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Review

APSAR-BSAR
Professional Association of Belgian Specialists in Anesthesia and Resuscitation
Narrative review

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“Alone you go faster, together you go further.”

Proverb - presumably of African origin

Abstract

Organized professional defense per medical specialty is a recent historical phenomenon, particularly for anesthesiologists, as modern anesthesia only emerged in the mid-19th century. In Belgium, such a corporatist association for anesthesiologists, which stands up to discuss and negotiate matters of training, qualification and working conditions was first founded in 1947 as the APSA (Association Professionnelle des Spécialistes en Anesthésie). This association played a crucial role in the nationwide introduction of structured anesthesia facilities shortly after World War II, before which no specific training, dedicated physicians or professional working conditions existed.

Key words: **Professional association, training, certification, corporatism, reimbursement, working conditions, anesthesia safety.**

Introduction

In 1947, a dozen Belgian anesthesiologists, who regularly met in Brussels, founded APSA, 100 years after Joseph Bosch delivered in a Brussels hospital the first successful ether anesthetic in Belgium[1,2,3]. Later, when the professional title anesthesia-resuscitation was coined, the R was added to the acronym: APSAR (Association Professionnelle Belge des Médecins Spécialistes en Anesthésie-Réanimation) in French and BSAR (Belgische Beroepsvereniging van Artsen-Specialisten in Anesthesie-Reanimatie) in Dutch. APSAR-BSAR transformed into a full-fledged legal entity in 1950 under the Professional Associations Act of 1898 and was amended in 2024 according to recent legislative changes [https://www.apsar-bsar.be/].

Before 1945, there was no nationwide organized, specific training and hardly any dedicated professionals for anesthesia were available[4,5,6]. Subsequently, APSA ab initio had to face 5 major challenges, such as: 1. acquiring equipment, instruments, and medications; 2. demonstrating the superiority of modern (general) anesthesia over the methods then currently in use; 3. acquiring a moral professional status to provide responsible medical anesthesia care; 4. obtaining satisfactory economic conditions; 5. educating and training future specialists.

There are no systematic APSAR-BSAR archives and long-term organized records are actually not available or lost and not every relevant information could be retrieved. Data for this review were therefore collected from the “grab-bag” of the past and perhaps names, details and facts may have been inadvertently omitted or overlooked.

Discussion

Historical background

During the “Ancien Régime”, doctors and barbers/surgeons united in separate guilds and later in *collegia medica* to regularize and organize their

profession[7]. It was not earlier than the 19th century, after the French Revolution and Waterloo, when modern medical corporatism emerged in 1845 at the "Congrès Médical de France - États Généraux de la Profession" in Paris, a turning point in the medical identity, that specialties were developed and the first professional associations in Belgium were founded from 1857 onwards[8]. These groups took the lead in theoretical knowledge, skills, working conditions and the supervision of the certification and recognition of their specialist profession after a university medical degree was obtained. Founded in 1863-64 and dissolved in 1964, the FMB (Fédération Médicale Belge) was the first national medical federation bringing together professional associations of both general practitioners and specialists[9]. Recent specialties, such as anesthesia, founded their own professional associations in the 20th century.

The early years of APSA

Among the APSA founders were the academics Henri Reinhold (ULB), who most likely took the lead, Marcel Hanquet (ULg), William De Weerdt (UCL), and Jan Van De Walle (KUL). They all trained in the UK, that was advanced in anesthesia practice, even housing as early as 1937 the first European academic chair at Oxford with Sir Robert R. Macintosh, Nuffield Professor of Anesthesia.

Reinhold, after practicing anesthesia in the British Army during World War II and attending the Battle of Normandy, completed his training after the war at Hammerschmidt and started his career in Brussels. Van de Walle and De Weerdt both trained in Oxford and, between 1947 and 1953, established the first anesthesia departments and training programs at the Catholic University of Leuven, initially as separate surgery sections and later as independent departments[10,11,12].

The introduction in 1944 of the social security system necessitated in 1949 the impetus of a fundamental reform of the medical profession[13]. APSA and other health-care stakeholders joined the government's initiative to officially recognize the qualifications of medical specialists. The aim was to ensure fair reimbursements, with a clear distinction between general practitioners and recognized specialists. Before this reform, since 1944, anesthetists could only charge a rate equal to 10% of that of surgeons. Not until 1951, the National Health Insurance, predecessor of the RIZIV-INAMI (National Institute for Health and Disability Insurance), completed this in 1949 announced nomenclature review. From then onward, anesthesia fees increased to 30% of the surgeon's fee. This cutoff percentage was established when simultaneous anesthesia was common and anesthesiologists treated multiple patients while surgeons performed only one case at a time. The basic idea, however, was fair proportionality, a principle that still applies, assuming that the complexity, risk and duration of both anesthesia and surgery are closely intertwined and intersected[14]. More complex procedures and longer operating times are directly related to the risks and the time required for anesthesia.

Modus operandi

From its founding to the present, APSAR-BSAR sought common ground with third parties and allies to defend its interests and achieve its goals. Because you don't get what you deserve, but what you negotiate (C.L. Karrass), partnerships and coalitions were forged through official and other positions in representative Belgian and European medical organizations, meetings, working groups, and committees, according to the famous Belgian concertation democracy[15]. After the 1964 doctors' strike against the Leburton Act and the subsequent founding of the RIZIV-INAMI, only the syndical unions, because they represent all physicians, were accepted as the sole legal and representative negotiators regarding the nomenclature (= all fee codes)[5,13]. These unions have been loyal allies in a number of APSAR-BSAR ambitions thus far.

The founding in 1964 of the scientific society SBAR (Société Belge d' Anesthésie et Réanimation), now BeSARPP, was welcomed, and APSAR-BSAR has always pursuit a mutual and complementary, yet still variable, collaboration to achieve common goals. Unsuccessful attempts were made to amalgamate or establish a collegium, such as the CIA (*consortium inter anaesthesiologi*) in the 1990s and also later in 2017[17]. Nevertheless, liaisons from both organizations are mutually and permanently invited to board meetings since the 1990s. Joint actions include publishing position papers or national conferences and accompanying surveys, such as the poll in 2004 on which support aids we need in the operating room[18-22]. Furthermore, APSAR-BSAR was never reluctant to conduct its own surveys or opinion polls to support its policies, even at the risk of criticism if the answers were biased, inconvenient, or misleading[23,24].

During the first quarter century of the 21st century, new or modified reimbursement codes have been acquired, including patient-controlled analgesia, monitored anesthesia care for ophthalmological procedures, chronic pain, preoperative consultations, and so on. Professional defense is a never-ending story with constantly changing goals to be pursued and maintained

once achieved. Best symbolized by the Sisyphus myth: once your stone reaches the top of the hill, it rolls down, and you must start over, facing new times and challenges. Resolved problems also may return in different forms requiring renewed attention, known as the "political Hydra", like the mythical monster. For example, by the end of the 20th century, the RIZIV-INAMI codes for reimbursement of anesthesia for non-anesthetists could be completely abolished. However, a new struggle is currently going on to re-legalize anesthesia and deep sedation for people who are less or not qualified[25].

In 2017, during a "States General" meeting, APSAR-BSAR protested against the introduction of a global fixed budget for low-variability care, including anesthesia fees[26-28]. The system was never fully implemented and the current hospital financing reform uses a different approach.

Finally, as activists in the collective interest, APSAR-BSAR does not hesitate to start legal proceedings in cases of non-medical anesthesia (private clinics), violation of the safety guidelines or other irregularities[29]. General advice on professional misconduct or legal matters can be obtained from APSAR-BSAR at any time, and board members are available to participate in audits if required.

Training, recognition and board certification

The growing dissatisfaction among specialists with the FMB since 1949 led to the founding of the GBS-VBS (Group of Belgian Professional Associations of Specialists) in 1954, with APSAR-BSAR as a prominent founding member[9,13,30]. The primary and main objective of the founding professional associations in establishing this empowered GBS-VBS structure was to obtain a legal title and a specific training program for specialists. At that time, the only available recognition of medical specialists was based on a joint-venture between the Order of Physicians and the existing professional associations. It was therefore a historic achievement that the GBS-VBS, due to its authority as an umbrella organization, managed to secure the publication in 1956 of a Royal Decree by Léon-Eli Troclet, Minister of Public Health, which resulted in the establishment of committees for the legal recognition of specialists in 1957[9,13]. From then on, the national anesthesia board consisted of eight members, nominated exclusively by APSAR-BSAR and appointed by the Minister for renewable terms of five years. Decisions were made by simple majority and had only to be communicated to the Minister for official publishing. The technical and professional criteria included a medical degree and completion of a well-defined internship. Applicants were also assessed on their loyalty and adherence to the statutes of their professional association, but were excluded when sanctioned by the Order of Physicians. A decade and a half later, the Royal Decree of October 1971 issued new conditions for the board certification of medical specialists[13]. The recognition committees were retained, but their composition and legal responsibilities significantly changed. Firstly, the committees henceforth consisted of a Dutch-speaking and a French-speaking chamber, each with a parity of professional and academic delegates, appointed by the professional association and the universities respectively. Secondly, they were only allowed to provide advice on the recognition criteria for medical specialties at the express request of the newly established HCMS (High Council for Medical Specialists). The professional association's monopoly on recognition and criteria development was replaced by a reshuffling of the tasks. From then on, the duties of the recognition committees also included the approval of internship plans and the setting of standards to recognize internship supervisors and services. With the 6th state reform from 2012 to 2014, the recognition committees were transferred to the French and Flemish Communities respectively, while the authority and tasks of the HCMS still remain federal matters. Unfortunately, the current recognition criteria for anesthesiology, approved by the HCMS, dates already from 1979[31]. Further to earlier bilateral agreements in 1992, the criteria were once more revised and adapted again by both the Dutch-speaking and French-speaking committees. Although an agreement was reached at a meeting organized by the HCMS in late 2016, these amended criteria are still awaiting publication by Ministerial Decree[32]. Furthermore, as anesthesiologists pioneered in the fields of intensive care, emergency medicine, and algology, APSAR-BSAR aims to provide sufficient experience during the basic training so that residents are still eligible for additional professional qualifications afterwards.

Safety First

In the 1980s, Edouard Dumoulin, then president of APSAR-BSAR, organized conferences in Mons to discuss current patient safety issues, such as the one-table concept and the added value of new monitoring technologies and anesthesia equipment. These Mons conferences were quickly embraced by the academic allies in these issues and resulted in the publication of the "Belgian Standards for Patient Safety in Anesthesia" in 1989 by the Belgian steering committee for patient safety in

anesthesia[33]. Considered among the most stringent in the European Community, these standards allowed APSAR-BSAR and other stakeholders, to achieve a global increase of 10% on all anesthesia codes reimbursed by the RIZIV-INAMI[34]. Subsequently, in a joint-venture with BeSARPP, these guidelines were repeatedly revised and updated to ensure full compliance with the current safety requirements and recent Belgian Quality Act[35-37]. As a consequence of the 6th state reform, the Flemish Community was able to unilaterally introduce a supplementary "Framework of Requirements for Operating Rooms" between 2012 and 2014, with specific additional rules that applied exclusively to anesthesiologists within the Flemish Community[38]. APSAR-BSAR contested this at the highest Flemish political level, with a plea to accept the Belgian guidelines as the sole standard[39].

Pre-ops

In 1997, at a joined meeting in Namur, organized by APSAR-BSAR in collaboration with the former SBAR (BeSARPP), the Belgian preoperative guidelines were approved[40]. After years of lobbying and due diplomacy against all odds, the reimbursement of a preoperative consultation by the RIZIV-INAMI was rewarded in 2004[41,42]. Unfortunately, for budgetary reasons, this reimbursement was only valid for day clinic cases. The reasoning was that preoperative rounds, the eve before surgery, are included in the anesthesia fee for procedures requiring hospitalization. Current efficiency-oriented care pathways for hospitalized patients no longer require the intake of every patient the day before the procedure. Therefore, although traditional preoperative rounds still have an added value, they are no longer feasible for all cases. As a logical consequence, an agreement was obtained in 2020 to reimburse a non-mandatory preoperative consultation, which is available to every patient on a voluntary basis[44].

UEMS and European Board of Anesthesiology

The UEMS (European Union of Medical Specialists), founded in 1958, aims to harmonize the training of medical specialists across Europe to ensure high quality through consistent education and training standards [https://eaccme.uems.eu/]. Therefore, ETRs (European Training Requirements) were developed and each specialty within the UEMS has its own curriculum, eligibility criteria, examination content and rules. APSAR-BSAR is authorized to appoint two delegates to the EBA (European Board of Anesthesiology), an UEMS section since 1962 that primarily deals with anesthesia and resuscitation, but also with intensive care, emergency care and pain management[45,46]. The inclusion of the three "subdisciplines" could only be achieved through joint efforts, in which the Belgian delegates played a prominent role[47,48].

Permanent education and accreditation

Following a 1993 directive from the European Academy for Continuing Education, Belgium was the first country to introduce a non-mandatory accreditation system for physicians, linked to a financial incentive, supervised and sponsored by the RIZIV-INAMI[49]. Despite initial skepticism, the first Accreditation Committee for Anesthesia with a parity of professional and academic delegates was established in 1994 under the leadership of APSAR-BSAR and the auspices of the RIZIV-INAMI. The committee approves continuing education activities and awards credit points for them. Around the same time, initiated by Paul Lust, APSAR-BSAR started to combine its annual general assembly with a congress that focuses on current and specific concerns of the profession.

Training quota

In 1997, after long-term ad hoc negotiations on restricting access to medical professions (numerus fixus), the entrance examination for students was introduced[50]. Part of the agreement was that from 2015 planning committees began to regulate and limit the number of training positions, or "tickets", per specialty for future cohorts of newly graduated physicians. These licenses are awarded exclusively at the discretion of the medical faculties, in combination with a compulsory master's-after-master's program, according to the European Bologna Agreements of 1999. Unfortunately, the license-to-practice quota only apply to Belgian citizens and not to applicants from abroad. Such issues may impact the overall quality of care and are scrutinized by APSAR-BSAR.

Current issues and policies anno 2026

Due to conflicting interests, the collaboration with GBS/VBS, which recently transformed into FMS (Federation of Medical Specialists), has been suspended since 2025[51-53]. The on-going hospital and nomenclature reform, started in 2019, requires a lot of debate and advocacy in many concertation bodies at different levels, with some rivalry between disciplines[54]. The reform aims to split the honorarium into a cost and a professional component. The latter is based on the Harvard RBRVS (Resource-based-relative-values-scales), widely considered a tool to reimburse physicians[55]. Current officials use a somewhat reduced version of this RBRVS by focusing mainly on three items:

duration, risk and complexity of a performance. APSAR-BSAR entered the negotiations arguing that the link with surgical reimbursements must be maintained as one of the most reliable, objective, and unbiased determinants of anesthesia fees, regardless of other viewpoints[56]. Furthermore, the APSAR-BSAR proposal states that anesthesia fees should sometimes be equal to or higher than those of the surgeon, as specific coefficients based on age, pregnancy and comorbidities may also be included. Fees are discussed for those on duty who, driven by due diligence and the need for careful care, voluntarily stay day and night when their immediate presence on-site is required for urgencies[57,58]. This applies in particular to hospitals with maternity wards, stroke units, trauma and cardiothoracic centers. Among other current actions, APSAR-BSAR advocates for standardized labeling of anesthetics and emergency medicines, because the lack thereof represents a persistent safety risk, despite previous warnings[59].

Conclusion

Anesthesia can be considered one of the greatest inventions since the printing press and is undoubtedly an indirect gift to humanity, as modern surgery in all its forms would be impossible without it[60]. Therefore, mankind deserves that compassionate anesthesiologists and their professional working conditions guarantee the highest possible quality and safety of care[61]. Attempting to acquire this Holy Grail should be an everlasting duty.

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Although only a few names are mentioned in the text or the references, many more deserving colleagues have contributed or still contribute to the activities or functioning of the professional association and dedicate(d) their free time to it. May this narrative be a tribute to them all, some of whom are sadly even forgotten during nearly eight decades of APSAR-BSAR. After all, success has many parents (Tacitus).

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