The anesthesia profession goes on moving and is still extending to the optimization of the perioperative care of surgical and sometimes nonsurgical patients, requiring more and more investment from anesthesia practitioners. Numerous tasks progressively add to the anesthesiologist workload. Time has come to think about means of making our functioning mode more efficient, while preserving quality of care and safety.

Perioperative care starts with the preoperative assessment. This intellectual action is time consuming and is still not reimbursed in Belgium, despite allowing adaptation of the patient preoperative treatment, explanation of the anesthesia technique, more patient confidence in the anesthesia management, and, overall, optimal preparation to surgery. The cardiologist, the internist or the generalist can help us in this field, but we are the only one expert knowing what exactly happens during and after surgery. There is some place here to get help in the initial disentangling of patient medical history and basic assessment.

The tools available to the anesthesiologist have greatly improved. There is no more limitation to the duration of surgery. Our loco-regional and general techniques are increasingly safe, thanks to progress in anesthesia drugs safety, and improvement in anesthesia workstation and monitoring quality, which encompass new technologies such as non-invasive cardiac output measurement, target-controlled infusion, electroencephalogram-derived parameters, and nociception indexes. The modern hypnotic and anti-nociception medications have very short duration of action, and hence have high flexibility of use. Side effects have been reduced, such as with the new antagonist of steroid muscle relaxants. This may let us think that we may need the help of a specialized nurse in anesthesia care in preparing patients for their anesthesia or in monitoring patients during this preparation.

Perfect postoperative pain control is absolutely mandatory in 2012. Help can also be gathered here for a direct bedside pain management according to pre-established protocols, since we are not able to visit all painful patients every day during their hospital stay. We also have to look forward to the long term outcome of our patients, manage transitional pain, and be attentive to the long term consequences of anesthesia. Nurses can be involved in this process.

There is increasing pressure on our shoulders. Work practices change, with increasing emphasis on efficiency. Working time is progressively restricted, safety requirements are more and more severe, tolerance for medical error decreases, patients are reluctant to accept risks associated with being managed by trainees, and the hospital managers insist on cost savings. This has led to a decline in the opportunities for anesthesiologist trainees to learn technical procedures under adequate supervision. Training of anesthetist residents and helping nurses requires increased attention and investment. There are no more places for the “look how the supervisor is doing, see one, and then do one”. We need more time to train our young residents in a safe environment. Other means must also
be used such as simulation manikins or modern computer simulation software in domains encompassing, for example, cardiac echocardiography or airway fibroscopy (1). The appropriate management of infrequent critical incidents has to be prepared, and repeated in a non-clinical environment using new training strategies. Multiple-scenario assessment has been shown to provide a reliable measure of the performance of anesthesia residents in managing simulated intraoperative events (2) and has been demonstrated to be beneficial to the management of critical events (3). Simulation acquired skills must be maintained by repetitive practice (4).

In the aviation, pilots are mainly trained by well advanced simulators and are regularly assessed on their level of competence. These tasks are part of their regular working time. Moreover, there is always a second pilot to help them in case of unusual situation. Our job is even more risky than the one of the aviation pilot, because we deliberately submit patients to the critical event of surgery, and the ‘flight’ often occurs in a body with already several hours of flying time. The anesthesia profession requires continuous education. The new helping anesthetist nurse profession will allow improving the quality of young anesthesiologist training, and investing more time in research and scientific work.

In the present issue, we publish the actual recommendations of the Society of Anesthesia and Resuscitation of Belgium (SARB) and of the Belgian Professional Association of Specialists in Anesthesia and Resuscitation (BPASAR) regarding anesthesia helping nurses. The part of this text devoted to loco-regional anesthesia has been proposed by the Belgian Association for Regional Anesthesia (BARA). English, Dutch, and French versions are provided. The text clearly sets the frame where the above-mentioned associations view the role of such nurses within the anesthetic management of patients. We actually need them, at the present time, to help us saving time and be able to assume full responsibility of the preoperative and postoperative care. The NASAR profession will valorize the anesthesia image, not only from the patient point of view, but also for the other medical specialties and paramedical professions. It will also improve the attractiveness of our profession, facilitating recruitment of promising young doctors. Finally, it will improve the global perioperative quality of care under our responsibility.

References