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:
1. AOA Residency Programs: http://opportunities.osteopathic.org/index.htm
5. DO-OnLine: www.do-online.org [American Osteopathic Association website].
6. AOA match: www.natmatch.com/aoairp
7. NRMP: www.nrmp.org
8. American Society of Anesthesiologists: www.asahq.org
9. ASA Resident Component: www.asahq.org/asarc
10. Medical Student Delegation: www.asahq.org/msd

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 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. 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

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post-anesthesia care unit, give a report to the nurse taking care of him, then go off to set up for and see his next patient. The day will fly by but before he can head home, he will need to check the schedule for the next day and prepare.

Meanwhile, Julie, who is a second-year anesthesiology resident, didn’t get out of bed until 5:30 a.m., because she lives in the neighborhood and walks to work. She’s rotating in the cardiothoracic ICU this month. She’s already had a rotation in the surgical-anesthesia ICU and one in the cardiothoracic rooms. She arrived in the unit at 6:30 a.m., completed her sign-out rounds, looked up lab values, had a chance to go to conference and even had a cup of coffee before rounds with the ICU anesthesiology attending at 8:30 a.m. Our units are “closed,” so that the ICU attending has the final word on all decisions. There is a lot of teaching during rounds. As each patient is discussed, the residents try to work as a team: while someone writes the orders, someone else is making phone calls for tests while the resident taking primary care of the patient is making sure that the treatment plan is understood. After rounds, there will still be some time to complete tasks not completed during rounds before the first wave of patients are admitted. There also will be time between patients to grab a bite to eat because they work until 6:30 or 7 p.m. Being in the CTICU is a 12-hour workday with call being about every five days. It’s hard work, but residents will learn a lot from their very ill patients and great attendings!

Research Careers in Anesthesiology

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The term anesthesia comes from the Greek α’νασφησι’α meaning “insensible” and is defined in the 1771 copy of the Encyclopedia Britannica as “a privation of the senses.” For the modern use of the words anesthesia and anesthetics, we are indebted to Oliver Wendell Holmes. Surgical anesthesia is the United States’ unique gift to medicine and is primarily responsible for the development of the surgical specialties. At a demonstration of diethyl ether in London for an amputation, the renowned British surgeon, Robert Liston, remarked in December 1846, “This Yankee dodge, gentlemen, beats mesmerism hollow!”

Academic activities performed by anesthesiologists are primarily based within university departments. The scope is quite broad and residents and medical students have always been encouraged to participate. These investigative endeavors range from molecular biology to observational patient studies and clinical trials. Traditionally, physician scientists in our specialty have focused on the pharmacology of drugs used in the perioperative period, as well as management and assessment of pathogenic mechanisms involved in acute pulmonary pathophysiology. For example, a number of anesthesiologists have been the driving force...