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ANESTHESIA ROTATION READY · FIELD GUIDE

The Anesthesia Rotation Survival Guide

What to know, what to do, and what not to touch, so you walk into the OR prepared, calm, and useful from day one.

PHYSICIAN-AUTHORED

BEGINNER-FRIENDLY

ORIENTATION ONLY

Patrick Nailer, MD · Cardiac Anesthesiology

How to use this guide

Anesthesia happens behind the drapes, so most students arrive unsure what the team does, where to stand, or how to be helpful. This guide covers it. Read it before day one. It is orientation: beginner-level concepts only, no doses, and no instruction to act independently. Always follow your institution's policies and your supervising clinicians.

1 BEFORE DAY ONE

Show up ready

Before you worry about any pharmacology, get the logistics right. That takes care of most of the first-day nerves.

What to wear

- Hospital-provided scrubs, changed into in the locker room.
- A surgical cap covering all your hair; a mask in the OR area.
- Eye protection when indicated. Ask if you're not sure.
- Comfortable closed-toe shoes; shoe covers per local policy.
- ORs run cold, so a warm layer for downtime helps.

What to bring

- Badge & access, a pen and small notebook.
- A snack and water for outside the OR.
- Phone, silenced and pocketed.

Where to go & when

- Arrive 15 to 30 minutes early, wherever your team says to meet, whether that's pre-op, a lecture, or somewhere else. It varies by rotation.
- You'll usually go into the OR with the resident or CRNA to set up.
- If you have EMR access, look up the day's cases the night before.

TAKE CARE OF YOURSELF

Eat beforehand and stay hydrated. Don't lock your knees. If you feel lightheaded, step back and tell someone. It's common and nothing to be embarrassed about.

Your first 30 minutes

1

Change into hospital scrubs & a cap.

2

Find the OR board and your assigned room.

3

Introduce yourself to the team.

4

Find the person doing anesthesia in your room.

5

Ask them where to sit and stash your bag.

What anesthesiologists actually do

Anesthesiology is perioperative medicine, not a single syringe at the start of a case. The anesthesiologist evaluates the patient before surgery, manages their physiology minute to minute during it, and oversees recovery afterward.

The five things to remember

- **It is perioperative medicine:** before, during, and after surgery.
- **It is real-time physiology:** airway, breathing, circulation, depth, fluids, temperature, and pain, adjusted continuously.
- **It is broad:** OR anesthesia, critical care, pain, obstetric, cardiac, pediatric, regional, and ambulatory practice.
- **It is a team specialty:** anesthesiologists, CRNAs, AAs, residents, surgeons, and nurses.
- **Vigilance is the core skill:** sustained attention to a patient who cannot protect themselves.

Where anesthesiologists work

OR anesthesia

Critical care

Pain medicine

Obstetric

Cardiac

Pediatric

Regional

Ambulatory

THE LENS TO KEEP

Surgeons think about fixing the problem. We think about whether this patient can safely tolerate the surgery and the anesthetic. Keep that question in mind and the rest starts to fit together.

Common misconceptions

"It's just putting people to sleep."

It's continuous management of airway, circulation, depth, and pain.

"The hard part is the start."

Maintenance and emergence demand just as much attention.

"They're not doing much."

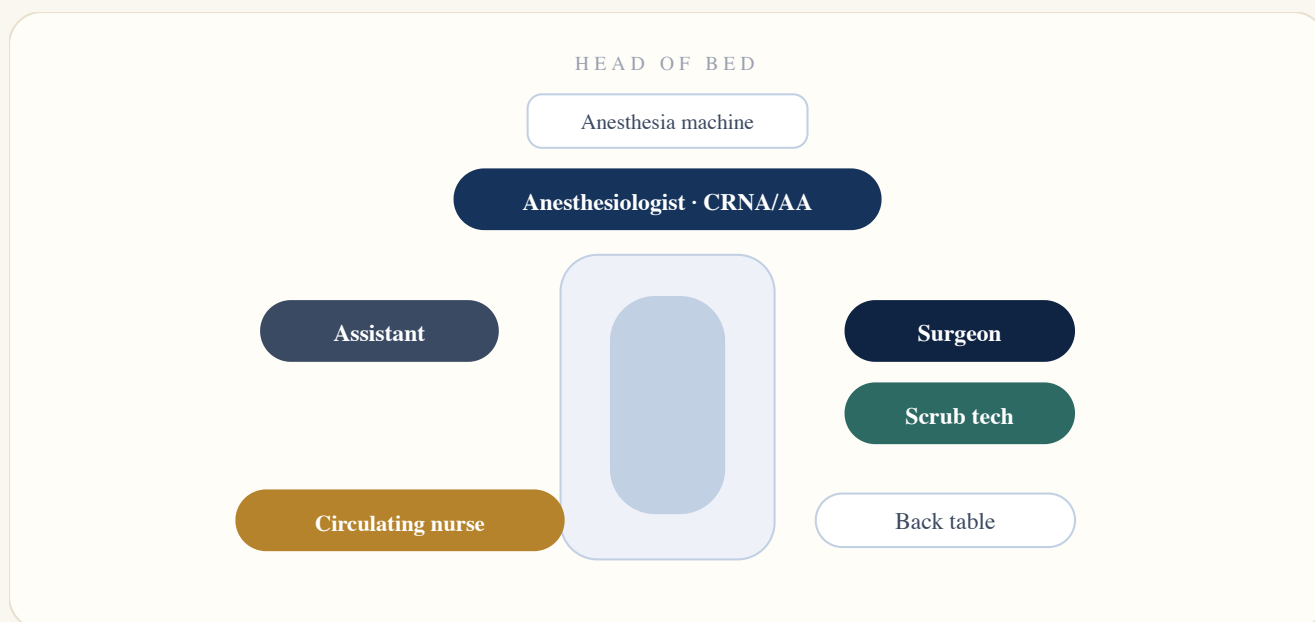
It looks calm because we're watching the patient closely the whole time.

3 THE ROOM

A day in the OR

The operating room has its own geography and its own rules, and nobody really explains them to you. Here is who is in the room and how a case flows from start to finish.

Who stands where



ANESTHESIA WORKS AT THE HEAD OF THE BED. THE PERSON DOING ANESTHESIA IN YOUR ROOM IS WHO YOU ASK WHERE TO SIT.

The arc of a case



PAY ATTENTION DURING INDUCTION AND EMERGENCE, THE TWO MOST FOCUSED MOMENTS.

YOUR ANCHOR PERSON

The person doing anesthesia in your room (the MD, resident, CRNA, or AA) is your anchor. When in doubt about where to sit, what to do, or where to put your bag, ask them.

INDUCTION & EMERGENCE

These are the focused moments, when the airway is secured or removed. Pay close attention and read the room: a calm, relaxed team usually means things are going well. Save your questions about them for after.

How to carry yourself

NEVER

Touch anything blue, green, or draped.
That's the sterile field. When unsure, assume sterile and keep your hands off.

ALWAYS ASK

"Where should I sit?" Ask the person doing anesthesia in your room, whether that's the MD, resident, CRNA, or AA you're working with.

Student etiquette checklist

- ☐ Introduce yourself to your anesthesia team, and to the charge nurse and circulator.
- ☐ Ask the anesthesia provider you're working with where to sit.
- ☐ Never touch anything blue, green, or draped. That is the sterile field.
- ☐ Phone away and silenced.
- ☐ Don't lean on the patient, the bed, or equipment.
- ☐ Pay close attention during induction and emergence; save your questions for after.
- ☐ If you feel faint, step back and tell someone. Don't be a hero.

WATCH FOR

Lock-kneed students go down more often than you'd think. Stay loose, stay hydrated, and step out the moment you feel lightheaded.

Scrubbing in & the sterile field

At a recognition level, the student rule is simple: **don't touch unless you're invited and shown.**

What "sterile" means

The surgical field and the scrubbed-in team, including their gowns and gloves, are kept free of microorganisms. Breaking that, even by brushing it, can contaminate the case and harm the patient. That's why the rules feel strict.

What's sterile, and what isn't

- **Sterile:** the draped field, and the front of a scrubbed person's gown from chest to waist.
- **Not sterile:** the back of the gown, anything below the waist, and the rest of the room.
- When unsure, treat it as sterile and stay clear.

How to move around it

- Face the field, and never reach across it.
- Keep your hands above your waist and in front of you.
- Keep a clear distance; don't walk between two sterile fields.

IF YOU CONTAMINATE SOMETHING

Say so immediately. The team will simply fix it. Nobody is upset by honesty here. They're upset by silence. You only scrub, gown, and glove if you're invited and someone shows you how.

Pre-op evaluation basics

Surgeons focus on the operation. We ask a different question: **can this specific person safely tolerate anesthesia and the stress of surgery?** You're learning the concepts here, not clearing patients yourself.

ASA physical status (the concept)

ASA I	A healthy patient.
ASA II	Mild systemic disease (e.g., well-controlled hypertension).
ASA III	Severe systemic disease that limits activity.
ASA IV	Severe disease that is a constant threat to life.
ASA V-VI	Moribund without surgery; or a declared organ donor. An "E" after the number (e.g., III E) means emergency.

Red flags we watch for

- **Airway:** small mouth opening, limited neck extension, prior difficult intubation.
- **Heart & lungs:** poor exercise tolerance, recent chest pain.
- **Blood thinners:** change bleeding risk and the plan.
- **NPO status:** a full stomach raises aspiration risk.
- **Allergies:** anesthetic agents, latex, antibiotics.

Questions anesthesia cares about

- ☐ When did you last eat or drink?
- ☐ Any prior problems with anesthesia (you or family)?
- ☐ What medications, including blood thinners?
- ☐ Heart or lung problems? How far can you walk?
- ☐ Loose teeth, dentures, jaw/neck issues?
- ☐ Any allergies?

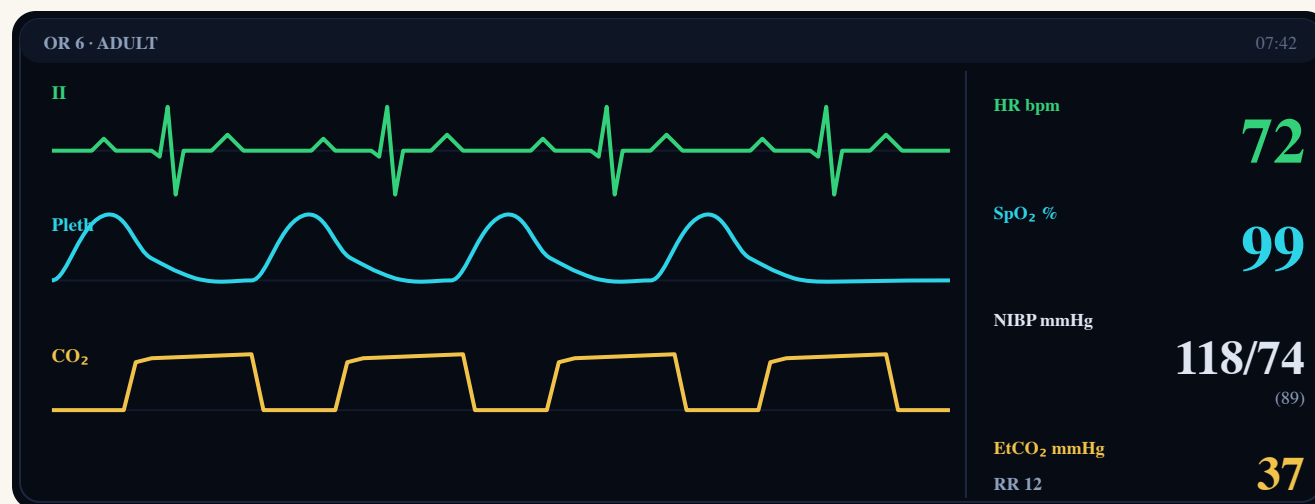
Airway, monitoring & medications

Recognize the equipment, read the screens. You're learning to **recognize** these, not to use them, and we won't talk about doses.

Recognize the airway devices

- **Face mask:** delivers oxygen and gas to pre-oxygenate and ventilate. A higher aspiration-risk airway.
- **Supraglottic airway (LMA):** sits above the vocal cords. Used when the case doesn't need muscle relaxation. Common for shorter cases, but used in longer ones too. Higher aspiration risk than an ETT.
- **Endotracheal tube (ETT):** passes through the cords into the trachea. The most secure airway, with the lowest aspiration risk.

Reading the monitors



SPO₂ = OXYGENATION · ETCO₂ = VENTILATION & TUBE PLACEMENT · ECG = RATE & RHYTHM · NIBP = BLOOD PRESSURE

LISTEN, DON'T JUST LOOK

The pulse-ox tone drops in pitch as SpO₂ falls, and experienced anesthesiologists often hear a problem before they see it. Get used to listening for it.

Your first monitor habit

Pick one waveform each case and just watch it for a while. When the timing is right, ask: "Is now a good moment to ask what you're seeing on the cap trace?" You'll pick it up faster that way than from reading about it.

Medications, lines & alarms

Medication classes, conceptually (no doses)

Induction agents	Take the patient from awake to anesthetized. e.g., propofol
Volatile agents	Keep them anesthetized via the breathing circuit. e.g., sevoflurane
Opioids	Manage pain and blunt the stress response. e.g., fentanyl
Neuromuscular blockers	Relax muscles for intubation and surgical access. e.g., rocuronium
Reversal agents	Restore muscle function or counteract specific medications at the end. e.g., sugammadex

Lines & access (recognize, don't place)

- **Peripheral IV:** almost every patient has one.
- **Arterial line ("A-line"):** continuous blood pressure and blood sampling, for bigger or sicker cases.
- **Central line:** central venous access for certain medications, monitoring, or poor peripheral access.

THE WORKSPACE

The anesthesia machine delivers oxygen, gas, and volatile anesthetics, and lets the team oxygenate and ventilate the patient. The monitor shows the vitals; the cart holds medications and airway gear. Keep your hands off the cart and any drawn-up medications.

WHEN AN ALARM SOUNDS

Most alarms are minor and constant, so don't startle. If the room gets busy or tense: stop talking, step back, give room, and don't ask questions. If given a direct instruction, follow it at once.

How to succeed on your rotation

Anesthesia teams remember the student who was prepared, present, and safe, and we go out of our way to teach that student. Here's how to be that person.

What to do in the room

- Arrive early; introduce yourself to everyone, including the circulator.
- Learn names and use them.
- Anticipate by keeping your eyes on the monitors and the field.
- When invited, stay at the head of the bed where you can see the airway and screens.

Good questions to ask

- **Attending:** "What made you choose this anesthetic plan?"
- **Resident:** "What are you watching for right now?"
- **CRNA/AA:** "What's the most useful thing a student can do in your room?"

THE LINE YOU NEVER CROSS

Ask before you do anything. Never touch the sterile field or the airway uninvited. If you don't know, say "I'm not sure, can you show me?" And speak up about anything that looks like a safety problem. "Useful" means anticipating and helping **within your scope**: never acting on your own.

Day-one readiness checklist

- ☐ Introduced myself to the whole team
- ☐ Phone silenced and away
- ☐ Reviewed today's cases and relevant basics
- ☐ Know where to stand and what not to touch
- ☐ Asked before doing anything
- ☐ Had at least one good question ready per case

Make yourself useful

You don't need to do procedures to be useful. Pay attention, help with the small things, and be ready when someone asks.

Ways to actually help

- Grab warm blankets or set up the forced-air warmer (Bair Hugger) when asked.
- Help position the patient on the team's count, and protect the IV lines and airway during any move.
- Hold a limb or retract only when you're explicitly directed to.
- Fetch supplies from the circulating nurse.
- Keep your eyes up and hand things over when asked.
- Anticipate the next step by watching both the surgery and the monitors.
- Bag-mask or assist only when a supervisor invites and guides you.

Questions you might get asked

What does the pulse ox (SpO₂) measure?

The oxygen saturation of the blood.

Why is the patient NPO?

A full stomach can be aspirated into the lungs under anesthesia.

LMA vs. ETT?

An LMA sits above the cords (higher aspiration risk, no muscle relaxation needed). An ETT passes through them, the most secure airway with the lowest aspiration risk.

What does EtCO₂ confirm?

That the patient is being ventilated and the tube is placed correctly.

What are the ASA classes?

A I-VI shorthand for how sick the patient is.

Why pre-oxygenate before induction?

To build an oxygen reserve, buying time to secure the airway.

General vs. regional anesthesia?

General makes you fully unconscious; regional numbs one area (spinal, epidural, or nerve block).

What's the anesthesiologist doing in a "quiet" case?

Continuously monitoring and adjusting. That's what the calm is.

IF YOU GET A QUESTION YOU CAN'T ANSWER

Say "I'm not sure, what's the answer?" That's a better answer than a wrong guess, and it usually turns into a quick teaching moment.

After the case

When surgery ends, the anesthetic is lightened and the patient wakes up (emergence), then moves to the PACU (post-anesthesia care unit) for monitored recovery.

The handoff

At the PACU the anesthesia team gives a structured handoff to the recovery nurse. Listen for it. A good one is complete and unhurried, and it covers:

- Who the patient is and what procedure was done.
- The anesthetic (general, regional, or sedation) and the airway used.
- Lines, fluids given, blood loss, and any medications still on board.
- Anything notable intra-op, and the plan for pain and monitoring.

Common early post-op issues

- **Pain:** managed and reassessed.
- **Shivering:** often from cooling in the OR.
- **Nausea / vomiting (PONV):** common and treatable.
- **Drowsiness:** expected as the anesthetic wears off.

Leaving the PACU

A patient moves on from recovery once they meet a few basic criteria: awake and oriented, breathing well on their own with stable vital signs, and with pain and nausea under control.

YOUR ROLE IN RECOVERY

Help with transport and the monitor hookup when asked, then pay attention to the handoff. A clear, organized handoff is a skill you'll use on every rotation, not just this one.

OR jargon glossary

The terms you'll hear in the first hour.

NPO	Nothing by mouth (empty stomach)	TIVA	Total intravenous anesthesia
Induction	Going from awake to anesthetized	RSI	Rapid sequence induction
Emergence	Waking up at the end	SpO₂	Blood oxygen saturation (pulse ox)
The field	The sterile surgical area (hands off)	EtCO₂	End-tidal CO ₂ (capnography)
Pre-op	Where patients are prepped before the OR	NIBP	Non-invasive blood pressure (cuff)
PACU	Post-anesthesia care unit (recovery)	A-line	Arterial line (continuous BP)
ETT	Endotracheal tube (through the cords)	Central line	Central venous catheter
LMA	Laryngeal mask airway (above the cords)	PONV	Post-operative nausea & vomiting
ASA	Physical status classification	Extubation	Removing the breathing tube
MAC	Monitored Anesthesia Care (sedation)	Circulator	The non-sterile nurse who runs the room

TIP

You don't need to memorize these. Skim them once before day one, and they'll click into place when you hear them used in context.



One-page cheat sheet

The hard lines

- Ask before you do anything.
- Never touch the sterile field or airway uninvited.
- Phone away. Silent during induction & emergence.
- "I'm not sure, can you show me?" is a great answer.

Questions anesthesia cares about

- When did you last eat or drink?
- Prior anesthesia problems?
- Medications, including blood thinners?
- Heart and lung problems? How far can you walk?
- Allergies?

Read the monitors

- **SpO₂**: oxygenation
- **EtCO₂**: ventilation & tube placement
- **ECG**: rate & rhythm
- **NIBP**: blood pressure

Top jargon

- NPO · induction · emergence · the field
- ETT · LMA · PACU · ASA · MAC
- SpO₂ · EtCO₂ · NIBP · A-line

Keep going, it's free

Take the quizzes and the pre/post confidence survey, and earn your completion certificate at the Anesthesia Rotation Ready course site. Bringing students through a rotation? Ask about a founding department pilot.

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