Symposium on Critical Care

Editorial Views

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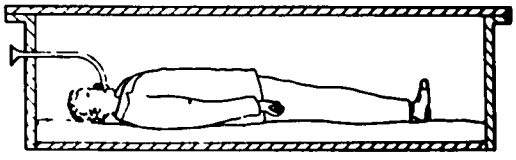
Critical Care, Critical Times



Artificial ventilation as proposed by William Davenport of London in 1905. His patent mentions a box, rubber collar, and a simple bellows or piston pump. Reprinted from Emerson JH: Evolution of "Iron Lungs." Crit Care Med 5:124, 1977.

It is little more than a quarter of a century since the establishment of a small neurosurgical intensive care unit at the Johns Hopkins Hospital.[1] Development of the concept of intensive care was accelerated with the advent of World War II, and the presence of one or more ICU's is now considered normal in the major medical center and community hospital alike.

The anesthesiologist stands in a unique relationship to critical care medicine, since daily practice in the operating and recovery rooms confronts the specialty with so many of the problems presented in this Symposium issue. It is not surprising, then, that numbers of our profession have extended themselves beyond (or even abandoned) the traditional environs of the operating room, a practice not meeting with universal enthusiasm.[2] Although the future relationship of anesthesiology and critical care medicine cannot be predicted with certainty, the major developments in the latter discipline make it highly appropriate to devote an issue of the Journal to this important field.

The Symposium may be divided conveniently into four sections. The first develops one of several possible approaches to education and organization in critical care medicine. In the second, several authors present the subject from the perspective of specific organ failure, while the third explores areas of major importance common to all patients requiring intensive care.

We live today in a society which is becoming increasingly concerned, articulate, and even demanding: has technology replaced compassion; how are our resources to be disbursed; on what basis (if any) are priorities to be established and who is to set these goals? It is increasingly apparent that the intensivist must consider seriously the psychiatric implications inherent in the intensive care environment.[3,4] For these reasons, the last section of this issue examines some of the questions from the point of view of the intensivist, philosopher, and patient. It is not unlikely that the thoughts expressed in this final section will underlie future developments not only in critical care but in all areas of medicine.

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