

The name of our specialty — with a historical perspective on “intensive care”

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A letter dated 8 September 2008 sent to fellows of the Joint Faculty of Intensive Care Medicine (JFICM) by our Dean, together with the Presidents of the Australian and New Zealand College of Anaesthetists (ANZCA) and the Royal Australasian College of Physicians (RACP), advises that agreement has been reached on the process for the formation of an independent College. It would be called the College of Intensive Care Medicine of Australia and New Zealand, abbreviated to the somewhat unwieldy CICM(ANZ), and would take over all the functions of the JFICM. This will be among the many changes for the new College. In focusing on the “Intensive Care Medicine” part of its name, I would like to examine some thoughts on whether this is the most suitable title for our specialty.

There is also the specialty’s workplace to note, which currently can be abbreviated to an ICU (or a DIC or DICM), or an ITU, or a DCCM (or a CCU). After Bjørn Ibsen’s formal unit was established in 1953 in Europe for the treatment of adults,¹ the original units in Australasia providing what is now usually referred to as intensive care (medicine) started as organisations that were general or multidisciplinary. In the United States, a unit that was dedicated and truly multidisciplinary is also documented, again in 1953.² Following on such units, offshoots of specialisation developed: major ones, such as medical, surgical and paediatric; or others more closely focused, such as neonatal, trauma, cardiovascular, neurosurgical, neurological, burns and transplant units.

Background to nomenclature

Following the foundation of intensive care medicine, arising out of the 1952–53 Copenhagen polio epidemic, Ibsen called his world-first, 1953 unit,¹ the *anaesthesiologic observation unit*, whose title he had changed by 1966 (if not before) to *intensive therapy unit* (ITU).³ (In that year, 1966, I was impressed by the advanced development of quality ICUs I visited throughout Scandinavia and Finland.) The development of ICUs in the US seems to have resulted from nursing care needed and provided in Special Nursing areas for the critically ill,^{4(p.82)} with support from medical colleagues. These areas were not initially heralded as “ICUs”; but with further formalising, they were eventually renamed Intensive Care Units. Harbingers of IC nursing included: Recovery Rooms, Special Care Rooms or Units,

Polio Units, and especially in Britain *Respiratory [Care] Units*, or similar, all providing “nursing care, triage and vigilance in the care of critically ill patients”.^{4(p.82)} Semantics are adroitly discussed by Julie Fairman^{4(p.82-3)} (also see Appendix, A). Papers from 1960 and before, comprehensively listed in a US Public Health Service publication,⁵ emphasise the nursing benefits of concentrating the sickest patients in the early ICUs.

The first(?) mention of “intensive care” itself was apparently the 1955–59 print edition of the American Hospital Association’s *Cumulative index of hospital literature*⁶ (see Footnote 1). It has been stated^{4(p.83)} that “Intensive care did not receive an independent heading until the 1955–59 *Index medicus* issue” (see Footnote 2). But “Intensive Care” could not be found as a separate heading in the print volumes of *Cumulated index medicus* until 1966, with 178 entries in that year’s volume 7 (issue 2, D–M, page S2076), and then only by the subject heading “Intensive Care Units”. Medline’s date notation for ICUs of “66(63)” indicates that from 1963 onwards, ICUs could be found through “see under” directions to another broader subject heading (providing in 1963, five titles; in 1964, 34; in 1965, 87). Today, Medline will find titles for the subject heading “Intensive Care Units” back to 1963.

At the Hospital of the University of Pennsylvania there was “An Intensive Care Unit” named as such from 1955 (February, likely).⁷ And perhaps surprisingly, it was as early as 1956 that the term “*Critical Care Unit*” was documented,⁸ such a title being an understandable description

Footnote 1. *Dr RR Cadmus (1914–1995) reminisced⁶ that his “original article² posed a problem for the American Hospital Association’s Cumulative Index of Hospital Literature; in the 1950–54 volume, it was listed under ‘Recovery Room’. Because the heading of ‘Intensive Care’ did not appear until the 1955–59 issue, many researchers never found our breakthrough article or the few others that followed and were forced to rediscover the wheel”!*

“In the 1955–59 issue the listing for ‘Intensive Care’ still referred the reader to ‘Progressive Care’ and ‘Recovery Room’. Nevertheless, in that volume, there was one such reference in 1955. In 1956, there were 6; in 1957, 3; in 1958, 19; and in 1959, 11. After this meager start the number skyrocketed”.

Footnote 2. *The Index referred to may have been the Cumulative index of hospital literature (produced by the American Hospital Association), as also indicated in Footnote 1, and not the Cumulated index medicus (produced by the US National Library of Medicine and usually just called Index medicus). They are different (see the chart at <<http://www.nlm.nih.gov/services/indexmedicus.html>>).*

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of the care provided for critically ill patients. In 1970 came inauguration of a Society of *Critical Care Medicine* (SCCM) in Los Angeles, with its journal *Critical Care Medicine* following 3 years later; while here, also in 1973, the Australian Society of Anaesthetists, so supportive locally to intensive care, introduced a new journal, *Anaesthesia and Intensive Care*. Victoria's (Australian) Society of *Critical Care Medicine* (SCCM, becoming ASCCM) started in November 1974. Following on developments and negotiations, principally in New South Wales and New Zealand, and after the June 1974 First World Congress of Intensive Care in London, our society, the Australian and New Zealand *Intensive Care Society* (ANZICS), was inaugurated in 1975; while launched in the same year was a *Section of Intensive Care* of the Royal Australasian College of Surgeons (RACS), within its Faculty of Anaesthetists. The RACP's *Specialist Advisory Committee in Intensive Care* (SAC-IC) was formed in 1977, with an inaugural meeting on 13 November (but note, without intensive care having subspecialty recognition). The year 1978 saw the intensive care and critical care titles combined in that of the World Federation of Societies of Critical and Intensive Care Medicine. A year later, the world's first examination in intensive care was held by the Faculty of Anaesthetists, RACS, enabling the FFARACS diploma to feature a "Certificate of Endorsement of Fellowship ... in: Intensive Care". Australia's National Specialist Qualification Advisory Committee recognised "intensive care" as a subspecialty of either anaesthesia or internal medicine in 1980. In New Zealand, intensive care stayed a subspecialty of anaesthesia or medicine until October 1999, when the Medical Council of New Zealand recognised its status as an independent specialty named *Intensive Care Medicine*. The Scandinavian Society of Anaesthesiologists has now added "and Intensive Care Medicine" to its name, and so from 1 January 2000 is the nicely succinct SSAl. (With regret, I am unable to extend this essay to Europe at large and other continents.)

These days, practitioners of both intensive care medicine and critical care medicine can all be called "intensivists", but not some descriptive word derived from critical care medicine (criticalists!?). But I have not noticed or been able to trace use of "intensivist" further back than Peter Safar's 1965 use, possibly the first.⁹

Obviously then, both the terms "intensive care" and "critical care," each with or without "medicine" attached, have been associated for most of our specialty's history, now of over a half century. Units in the US are called either ICUs or CCUs; but in the United Kingdom the term ITU, for an Intensive Therapy Unit, has also been favoured. In Australasia, the specialty's title was under consideration on two later occasions: in 1993 when the Faculty of Intensive Care (FIC), ANZCA, was established, and in 2002 when the

JFICM was. Thus in our region, to date we have a Society that is Intensive Care, we have had two successive Faculties of Intensive Care, and we have a noble journal that is *Critical Care (and Resuscitation)*. Now "CICM(ANZ)" is mooted.

Intensive care, ICUs and intensive care medicine

The terms intensive care, ICU and intensive care medicine are widespread, familiar, and well understood publicly. In articles from the later 1950s, I have not been able to trace use of the term intensive care back earlier than 1955⁷ (but see Appendix, A). Although "intensive care" was long used free-standing as an expression, the addition of "medicine" converted it from "what the nurses do" (as I was so used to hearing the term described by my former chief, Matt Spence) into a medical pursuit, ICM (or, as the same chief preferred for his unit, Critical Care Medicine [CCM]). In the late 1990s, when working towards specialty recognition for ICM/CCM in New Zealand, I was so determined to have the "medical" tag registered with it, I overlooked aiming for the other laudable objective (so it now appears, at least to me) of exchanging "intensive care" for, say, "intensive therapy" — which was, again as I saw it, what doctors actually did or prescribed.

In my last years on the FIC Board, at the approaching conversion of FICANZCA into a Joint Faculty, I was again concerned that the title of the new Faculty should incorporate the word medicine (it was for intensive care medicine, not for intensive care, that we had recently sought and obtained specialty recognition in New Zealand, in 1999). But the opportunity for floating the question — should we move away from the term intensive care and to intensive therapy (IT), say, instead — was allowed to escape. ICU has been a readily used abbreviation, with popular usage in Australasia. My attempt to count the various titles favoured among the hundreds of our ICUs was soon abandoned, with the realisation that most were called Intensive Care Units, some Departments of Intensive Care. In the US, I note "ICU" can be spoken of for places that are formally Critical Care (Medicine) Units. And it is strange to hear "ICU" when people often mean IC[M], the specialty.

Critical care medicine and CCUs

It is too easy to regard critical care medicine as an American term, although Peter Safar¹⁰ (generally regarded by US practitioners as their first full-time intensivist) and others¹¹ ran a named "ICU" before the term CCM became popular there (also see Appendix, B). Once "CCM" achieved officialdom's recognition as a legitimate descrip-

tion it has been taken as synonymous with ICM. In Auckland, we who knew Matt Spence's aversion to the terms IC or ICU (although he was not above using it in his epochal 1967 paper¹² — it is not surprising what humble pie can be eaten to achieve publication) found we had "Department of Critical Care" (DCC), suddenly dumped on us one morning in 1972. I surmised that he preferred DCC to CCU, lest calling the unit by the latter term caused confusion (so unacceptably!) with a Coronary Care Unit. On his retirement in 1983, I secured consensus for Medicine to be added to our unit's title, now making DCCM. And I note occasional DCCMs in Australia.

The difficulty I see for Australia with the term "critical care" is that it has been taken over there for a wider, enveloping role, being adopted particularly by official health services to cover many emergency or acute branches of care. So throughout Australia, the phrase critical care does not represent solely "our own" CCM, for which reason it does not seem to me at all the best title for Australian units.

Intensive therapy and ITUs

I have seen IT translated as Intensive Treatment but perhaps *therapy* indicates a wider spectrum than does *treatment*. This was my personal preference back in the 1970s and, unlike the US term CCM, it was popular in the UK. To generalise (always dangerous), despite having close Commonwealth ties, New Zealand's ICM has looked more to North America than the UK, principally because of American research and SCCM conferences (but times are changing and, especially in the past few decades, links with Europe have become stronger). The expression IT is not unknown in New Zealand, where Waikato and Nelson Hospitals have ITUs, as does Sydney's Royal North Shore and other Australian hospitals (though I puzzle that doctors from the same unit may not give exact word-matching addresses to their papers). To me this title warrants considering.

Does IT need its own M to make ITM? I doubted that, until it was pointed out that, recognising what IT stands for in today's IT world, we cannot leave IT to stand alone, and would have to make it ITM or ITU. But the word Therapy is an honourable one — think radiotherapy, chemotherapy, physiotherapy, etc (if not aromatherapy).

Historically, the expression "Intensive Therapy Unit" is longstanding, being used by, among others, surgeon Max Sadove et al repeatedly in their 1954 paper,¹³ which foresaw extension of the functions of an elaborately upgraded Recovery Room (University of Illinois Hospitals, Chicago) to include treating all "major critical patients", such as those with coma, shock or poisoning, and resuscitation emergencies.

Conclusions

The time is short for Australasian intensivists to consider whether they are content that their specialty's formal title should include Intensive Care, and whether that should be part of a new College's name. It is now or never, before all the headed paper, door notices and so on are printed or tacked up.

- There are arguments that the meaning of "Critical Care" widened in Australia to the extent that it no longer equates selectively with ICM.
- The older expression Intensive Therapy can be at least considered as an attractive alternative to ICM.
- Polling of fellows could be a way to determine the best solution, should the Dean and Board consider that warranted.
- Possible effects from our sounding too differently from intensivists and their units in other countries are not known.
- A final point: when officialdom lists the medical specialties of our two countries, one starting with A, as in ANZ, would be closer to the top of the list, with some fringe advantages, than one starting with C, as in CICM(ANZ).

Postscript

This essay was written (in haste) and accepted before a second letter from our Dean asked for opinions about nominals and the name for a new College.

I have commented to the Editor of the Journal that hard-working intensivists do not seem to have time to write letters of disputation to him. Perhaps this *Point of View* may set me up as a straw man.

With all I have written here, I shrink from commenting on "CICM" which, for some, could sound like a "sic 'em" direction to a dog.

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Appendix

A. Some other early intensive care units

Retrospective claims for special rooms with one or two beds being a first or early ICU can be met with. But I am unsure what can be made of the claim on-line at <<http://www.answers.com/topic/pennsylvania-hospital>> that:

"In 1950 Pennsylvania Hospital was recognised for becoming more highly specialised as it established, in addition to its sophisticated maternity programs, an intensive care unit for neurological patients, a coronary care unit"

Nursing and intensive care historian Julie Fairman⁴[p.82-3] states:

"Reports of the innovative reorganisation of the care of the critically ill began to appear in hospital journals in late 1954, when Robert Cadmus reported on the pediatric unit opened in 1953 at the North Carolina Memorial Hospital, Chapel Hill, North Carolina."

[I have not detected "pediatric" in two papers by Cadmus, but he does write of (open) admission irrespective of age, and of the unit being "not satisfactory for neonatal or burn care, so separate units were created".]

*And: "Manchester Memorial Hospital, Manchester, Connecticut, also opened an intensive care unit in 1953 [no further elaboration is given], as did other hospitals, but their accounts were not as publicly heralded. The early reports were somewhat hidden, appearing in the *Index medicus* under the heading "recovery room" — probably because some of the earlier units were called "recovery areas" (eg, "critical recovery unit")."⁴[p.82-3]*

In comment, I would find it interesting to be able to compare the advances in interventions in such US units with, for instance, those contemporaneously in Bjørn Ibsen's unit: how much those in the US were beyond the nursing triad of "nursing care, triage and vigilance in the care of critically ill patients", and towards medical reliance "heavily on machines and advanced therapeutics".⁴[p.81, FN4]

B. Some other early (pioneering cardiothoracic) intensivists

Despite there being substantial accord for Peter Safar as the US pioneering adult intensivist with a multidisciplinary ICU, Julie Fairman directs our attention to Robert Cadmus,² pioneering hospital director. The following claims can also be seen on-line:

Dr Dwight Emary Harken (1910–1993)

Multiple (unauthoritative) information sites claim that the intensive care unit opened by this cardiovascular surgical pioneer at Peter Bent Brigham hospital, Boston, in 1951 was the world's first. Although I saw that as a definite statement on the hospital website itself a couple of years ago, it now appears withdrawn. Harken's obituary in the New York Times, 29 August 1992, proclaimed "he opened the world's first intensive care unit in 1951 at Brigham". The renowned Denton Cooley echoed this, in the Texan Heart Institute Journal, 1993, with "he [Harken] and a nurse colleague [Edith Heideman] established the world's first intensive care unit at Peter Bent Brigham Hospital" for cardiovascular post-operative care. I have not determined the level of ICM required or supplied.

Dr William Mosenthal (died 26 November 2003, aged 87)

The Dartmouth Medicine home page states concerning "The concept of grouping a hospital's sickest patients in one place and concentrating nursing resources there ... that obvious idea eluded everyone until 1955. Before then, acute and nonacute patients would be sprinkled randomly through a hospital's wards. The Dartmouth surgeon William Mosenthal, MD, established the first intensive-care unit in the nation".