

STATEMENT ON THE ANESTHESIA CARE TEAM

Committee of Origin: Anesthesia Care Team

(Approved by the ASA House of Delegates on October 26, 1982, and last amended on October 16, 2013)

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 includes perioperative consultation, the management of coexisting disease, the prevention and management of untoward perioperative patient conditions, the treatment of acute and chronic pain, and the practice of critical care medicine. This care is personally provided by or directed by the anesthesiologist.

In the interests 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 necessary. Almost all anesthesia care is either provided personally by an anesthesiologist or is provided by a non-physician anesthesia practitioner 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 non-physicians. 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 patients' safety ultimately rests with the anesthesiologist.

Definitions

1. Core Members of the Anesthesia Care Team

The Anesthesia Care Team includes both physicians and non-physicians. All members of the team have an obligation to accurately identify themselves and other team members to patients and families. Anesthesiologists should not permit the misrepresentation of non-physician personnel as resident physicians or practicing physicians. The nomenclature below is appropriate terminology for this purpose.

a. 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 subspecialties of anesthesiology.

ANESTHESIOLOGY RESIDENT: A **physician** enrolled in an accredited anesthesiology residency program.

b. Non-physicians

ANESTHETIST: A **nurse anesthetist** or **anesthesiologist assistant**, as each is defined below. (Note: In some countries where non-physicians do not participate in the administration of anesthesia, a physician who practices anesthesiology is known as an “anaesthetist” or “anesthetist”)

NURSE ANESTHETIST: A **registered nurse** who has satisfactorily completed an accredited nurse anesthesia training program and certifying examination (also, “CRNA”).

ANESTHESIOLOGIST ASSISTANT: A **health professional** who has satisfactorily completed an accredited anesthesiologist assistant training program and certifying examination (also, “AA”).

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

ANESTHESIOLOGIST ASSISTANT STUDENT: A **health profession graduate student** who has satisfied all prerequisite coursework typical of an accredited school of medicine and is enrolled in an accredited anesthesiologist assistant training program.

NON-PHYSICIAN ANESTHESIA STUDENT: Student nurse anesthetists, anesthesiologist assistant students, dental anesthesia students and others who are enrolled in accredited anesthesia training programs.

OTHERS: 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).

2. Additional Terms

ANESTHESIA CARE TEAM: Anesthesiologists supervising resident physicians and/or directing qualified non-physician anesthesia practitioners 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 OR PRACTITIONERS: Anesthesiologists, anesthesiology fellows, anesthesiology residents, oral surgery residents, anesthesiologist assistants, and nurse anesthetists.

MEDICAL SUPERVISION AND MEDICAL DIRECTION: Terms used to describe the physician work required to oversee, manage and guide both residents and non-physician members of 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 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 physician (MD or DO).

PROCEDURE ROOM: An operating room or other location where an operation or procedure is performed under anesthesia care.

IMMEDIATELY AVAILABLE: Wherever it appears in this document, the phrase "immediately available" is used as defined in the ASA policy statement "Definition of 'Immediately Available' When Medically Directing" (see Addendum C).

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 non-physician 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 non-physicians 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 or guardian, as appropriate, the anesthetic risks, benefits and alternatives, and obtains informed consent. When part of the anesthetic care will be performed by another qualified anesthesia practitioner, 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 will determine which perioperative tasks, if any, may be delegated. The anesthesiologist may delegate specific tasks to qualified

- non-anesthesiologist members of the Anesthesia Care Team providing that quality of care and patient safety are not compromised, will participate in critical parts of the anesthetic, and will remain immediately available for management of emergencies regardless of the type of anesthetic (see Addendum C).
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 non-physicians.

Safe Conduct of Minimal and Moderate Sedation Utilizing Sedation Nurses and Physician Assistants

The supervising physician is responsible for all aspects of the continuum of care: pre-, intra-, and post-procedure. While a patient is sedated, the responsible physician must be physically present and immediately available in the procedure suite. Although the supervising physician 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 perceive a threat to quality of care or patient safety.

The supervising physician 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 who supervise them. However, because non-anesthesia professionals seldom perform controlled mask ventilation or tracheal intubation often enough to remain proficient, their training should emphasize avoidance of excessive sedation over rescue techniques.

Medical Supervision of Nurse Anesthetists by Non-Anesthesiologist Physicians

Note: In this section, the term “surgeon” may refer to any appropriately trained, licensed and credentialed non-anesthesiologist physician who may supervise nurse anesthetists when consistent with applicable law.

General anesthesia, regional anesthesia, and monitored anesthesia care expose patients to risks. Non-anesthesiologist 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 (such as oral surgery and maxillofacial surgery) provide some anesthesia-specific education, no non-anesthesiology programs prepare their graduates to provide an anesthesiologist’s level of medical supervision and perioperative clinical expertise. However, surgeons and other physicians significantly add to patient safety and quality of care by assuming medical responsibility for 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 physician is not required to supervise non-physician anesthesia practitioners. The surgeon may be the only physician on site. Whether the need is preoperative medical assessment or intraoperative resuscitation from an unexpected complication, the surgeon may be called upon, as the most highly trained professional present, to provide medical direction of perioperative health care, including nurse anesthesia care. To optimize patient safety, careful consideration is required when a surgeon will be the only physician available, as in some small hospitals, freestanding surgery centers, and surgeons' offices. In the event of an emergency, lack of immediate support from other physicians trained in critical medical management may reduce the likelihood of successful resuscitation. This should be taken into account when deciding which procedures should be performed in settings without an anesthesiologist, and which patients are appropriate candidates.

Medical Supervision of Non-Physician Anesthesia Students

Anesthesiologists who teach non-physician anesthesia students are dedicated to their education and to providing optimal safety and quality of care to every patient. The ASA Standards for Basic Anesthetic Monitoring define the minimum conditions necessary for the safe conduct of anesthesia. The first standard states, "Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care." This statement does not completely address the issue of safe patient care during the training of non-physician student anesthetists. Further clarification of the issues involved is in the best interests of patients, students, and anesthesia practitioners.

During 1:1 supervision of non-physician anesthesia students, it may become necessary for the supervising anesthesiologist or nurse anesthetist to leave briefly to attend to other urgent needs or duties. This should only occur in circumstances judged to cause no significant increased risk to the patient.

This practice is to be distinguished from that of scheduling a non-physician student as the primary anesthetist, meaning that no fully-trained anesthesia practitioner is also continuously present to monitor the anesthetized patient. Though the brief interruption of 1:1 student supervision may be unavoidable for the efficient and safe functioning of a department of anesthesiology, the use of non-physician students as primary anesthetists in place of fully trained and credentialed anesthesia personnel is not endorsed as a best practice by the ASA. While the education of non-physician anesthesia students is an important goal, patient safety remains paramount. Therefore, the supervision of students at a ratio other than 1:1 must meet criteria designed to protect the safety and rights of patients and students, as well as the best interests of all other parties directly or indirectly involved: anesthesia practitioners, families, and health care institutions.

1. **Delegation:** All delegating anesthesiologists and the department chairperson must deem non-physician student anesthetists fully capable of performing all duties delegated to them, and all students must express agreement with accepting responsibility delegated to them.

2. **Privileging:** An official privileging process must individually deem each student as qualified to be supervised 1:2 by an anesthesiologist who remains immediately available (see Addendum C). Students must not be so privileged until they have completed a significant portion of their didactic and clinical training and have achieved expected levels of safety and quality (if at all, no earlier than the last 3-4 months of training). Privileging must be done under the authority of the chair of anesthesiology and in compliance with all federal, state, and professional organization and institutional requirements.
3. **Case Assignment and Supervision:** Students must be supervised at a 1:1 or 1:2 anesthesiologist to student ratio. Assignment of cases to students must be done in a manner that assures the best possible outcome for patients and the best education of students, and must be commensurate with the skills, training, experience, knowledge and willingness of each individual non-physician student. Care should be taken to avoid placing students in situations beyond their level of skill. It is expected that most students will gain experience caring for high-risk patients under the continuous supervision of qualified anesthesia practitioners. This is in the best interest of education and patient safety. The degree of continuous supervision must be at a higher level than that required for fully credentialed anesthesiologist assistants and nurse anesthetists. If an anesthesiologist is engaged in the supervision of non-physician students, he/she must remain immediately available. This means not leaving the procedure suite to provide other concurrent services or clinical duties that would be considered appropriate if directing fully credentialed anesthesiologist assistants or nurse anesthetists.
4. **Back-up Support:** If an anesthesiologist is concurrently supervising two non-physician students assigned as primary anesthetists (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 designated to provide back-up support and must remain immediately available.
5. **Informed Consent:** The chair of anesthesiology is responsible for assuring that every patient (or the patient's guardian) understands through a standardized departmental informed consent process that the patient may be in the procedure room with only a non-physician student physically present, although still directed by the responsible anesthesiologist. 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 chair of anesthesiology 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

1. 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 procedure room.

CRITICAL CARE NURSE: A **registered nurse** who cares for patients in a special care area such as an intensive care unit.

OBSTETRIC NURSE: A **registered nurse** who provides care to patients during labor and delivery.

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 PERFUSIONIST: An **allied health professional** who operates cardiopulmonary bypass machines.

2. Support personnel for technical procedures, equipment, supply and maintenance:

ANESTHESIA TECHNOLOGISTS AND TECHNICIANS
ANESTHESIA AIDES
BLOOD GAS TECHNICIANS
RESPIRATORY TECHNICIANS
MONITORING TECHNICIANS

ADDENDUM B

Commonly Used Payment Rules and Definitions

ASA recognizes the existence of commercial and governmental payer rules applicable to payment for anesthesia services and encourages its members to comply with them. 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 practitioners;

- Monitoring the course of anesthesia at frequent intervals;
- Remaining immediately available for diagnosis and treatment while medically responsible;
- Providing indicated postanesthesia care;
- Performing and documenting a post-anesthesia evaluation.

ASA also recognizes the lack of total predictability in anesthesia care and the variability in patient needs. In certain rare circumstances, it may be inappropriate from the viewpoint of overall patient safety and quality to comply with all payment rules 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 payment term describing the specific anesthesiologist work required and restrictions involved in billing payers for the management and oversight of non-physician anesthesia practitioners. This pertains to situations where anesthesiologists are involved in not more than four concurrent anesthetics.

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 non-physician anesthesia practitioners by the operating practitioner/surgeon. Surgeon-provided supervision pertains to general medical management and to the components of anesthesia care that are physician and not nursing functions (e.g., determining medical readiness of patients for anesthesia and surgery, and providing critical medical management of unexpected emergencies).]

See the Medicare Claims Processing Manual (Chapter 12, Section 50.C-D) and individual payer manuals for additional information.

ADDENDUM C

Definition of “Immediately Available” When Medically Directing (HOD 2012)

A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department.

Differences in the design and size of various facilities and demands of the particular surgical procedures make it impossible to define a specific time or distance for physical proximity.