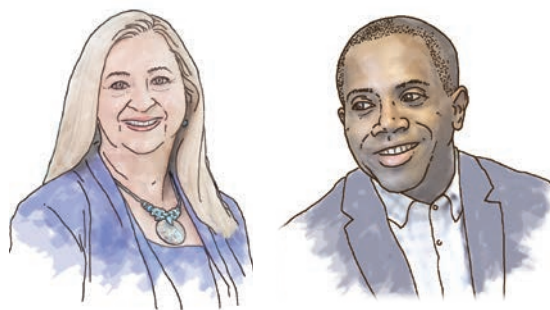


# Editorial

## AACN'S 50TH ANNIVERSARY: BUILDING ON OUR PAST TO ENSURE A BRIGHT FUTURE

By Cindy L. Munro, PhD, RN, ANP, and Aluko A. Hope, MD, MSCE



In 1969, the American Association of Cardiovascular Nurses (AACN) was formed, and 2 years later the name was changed to American Association of Critical-Care Nurses, reflecting a broadened focus on specialty nursing care for the very sickest patients no matter their underlying disease.<sup>1</sup> A recent *Bold Voices* interview with Penny Vaughan, the first secretary of AACN, highlights her experiences in the formation of AACN and its early days. Ms Vaughan reflected,

“the greatest need the nurses had was to learn, and to learn more, and it was both how to manage these patients, but it also was this evolving new role for nurses . . . we had to learn to manage technology, new drug therapy, and every day it was something new.”<sup>2</sup>

Although AACN emerged from nurses working with coronary care patients in specialized settings, there were other influences on the growth of critical care as well. Two important factors shaped the development of intensive care units: watchful vigilance by nurses, and architectural or environmental factors. The watchful vigilance that is a foundation of critical care is evident in the work of Florence Nightingale<sup>3</sup> and Louisa May Alcott,<sup>4</sup> but as treatments for hospitalized

patients became more complex, care was increasingly shifted to specialty units that evolved into intensive care units. Post-World War II architectural and environmental influences in hospitals contributed to the rise of critical care nursing as well. In the 1940s and 1950s, the sickest patients on a general ward were often located closest to the nurses' station, permitting more intensive observation of and individualized attention to the most vulnerable patients. This in itself was not an innovation—nurses had grouped patients by acuity since the 19th century<sup>4</sup>—but hospitals began to establish specialized units for these very ill patients with lower nurse to patient ratios than the general hospital, which enhanced watchful vigilance.

Polio epidemics in the 1950s led to large numbers of patients with respiratory paralysis and provided proof of concept of the power of grouping together those patients with life-threatening illness and engaging nurses' watchful vigilance.<sup>5</sup> Throughout Europe and the United States, many polio patients were able to survive through positive-pressure mechanical ventilation delivered via an “iron lung” under the supervision of expert nurses. In 1952, in the midst of a polio outbreak in Copenhagen, Denmark, “Dr Bjorn Ibsen had the idea of caring for all such patients in a dedicated ward, where each patient could have their own nurse. Thus, in December 1953, the specialty of intensive care was born.”<sup>5</sup>

©2019 American Association of Critical-Care Nurses  
doi:<https://doi.org/10.4037/ajcc2019974>

Downloaded from <http://ajcconline.org/ajcconline/article-pdf/28/3/166/1187131/166.pdf> by guest on 19 April 2024

“ At its core, critical care nursing has always been about pushing the envelope and the health care system—as well as ourselves and our colleagues—to meet the needs of the patients entrusted to our care and their families. ”

This convergence of watchful vigilance by skilled nurses and environmental design that concentrated critically ill patients defined specialty care in mechanical ventilation and coronary care that evolved into our modern conception of critical care. When AACN was founded in 1969, available technology was relatively primitive. What was most innovative about these new intensive care spaces was the expert nurses who actively sought knowledge about how to improve care for patients with high acuity, and the active collaboration between nurses, physicians, and other professionals in designing and providing specialized care.

On the early frontiers of critical care, previous nursing knowledge was insufficient to meet the emerging needs of high-acuity patients or to competently manage the new technological environment of care. Knowledge for critical care had to be created. As intensive care units developed, “Nurses actively chose to seek out the knowledge they needed to care for patients. . . . Their choice to seek out knowledge was historically significant.”<sup>4</sup> Seeking out new knowledge for care elevated the status of nurses and transformed the care they provided.

This active engagement with learning, and learning more, was evident in AACN’s founding, its history, and its aspirations for the future. Within 5 years of its founding, AACN offered the first annual National Teaching Institute and Critical Care Exposition (NTI),<sup>1</sup> which continues to be the premier critical care nursing conference. AACN subsequently launched 3 journals dedicated to expanding knowledge for critical care practice: *Critical Care Nurse* in 1980, *Advanced Critical Care* in 1989, and *American Journal of Critical Care* in 1992. AACN developed a series of specialty certifications (CCRN and others) to encourage and validate critical care nurses’ life-long commitment to excellence in applying knowledge to practice.

Early intensive care unit structures were fertile grounds for the development of interdisciplinary

teams. Complexity of care, nurses’ possession of a unique and emerging knowledge base, and physical proximity of nurses, physicians, and other health care professionals during long shifts in the intensive care unit facilitated mutual respect and camaraderie.<sup>6</sup> The intensive care unit environment provided an opportunity for physicians to gain a better understanding of nursing care, nursing capabilities, and nursing’s ability to positively affect patient outcomes. Hierarchies of power between nursing and medicine were less well established and sometimes more malleable in the new environment of the intensive care unit. Expanded roles evolved for critical care nurses in patient assessment, use of standing orders and protocols, and independent performance of procedural and technical activities previously reserved for physicians (eg, arrhythmia monitoring, drug titration, and insertion of invasive catheters). These expanded roles for critical care nurses fit well with other trends in health care, including the start of the first nurse practitioner program in 1965<sup>7</sup> and the endorsement of physician assistants by the American Medical Association in 1969.<sup>8</sup>

Critical care nursing today is built on the foundation that was laid by the founders of AACN. Today’s intensive care unit may seem very different, with more complicated technology, more complex treatments, and increasing patient acuity compared with 1969. However, early critical care nurses successfully dealt with the very similar challenge of incorporating cutting-edge technology and new knowledge into caring for the sickest patients of their time. At its core, critical care nursing has always been about pushing the envelope and the health care system—as well as ourselves and our colleagues—to meet the needs of the patients entrusted to our care and their families. Watchful vigilance, teamwork, and a patient-centered approach are the heart of nursing; that was true in 1969, and it remains true.

We are proud of the role that the *American Journal of Critical Care* plays in equipping nurses with new interdisciplinary knowledge to guide evidence-based practice. Standing on the shoulders of the AACN founders, we look forward to what the next 50 years will bring to the advancement of critical care.

The statements and opinions contained in this editorial are solely those of the coeditors in chief.

#### About the Authors

**Cindy L. Munro** is coeditor in chief of the *American Journal of Critical Care*. She is dean and professor, School of Nursing and Health Studies, University of Miami, Coral Gables, Florida. **Aluko A. Hope** is coeditor in chief of the *American Journal of Critical Care*. He is an associate professor at Albert Einstein College of Medicine and an intensivist and assistant bioethics consultant at Montefiore Medical Center, both in New York City.

## FINANCIAL DISCLOSURES

None reported.

## REFERENCES

1. AACN. Complete history of AACN. <https://www.aacn.org/About%20AACN/Complete%20History%20AACN>. Accessed February 14, 2019.
2. Out of the Shoebox: the birth of AACN, an interview with Penny Vaughan. *AACN Bold Voices*. 2019;11(1):12-13.
3. Munro CL. The "lady with the lamp" illuminates critical care today. *Am J Crit Care*. 2010;19(4):315-317.
4. Fairman J. Watchful vigilance: nursing care, technology, and the development of intensive care units. *Nurs Res*. 1992;41(1):56-60.
5. Kelly FE, Fong K, Hirsch N, Nolan JP. Intensive care medicine is 60 years old: the history and future of the intensive care unit. *Clin Med (Lond)*. 2014;14(4):376-379.
6. Wilson V. Critical care: from sentinels to specialists. *Am J Nurs*. 1990;90(10):32-34, 39-43.
7. Pierson CA. Constructing the next 50 years of nurse practitioner history. *J Am Assoc Nurse Pract*. 2015;27(5):235.
8. Cawley JF, Cawthon E, Hooker RS. Origins of the physician assistant movement in the United States. *JAAPA*. 2012; 25(12):36-40, 42.

---

To purchase electronic or print reprints, contact American Association of Critical-Care Nurses, 101 Columbia, Aliso Viejo, CA 92656. Phone, (800) 899-1712 or (949) 362-2050 (ext 532); fax, (949) 362-2049; email, [reprints@aacn.org](mailto:reprints@aacn.org).