Application for Educational Student Membership

American Society of Anesthesiologists

PERSONAL INFORMATION *(Please print or type)*

Name: _____ Date: _____
(Full Legal Name)

Date of Birth: _____ Gender: ❑ Male ❑ Female

Address: _____ Suite No: _____

City: _____ State: _____ ZIP: _____

*E-mail: _____ ❑ Do Not Display

*Tel: _____ ❑ Do Not Display *Fax: _____ ❑ Do Not Display

**Unless indicated in the "Do Not Display" box, this information will be included in your online directory listing that can be viewed by other ASA members.*

Training Program: _____

Current Appointment: _____ Suite No: _____

FOR STUDENT APPLICANTS

Training Site (Hospital): _____

Date of Enrollment: _____ Anticipated Date of Graduation: _____

Program Director Name: _____

Program Director's Signature: _____

I agree with the "Guidelines for the Ethical Practice of Anesthesiology" and subscribe to the "Anesthesia Care Team" statement, as provided with this application.

Applicant's Signature: _____ **Date:** _____

PAYMENT METHOD *(Payment must accompany application to be processed)*

❑ **$25** Annual Dues ❑ **$12.50** after June 30th

❑ American Express ❑ MasterCard ❑ VISA

***Note:** Dues payments are based on a calendar year. Please pay only the amount indicated based on the date of your application. Dues payments are not refundable.*

❑ Check *(Payable to American Society of Anesthesiologists)*

Total Amount: _____

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____ Card ID: _____

Signature: _____

Mail payment and completed form to:
American Society of Anesthesiologists
Attn: Membership
520 N. Northwest Highway
Park Ridge, IL 60068-2573

Or fax to:
Attn: Membership
(847) 825-1692

GUIDELINES FOR THE ETHICAL PRACTICE OF ANESTHESIOLOGY

American Society of Anesthesiologists

Committee of Origin: Ethics

(Approved by the ASA House of Delegates on October 15, 2003, and last amended on October 22, 2008)

PREAMBLE

Membership in the American Society of Anesthesiologists is a privilege of physicians who are dedicated to the ethical provision of health care. The Society recognizes the Principles of Medical Ethics of the American Medical Association (AMA) as the basic guide to the ethical conduct of its members.

AMA Principles of Medical Ethics

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals and to self. The following Principles adopted by the American Medical Association are not laws but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues and other health professionals and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to improvement of the community and betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

AMA, 2001

The practice of anesthesiology involves special problems relating to the quality and standards of patient care. Therefore, the Society requires its members to adhere to the AMA Principles of Medical Ethics and any other specific ethical guidelines adopted by this Society.

ASA ETHICAL GUIDELINE

There may be specific circumstances when elements of the following guidelines may not apply and wherein individualized decisions may be appropriate.

I. Anesthesiologists have ethical responsibilities to their patients.

1. The patient-physician relationship involves special obligations for the physician that include placing the patient's interests foremost, faithfully caring for the patient and being truthful.
2. Anesthesiologists respect the right of every patient to self-determination. Anesthesiologists should include patients, including minors, in medical decision-making that is appropriate to their developmental capacity and the medical issues involved. Anesthesiologists should not use their medical skills to restrain or coerce patients who have adequate decision-making capacity.
3. Anesthetized patients are particularly vulnerable, and anesthesiologists should strive to care for each patient's physical and psychological safety, comfort and dignity. Anesthesiologists should monitor themselves and their colleagues to protect the anesthetized patient from any disrespectful or abusive behavior.
4. Anesthesiologists should keep confidential patients' medical and personal information.

5. Anesthesiologists should provide preoperative evaluation and care and should facilitate the process of informed decision-making, especially regarding the choice of anesthetic technique.
6. If responsibility for a patient's care is to be shared with other physicians or nonphysician anesthesia providers, this arrangement should be explained to the patient. When directing non-physician anesthesia providers, anesthesiologists should provide or ensure the same level of preoperative evaluation, care and counseling as when personally providing these same aspects of anesthesia care. Anesthesiologists should be guided by the most recently adopted ASA Statement on the Anesthesia Care Team.
7. When directing nonphysician anesthesia providers or physicians in training in the actual delivery of anesthetics, anesthesiologists should remain personally and continuously available for direction and supervision during the anesthetic; they should directly participate in the most demanding aspects of the anesthetic care.
8. Anesthesiologists should provide for appropriate postanesthetic care for their patients.
9. Anesthesiologists should not participate in exploitive financial relationships.
10. Anesthesiologists share with all physicians the responsibility to provide care for patients irrespective of their ability to pay for their care. Anesthesiologists should provide such care with the same diligence and skill as for patients who do pay for their care.

II. Anesthesiologists have ethical responsibilities to medical colleagues.

1. Anesthesiologists should promote a cooperative and respectful relationship with their professional colleagues that facilitates quality medical care for patients. This responsibility respects the efforts and duties of other care providers including physicians, medical students, nurses, technicians and assistants.
2. Anesthesiologists should provide timely medical consultation when requested and should seek consultation when appropriate.
3. Anesthesiologists should cooperate with colleagues to improve the quality, effectiveness and efficiency of medical care.
4. Anesthesiologists should advise colleagues whose ability to practice medicine becomes temporarily or permanently impaired to appropriately modify or discontinue their practice. They should assist, to the extent of their own abilities, with the re-education or rehabilitation of a colleague who is returning to practice.
5. Anesthesiologists should not take financial advantage of other physicians, nonphysician anesthesia providers or staff members. Verbal and written contracts should be honest and understandable, and should be respected.

III. Anesthesiologists have ethical responsibilities to the health care facilities in which they practice.

1. Anesthesiologists should serve on health care facility or specialty committees. This responsibility includes making good faith efforts to review the practice of colleagues and to help develop departmental or health care facility procedural guidelines for the benefit of the health care facility and all of its patients.
2. Anesthesiologists share with all medical staff members the responsibility to observe and report to appropriate authorities any potentially negligent practices or conditions which may present a hazard to patients or health care facility personnel.
3. Anesthesiologists personally handle many controlled and potentially dangerous substances and, therefore, have a special responsibility to keep these substances secure from illicit use. Anesthesiologists should work within their health care facility to develop and maintain an adequate monitoring system for controlled substances.

IV. Anesthesiologists have ethical responsibilities to themselves.

1. The achievement and maintenance of competence and skill in the specialty is the primary professional duty of all anesthesiologists. This responsibility does not end with completion of residency training or certification by the American Board of Anesthesiology.
2. The practice of quality anesthesia care requires that anesthesiologists maintain their physical and mental health and special sensory capabilities. If in doubt about their health, then anesthesiologists should seek medical evaluation and care. During this period of evaluation or treatment, anesthesiologists should modify or cease their practice.

V. Anesthesiologists have ethical responsibilities to their community and to society.

1. An anesthesiologist shall recognize a responsibility to participate in activities contributing to an improved community.
2. An anesthesiologist who serves as an expert witness in a judicial proceeding shall possess the qualifications and offer testimony in conformance with the ASA "Guidelines for Expert Witness Qualifications and Testimony."

STATEMENT ON THE ANESTHESIA CARE TEAM

American Society of Anesthesiologists

Committee of Origin: Anesthesia Care Team

(Approved by the ASA House of Delegates on October 18, 2006, and last amended on October 21, 2009)

Anesthesiology is the practice of medicine including, but not limited to, preoperative patient evaluation, anesthetic planning, intraoperative and postoperative care and the management of systems and personnel that support these activities. In addition, anesthesiology involves perioperative consultation, the prevention and management of untoward perioperative patient conditions, the treatment of acute and chronic pain, and the care of critically ill patients. This care is personally provided by or directed by the anesthesiologist.

In the interest of patient safety and quality of care, the American Society of Anesthesiologists believes that the involvement of an anesthesiologist in the perioperative care of every patient is optimal. Almost all anesthesia care is either provided personally by an anesthesiologist or is provided by a nonphysician anesthesia provider directed by an anesthesiologist. The latter mode of anesthesia delivery is called the Anesthesia Care Team and involves the delegation of monitoring and appropriate tasks by the physician to nonphysicians. Such delegation should be specifically defined by the anesthesiologist and should also be consistent with state law or regulations and medical staff policy. Although selected tasks of overall anesthesia care may be delegated to qualified members of the Anesthesia Care Team, overall responsibility for the Anesthesia Care Team and the patients' safety rests with the anesthesiologist.

Core Members of the Anesthesia Care Team

The Anesthesia Care Team includes both physicians and nonphysicians. Each member of the team has an obligation to accurately identify themselves and other members of the team to patients and family members. Anesthesiologists should not permit the misrepresentation of nonphysician personnel as resident physicians or practicing physicians. The nomenclature below is appropriate terminology for this purpose.

Physicians:

ANESTHESIOLOGIST **– director of the anesthesia care team -** a **physician** licensed to practice medicine who has successfully completed a training program in anesthesiology accredited by the ACGME, the American Osteopathic Association or equivalent organizations.

ANESTHESIOLOGY FELLOW— an **anesthesiologist** enrolled in a training program to obtain additional education in one of the subdisciplines of anesthesiology.

ANESTHESIOLOGY RESIDENT – a **physician** enrolled in an accredited anesthesiology residency program.

Nonphysicians:

NURSE ANESTHETIST – a **registered nurse** who has satisfactorily completed an accredited nurse anesthesia training program.

ANESTHESIOLOGIST ASSISTANT – a **health professional** who has satisfactorily completed an accredited anesthesiologist assistant training program.

STUDENT NURSE ANESTHETIST – a **registered nurse** who is enrolled in an accredited nurse anesthesia training program.

ANESTHESIOLOGIST ASSISTANT STUDENT – a **health professions graduate student** who has satisfied the required coursework for admission to an accredited school of medicine and is enrolled in an accredited anesthesiologist assistant training program. Although not considered core members of the Anesthesia Care Team, other health care professionals make important contributions to the perianesthetic care of the patient (see **Addendum A**).

Definitions

ANESTHESIA CARE TEAM – Anesthesiologists supervising resident physicians in training and/or directing qualified nonphysician anesthesia providers in the provision of anesthesia care wherein the physician may delegate monitoring and appropriate tasks while retaining overall responsibility for the patient.

QUALIFIED ANESTHESIA PERSONNEL/PRACTITIONER -- Anesthesiologists, anesthesiology fellows, anesthesiology residents, oral surgery residents, anesthesiologist assistants and nurse anesthetists. An exception is made by some clinical training sites for non-physician anesthetist students (see "Non-physician Anesthetist Students" below).

SUPERVISION AND DIRECTION – Terms used to describe the physician work required to oversee, manage and guide both residents and nonphysician anesthesia providers in the Anesthesia Care Team. For the purposes of this statement, supervision and direction are interchangeable and have no relation to the billing, payment or regulatory definitions that provide distinctions between these two terms (see **Addendum B**).

SEDATION NURSE AND SEDATION PHYSICIAN ASSISTANT – A licensed registered nurse, advanced practice nurse or physician assistant (PA) who is trained in compliance with all relevant local, institutional, state and/or national standards, policies or guidelines to administer prescribed sedating and analgesic medications and monitor patients during minimal sedation ("anxiolysis") or moderate sedation ("conscious sedation"), but not deeper levels of sedation or general anesthesia. Sedation nurses and sedation physician assistants may only work under the direct supervision of a properly trained and privileged medical doctor (M.D. or D.O.).

Safe Conduct of the Anesthesia Care Team

In order to achieve optimum patient safety, the anesthesiologist who directs the Anesthesia Care Team is responsible for the following:

1. **Management of personnel** – Anesthesiologists should assure the assignment of appropriately skilled physician and/or nonphysician personnel for each patient and procedure.
2. **Preanesthetic evaluation of the patient** – A preanesthetic evaluation allows for the development of an anesthetic plan that considers all conditions and diseases of the patient that may influence the safe outcome of the anesthetic. Although nonphysicians may contribute to the preoperative collection and documentation of patient data, the anesthesiologist is responsible for the overall evaluation of each patient.
3. **Prescribing the anesthetic plan** – The anesthesiologist is responsible for prescribing an anesthesia plan aimed at the greatest safety and highest quality for each patient. The anesthesiologist discusses with the patient (when appropriate), the anesthetic risks, benefits and alternatives, and obtains informed consent. When a portion of the anesthetic care will be performed by another qualified anesthesia provider, the anesthesiologist should inform the patient that delegation of anesthetic duties is included in care provided by the Anesthesia Care Team.
4. **Management of the anesthetic** – The management of an anesthetic is dependent on many factors including the unique medical conditions of individual patients and the procedures being performed. Anesthesiologists should determine which perioperative tasks, if any, may be delegated. The anesthesiologist may delegate specific tasks to qualified nonanesthesiologist members of the ACT providing that quality of care and patient safety are not compromised, but should participate in critical parts of the anesthetic and remain immediately physically available for management of emergencies regardless of the type of anesthetic (see **Addendum B**).
5. **Postanesthesia care** – Routine postanesthesia care is delegated to postanesthesia nurses. The evaluation and treatment of postanesthetic complications are the responsibility of the anesthesiologist.
6. **Anesthesia consultation** – Like other forms of medical consultation, this is the practice of medicine and should not be delegated to nonphysicians.

Safe Conduct of Minimal and Moderate Sedation Utilizing Sedation Nurses and PA's

The supervising doctor is responsible for all aspects involved in the continuum of care – pre-, intra-, and post-procedure. While a patient is sedated, the responsible doctor must be physically present and immediately available in the procedure suite. Although the supervising doctor is primarily responsible for pre-procedure patient evaluation, sedation practitioners must be trained adequately in pre-procedure patient evaluation to recognize when risk may be increased, and related policies and procedures must allow sedation practitioners to refuse to participate in specific cases if they feel uncomfortable in terms of any perceived threat to quality of care or patient safety.

The supervising doctor is responsible for leading any acute resuscitation needs, including emergency airway management. Therefore, ACLS (PALS or NALS where appropriate) certification must be a standard requirement for sedation practitioners and for credentialing and privileging the non-anesthesiologist physicians that supervise them. However, because non-anesthesia professionals do not perform controlled mask ventilation or tracheal intubation with enough frequency to remain proficient, their training should emphasize avoidance of over-sedation much more than treatment of the same.

Supervision of Nurse Anesthetists by Surgeons

Note: In this paragraph "surgeon(s)" may refer to any appropriately trained, licensed and credentialed nonanesthesiologist who may supervise nurse anesthetists.

General, regional and monitored anesthesia care all expose patients to risks. Nonanesthesiologist physicians may not possess the expertise that uniquely qualifies and enables anesthesiologists to manage the most clinically challenging medical situations that arise during the perioperative period. While a few surgical training programs provide some anesthesiology specific education (e.g., some oral and maxillofacial residencies), no surgical, dental, podiatric or any other nonanesthesiology training programs provide enough training specific to anesthesiology to enable their graduates to provide the level of medical supervision and clinical expertise that anesthesiologists provide. However, surgeons can still significantly add to patient safety and quality of care by assuming medical responsibility for all perioperative

care when an anesthesiologist is not present. Anesthetic and surgical complications often arise unexpectedly and require immediate medical diagnosis and treatment. Even if state law or regulation says a surgeon is not "required" to supervise nonphysician anesthesia providers, the surgeon may be the only medical doctor on site. Whether the need is preoperative medical clearance or intraoperative resuscitation from an unexpected complication, the surgeon, both ethically and according to training and ability, should be expected to provide medical oversight or supervision of all perioperative health care provided, including nonphysician nurse anesthesia care. To optimize patient safety, careful consideration is required when surgeons can be expected to be the only medical doctor available to provide oversight of all perioperative care. This is especially true in freestanding surgery centers and surgeons' offices where, in the event of unexpected emergencies, consultation with other medical specialists frequently is not available. In the event of unexpected emergencies, lack of immediately available and appropriately trained physician support can reduce the likelihood of successful resuscitation. This should always be a consideration when deciding which procedures should be performed in these settings, and on which patients, particularly if the individual supervising the nurse anesthetist is not a medical doctor with training appropriate for providing critical perioperative medical management.

Non-Physician Anesthetist Students

Definition: AA students, SRNAs, dental anesthesia students, or possibly other student types satisfactorily enrolled in nationally accredited training programs. Anesthesiologists should be dedicated to providing optimal patient safety and quality of care to every patient undergoing anesthesia and also to education of anesthesia students that is commensurate with that dedication. The ASA Standards for Basic Anesthetic Monitoring sets forth the minimum conditions necessary for the safe conduct of anesthesia. Standard #1 of that document states that, "Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care." The definitions above are inadequate to address the issue of safe patient care during the training of non-physician anesthetist students. Further clarification of the issues involved is in the best interests of patients, students, and the anesthesia practitioners involved in the training of non-physician anesthetists.

Distinction between situations where students may be alone with patients: During supervision of non-physician anesthetist students it may become necessary to leave them alone in operating rooms or procedure rooms (OR/PR) to accommodate needs of brief duration. This should only occur if judged to cause no significant increased risk to the patient.

This practice must be distinguished from that of scheduling non-physician students to patients as the primary anesthesia provider, meaning no fully trained anesthesia practitioner also assigned to the case and expected to be continuously present monitoring the anesthetized patient. While the brief interruption of 1:1 student supervision may well be necessary for the efficient and safe functioning of a department of anesthesiology, the use of non-physician students in place of fully trained and credentialed anesthesia personnel is not endorsed as best practice by the American Society of Anesthesiologists. While the education of non-physician anesthetist students is an important goal, patient safety remains paramount. Therefore, the conduct of this latter type of practice must meet certain conditions intended to protect the safety and rights of patients and students, as well as the best interests of all other parties directly or indirectly involved (i.e. involved qualified practitioners, patients' families, institutions, etc.).

1. All delegating anesthesiologists and the department chairperson must deem these non-physician student anesthetists fully capable of performing all duties delegated to them, and all students being delegated to must express agreement with accepting any responsibility delegated to them.
2. **Privileging** – A privileging process must precede this practice to officially and individually label each student as qualified to be supervised 1:2 by a qualified anesthesia practitioner who remains immediately physically available. Students must not be so privileged until they have completed a significant predetermined portion of both their didactic and clinical training that may reasonably be assumed to make this practice consistent with expected levels of safety and quality (if at all, at the earliest the last 3-4 months of student training). Privileging must be done under the authority of the Chief of Anesthesiology and in compliance with all federal, state, professional organization and institutional requirements.
3. **Case Assignment and Supervision** – These students must be supervised on a one-to-one or on a one-to-two ratio. Assignment of cases with regards to students must always be done in a manner that assures the best possible outcome for patients and the best education of students and therefore must be commensurate with the skills, training, experience, knowledge and willingness of each individual non-physician anesthesia student. Care should be taken to avoid placing students in situations that they are not fully prepared for. It is expected that most students will get their experience caring for high risk patients under the continuous supervision of fully trained anesthesia personnel. This is in the best interest of both education and patient safety. As students are incompletely trained, the degree of continuous supervision must be at a higher level than that required for fully trained and credentialed AAs and NAs. If an anesthesiologist is engaged in the supervision of non-physician students, he/she must remain immediately physically available throughout the conduct of the involved anesthetics, meaning not leaving the OR/PR suite to provide other services or clinical duties that are commonly considered appropriate concurrent activities while directing fully trained and credentialed AAs or NAs.

4. **Backup support** – If an anesthesiologist is concurrently supervising two non-physician anesthetists students assigned as primary anesthesia providers (meaning the only anesthesia personnel continuously present with a patient), the anesthesiologist could be needed simultaneously in both rooms. To mitigate this potential risk, one other qualified anesthesia practitioner must also be assigned and must remain immediately physically available if needed (e.g., alone on call anesthesiologist should not be supervising more than one student without appropriately trained and credentialed back up immediately available).
5. **Informed Consent** – The Chief of Anesthesia is responsible for assuring that every patient (or their guardian) understands through a standardized departmental informed consent process that they may be in the OR/PR with only a non-physician student physically present, although still directed by the responsible anesthesiologist. As it is in the best interest of all involved parties, documentation of this aspect of informed consent must be included in the informed consent statement.
6. **Disclosure to Professional Liability Carrier** – To be assured of reliable professional liability insurance coverage for all involved (qualified anesthesia practitioners, their employers and the institution), the Chief of Anesthesia must notify the responsible professional liability carrier(s) of the practice of allowing non-physician anesthesia students to provide care without continuous direct supervision by a fully trained, credentialed and qualified anesthesia practitioner.

ADDENDUM A:

Other personnel involved in perianesthetic care:

POSTANESTHESIA NURSE – a **registered nurse** who cares for patients recovering from anesthesia.

PERIOPERATIVE NURSE – a **registered nurse** who cares for the patient in the operating room.

CRITICAL CARE NURSE – a **registered nurse** who cares for patients in a special care area such the intensive care unit.

OBSTETRIC NURSE – a **registered nurse** who provides care to laboring patients.

NEONATAL NURSE – a **registered nurse** who provides cares to neonates in special care units.

RESPIRATORY THERAPIST – an **allied health professional** who provides respiratory care to patients.

CARDIOVASCULAR PERFUSIONISTS – an **allied health professional** who operates cardiopulmonary bypass machines.

Support personnel whose efforts deal with technical expertise, supply and maintenance:

ANESTHESIA TECHNOLOGISTS AND TECHNICIANS

ANESTHESIA AIDES

BLOOD GAS TECHNICIANS

RESPIRATORY TECHNICIANS

MONITORING TECHNICIANS

ADDENDUM B:

Commonly Used Billing Rules and Definitions

ASA recognizes the existence of commercial and governmental payer rules applying to billing for anesthesia services and encourages its members to comply with them whenever possible. Some commonly prescribed duties include:

- Performing a preanesthetic history and physical examination of the patient;
- Prescribing the anesthetic plan;
- Personal participation in the most demanding portions of the anesthetic, including induction and emergence, where applicable;
- Delegation of anesthesia care only to qualified anesthesia providers;
- Monitoring the course of anesthesia at frequent intervals;
- Remaining physically available for immediate diagnosis and treatment while medically responsible;
- Providing indicated postanesthesia care, and;
- Performing and documenting a post-anesthesia evaluation.

ASA also recognizes the lack of total predictability in anesthesia care and the variability in patient needs that can, in particular and infrequent circumstances, make it less appropriate from the viewpoint of overall patient safety and quality to comply with all payment rules in each patient at every moment in time. Reporting of services for payment must accurately reflect the services provided. The ability to prioritize duties and patient care needs, moment to moment, is a crucial skill of the anesthesiologist functioning safely within the anesthesia care team. Anesthesiologists must strive to provide the highest quality of care and greatest degree of patient safety to ALL patients in the perioperative environment at ALL times.

MEDICAL "DIRECTION" by anesthesiologists – A billing term describing the specific anesthesiologist work required in and restrictions involved in billing payers for the management and oversight of nonphysician anesthesia providers. This pertains to situations where anesthesiologists are involved in not more than four concurrent anesthetics. See individual payer manuals for specifics.

MEDICAL "SUPERVISION" by anesthesiologists – Medicare payment policy contains a special payment formula for "medical supervision" which applies "when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures." [Note: The word "supervision" may also be used outside of the Anesthesia Care Team to describe the perioperative medical oversight of nonphysician anesthesia providers by the operating practitioner/surgeon. Surgeon provided supervision pertains to general medical perioperative patient management and the components of anesthesia care that are medical and not nursing functions (e.g., determining medical readiness of patients for anesthesia and surgery, and providing critical medical management of unexpected emergencies).]