006.² Finally, there are a few dually accredited internship programs (AOA/ACGME) that allow flexibility for entrance into both allopathic and osteopathic pathways.

Another consideration for internship is the restructuring of the traditional osteopathic internship. Starting July 1, 2008, all osteopathic anesthesiology residencies will be four-year residency positions similar to categorical ACGME programs. This means osteopathic students will match directly into their residency programs.²

The ACGME is also moving towards integrating internship into the anesthesiology residency continuum. Although this will be gradual, it will force change to the AOA internship requirements or mean more DO anesthesiologists may not have AOA approval and they will face geographic practice restraints as previously mentioned.⁴

Currently, there are separate matches for osteopathic and allopathic anesthesiology residencies. According to the D.O.-online website, it is important for osteopathic students to know if they are matched through the AOA match and have also registered to participate in the allopathic match program in the same year they will be withdrawn from the allopathic match program for concurrent programs.²

Osteopathic medical students applying for ACGME-approved residencies may want to consider taking the USMLE Step 1 (United States Medical Licensing Exam). Taking the USMLE is not required; however, osteopathic medical students are essentially prepared for the USMLE when they have studied for COMLEX. Thus, adding USMLE scores to your application only requires an extra day of testing and an exam fee. If you perform well on standardized exams, taking the USMLE may well serve to your advantage. Remember that you are an osteopathic medical student applying for a position in the allopathic training world. Allopathic program directors may be largely unfamiliar with the reputation of each specific osteopathic medical school; therefore, the USMLE provides them with a consistent measure to compare their osteopathic and allopathic student applicants.

Finally, if the osteopathic applicant elects to take only the COMLEX, it would be prudent to send each program director a letter explaining what your COMLEX score represents. Further, please note that in the past, the National Board of Osteopathic Medical Examiners has only released to programs the 3-digit COMLEX score. If you have a strong 2-digit percentile score, it may be beneficial to send it with the aforementioned letter that highlights this information.

The above article is not meant to be a comprehensive guide to making the decision on whether to choose an osteopathic or allopathic anesthesiology residency, but rather a tool to bring up some of the issues that each applicant should consider. To make a final decision on your anesthesiology path please talk with your college advisors, the AOA, and AOCA to find out the current rules and regulations. If you are considering an allopathic residency, speak to the anesthesiology program directors at the specific training programs you are interested in to find out how

they accommodate their osteopathic residents. Be sure to talk with D.O.s in the states in which you would consider practicing who have completed training at an allopathic or osteopathic anesthesiology residency and discuss any issues they have faced. Helpful articles and websites have been referenced for you. I hope I have helped you in your decision-making process and invite you to become involved with the American Society of Anesthesiologists. Even as a student there are opportunities to help lead and shape the future of our specialty.

References:

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I am carrying the cardiac arrest airway equipment bag, they make room for me to get to the head of the bed. After obtaining a brief history, I'll set up to secure the airway. Once the airway is secured, and I write my note, I head back to the O.R. to help expedite the completion of the ongoing cases and start other emergencies. By 7 or 8 p.m., most of the elective cases are wrapping up, leaving emergencies for the rest of the night.. Perhaps we can sit down for some dinner; this is the best part of the evening because not only is the food good (compliments of the attending-on-call), but this gives us a chance to socialize. Over the course of the evening, as everything winds down, I may even get some shut-eye. The arrest beeper will probably go off again but before I know it, it will be 7 a.m. and time to sign-out to the day staff. I'll head home having survived the night as team captain but knowing that I have begun to master what it is like to be a leader of a health care team.

For Henry, however, his alarm has gone off at 5 a.m. He'll leave his apartment and have changed into his scrubs by 6:30 a.m. It still takes him 25 to 30 minutes to set up his room, but he'll get faster with time. He's a first-year anesthesiology resident. He'll go to conference before seeing his first patient. He should already know quite a bit about the patient since laboratory results and history can be obtained from the hospital information system the evening before. He already has an idea about what type of anesthesia he'll recommend since he discussed this with his attending the evening prior as well. His job this morning is to confirm and collect additional data about the patient, discuss the options for anesthesia, explain the risks, benefits and alternatives of these options, calm the patient, and inspire confidence in his ability; all in a short period of time. Despite the patient's multiple comorbid diseases, the anesthesia preparation time (two IVs and an arterial line), induction, maintenance and emergence from anesthesia go without a hitch. During the case, his attending has discussed the anesthetic concerns of a patient with COPD and has given him a morning break. After extubating the patient, he will take him to the

CHAPTER 14

A Day in the Life of an Anesthesiology Resident

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Hello. I'm Helen, and I'm a third-year anesthesiology resident. I'm the team captain tonight, which means I'll be coordinating the anesthesia service in our hospital. I can sleep as late as I want this morning because my day won't begin until 4 p.m. Nights can be busy, which is why I'm going to need the extra rest. When I arrive at the hospital, my first tasks are to report to the attending-in-charge, review the board that summarizes all the operating rooms still running and their estimated times for finishing, and to pick up the arrest beeper. There's always an attending available to help or ask for advice and guidance, but as team captain, I'm in charge. After reviewing the board, I will make rounds in the PACU to receive sign-out from the PACU resident. Inevitably, the arrest pager will let out its typical adrenaline-provoking beep. I run to the nursing floor and find that a patient has arrested. Others have started basic life support, but since they recognize that