PRESIDENT'S LETTER

Thank you for inviting me to be your President. When your Chair, Pat Smedley, first suggested it, I was surprised, and, on reflection, flattered and delighted. In a long career in anaesthesia, I have learned to appreciate anaesthetic and recovery nurses as close colleagues, and as members of the anaesthetic team who have essential and complementary skills of their own. They have acted as a source of technical expertise, wise advice, an extra pair of eyes and hands, an early warning system, and occasionally, – when nothing else would help – a large mug of steaming coffee and a friendly face.

Anaesthetic and recovery nurses, like all other members of the anaesthesia team, suffer from the great anaesthetic paradox – the better you are at your job, the less people notice you. If the patient goes through the operation pink, warm, still and stable, and then recovers quietly, without coughing or obstructing, and returns to the ward pain-free and well-hydrated, nobody notices. That is exactly the way it should be. If, however, the whole operation is marred by a patient whose vital parameters are all over the place, in whom the muscle relaxant wears off just as the surgeon is trying to close the abdomen, who spends his time in recovery coughing, going blue and pulling out all the lines and drains – well, they certainly notice us then.

It takes a special kind of personality to take on this role. I would define the primary characteristics as competence, confidence and a rigorous attention to detail. It has been said that anaesthesia, and by extension, recovery, are like flying an aircraft – 90% boredom, 10% terror. I know what they mean, but it is not strictly true. The 90% is not boredom. It is a calm, focused vigilance, aimed at preventing trouble rather than responding to it, and the 10% is not terror (well, most of the time—); it is structured and speedy activity in response to a problem. It takes a special kind of person to be able to go through long periods of alert watchfulness, with little actual activity, and then switch rapidly into acute care mode as soon as the need arises.

The role of anaesthetic and recovery nurses is changing. But then, that is nothing new. When you consider that the first assistants to the anaesthetist were theatre porters without training, whose essential job was to lift (or hold down) patients, and that the first recovery nurses were usually inexperienced student nurses recovering unconscious patients in dark, draughty theatre corridors, we have come a long way. Dr. John Silas Lundy is credited with opening the first post- anaesthesia observation room (recovery room) in 1942 at St. Mary's Hospital, Rochester, Minnesota, nearly 100 years after the introduction of clinical anaesthesia, [Rushman et al 1996]. Who nowadays would be brave or foolhardy enough to embark on an anaesthetic without a skilled and dedicated assistant, or in the absence of a fully staffed and equipped recovery room?

In the August edition of this very Journal, there appeared an article entitled 'New Ways of Working in Anaesthesia.' This reported on a pilot scheme established by the Changing Workforce Programme of the Department of Health to look at different ways of fulfilling the requirement for ever greater numbers of anaesthetic personnel. Other countries have long used non-medically qualified staff to help to deliver anaesthetic services. The intention is to try to learn from their experience, and develop a new type of anaesthetic practitioner, who has a specific set of skills and competencies, and who can contribute to the work of the anaesthesia team in a number of defined ways. Your Chair, Pat Smedley, sits on the Stakeholder Board which is masterminding the whole project, and through her, you should be able to feed in your thoughts and views. They would be most welcome. The anaesthetic practitioner will be a new animal, not a redesigned anaesthetist, anaesthetic, recovery or ICU nurse or an ODP, although the role will contain elements of all of these. It would be nice to get the design right.

I was privileged to attend the BARNA Conference in Hove in June 2003 and was impressed by the standard of the papers, and the commitment and professionalism of all the debates and discussions. Perhaps most interesting to me, in the light of what I have written above, was the open forum on 'The Role of the Non-Physician Anaesthetist'. Many of the views expressed were not what I would have predicted. It was apparent that you have a very strong sense of your own professional identity within the anaesthetic community. This ties in neatly with something Melanie Oakley wrote in her Editorial in the same edition of this Journal (Oakley 2003). 'In the perioperative arena where much of what we do is technical and task-orientated there is still room for nursing'. That is your unique skill. From what I heard in Hove, you are very conscious of it.

That is exactly as it should be.

Anna-Maria Rollin

References

New Ways of Working in Anaesthesia *BJARN* 4[3] 12-14

Oakley M Editorial. Are We Concerned With The Technical And Medical Side of Nursing to the Detriment Of Caring For The Patient? *BJARN* 4[3] 3

Rushman G B Davies N J H and Atkinson R S A [1996] *Short History of Anaesthesia* London: Butterworth Heinemann

https://doi.org/10.1017/S1742645600001091 Published online by Cambridge University Press