

Editorial

MY LAST EDITORIAL

By Kathleen Dracup, RN, DNSc



This is my last editorial for the *American Journal of Critical Care (AJCC)*. I have served as an editor of the scientific journal of the American Association of Critical-Care Nurses (AACN)—first *Heart & Lung* and then *AJCC*—for a total of 28 years. When Dr Chris Bryan-Brown resigned as coeditor last year, he wrote a final editorial¹ that provided a compelling history of critical care from its inception. I could never top his portrayal and would rather give you a more personal account of my journey both as a nurse working in critical care and as an editor of this critical care journal.

My journey has been a long one. I graduated from a school of nursing in 1967 when the term *evidence-based practice* had not yet been coined, the Internet did not exist, and “Google” was not a verb. Critical care units, now often electronic and paperless, were piled with old medical records and giant vital sign sheets. In retrospect, the process of editing this journal was just as quaint as the ICU environment in its dependence on paper. As editors, we required authors to submit 4 copies of every manuscript, and every communication between the editor and author called for postage. Both critical care as a specialty and our journal have evolved and changed in dramatic ways.

My choice of critical care as a specialty at the beginning of my career was motivated by a casual conversation with an intern at the university medical center that I had just joined as a recent graduate.

I had taken a position as a staff nurse on a medical-surgical ward, and he had just joined the team. He mentioned that he had just come from a month-long rotation in the coronary intensive care unit (ICU). When I asked him how he liked it, he said that it was his worst rotation to date and he hoped he never had to go back. When I asked him why he hated it, he said, “The nurses can run the unit without any help from physicians, and most of the time they make interns feel as if we are just in the way.” I transferred to the ICU the next day.

By today’s standards, the technology we used in the first critical care units was incredibly primitive. We had little to offer patients beyond rest, monitoring, mechanical respiration, and defibrillation. But nurses were expected to demonstrate a high level of expertise and an autonomy that was unique in the hospital practice of the day. In contrast to the description of my intern friend, I found the ICU to be team-based and collaborative to the core. I immediately liked everything about it: the acuity of the patients, the technology available at the bedside, the urgent needs of the families, and the mutual respect of the various disciplines for one another.

Evolution of a Profession

Critical care nursing as a specialty has evolved remarkably. So, too, has the profession of nursing. The number of nurses in the United States has increased dramatically in the past 3 decades since I became an editor, from 1 million in 1980 to 3 million today. Of these, an increasing proportion of

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graduates are prepared as advanced practice nurses (ie, nurse practitioners and clinical nurse specialists) and as nurse scientists. Today roughly 350 000 nurses in the United States have graduate degrees; most are in clinical settings caring for patients and supporting the care of other nurses, but many are conducting scientific studies. They are leading large interdisciplinary studies and randomized clinical trials. These studies are providing the evidence that nurses need to care for patients effectively and safely.

For many of our patients and the general public, the concept of a nurse scientist may be somewhat foreign—if not an oxymoron. As basic nursing education moved out of hospital-based training schools and into universities in the 1960s, nursing experienced the gale force winds of professionalization. Nursing faculty were held to the same high standards of scholarship as other disciplines in the university, with expectations for publications and external funding that were identical to those for professors in the basic sciences and medicine. The National Institutes of Health was lobbied to create a center specifically to support nursing research, which happened in 1986. Holding the profession to the same standards as other scientific disciplines and supporting its research with tax dollars has been good for nursing. It has been good for critical care practice. It has been good for acutely ill patients.

Evolution of the Journal

Like the specialty it represents, this journal has been multidisciplinary since its founding, with 2 coeditors selected to represent nursing and medicine and an editorial board and reviewers who represent numerous disciplines. From its founding, AACN embraced and promoted multidisciplinary collaboration in its journals, its conferences, and its mission statements. However, the content of the journal has changed as the science supporting patient care has grown. Today the articles are more likely to report

research findings than in the early years of the journal, and the editors and reviewers are more likely to require that clinical recommendations be evidence-based before they accept a manuscript for publication.

As the journal has evolved to publish more scientific studies and fewer clinical reviews, we have struggled as editors to maintain the relevancy of the journal for busy clinicians who may not be that familiar with the research process or comfortable with statistical analyses. We have introduced regular clinical features and reworked the layout of the journal. The new coeditors, Dr Peter Morris and my successor (soon to be named), will continue to respond to this challenge of providing the latest science in a manner that emphasizes how empirical findings can make clinical practice more effective and safer.

I am leaving the position of editor with an incredible mixture of feelings. I am excited to think about the new possibilities that await me with more time in my schedule, but I am also sad to leave a position that has been so satisfying. Over the years I have come to know many of the authors and reviewers whom I first met “remotely” by reading their letters, manuscripts, and critiques. Later I met these same authors and reviewers face-to-face at professional meetings and watched their careers flourish. Many have become close colleagues. It is sad for me to leave a position that gives me a reason to be frequently in touch with old friends and allows me to meet new professionals entering the field of critical care.

I am also sad to leave a position that has taught me so many important lessons. After reading thousands of reviewers’ critiques and authors’ responses to them, I have learned how to respond to criticism about my own written work without taking it personally (at least most of the time). I have learned how to critique a manuscript fairly and completely. I particularly have learned the magic of the peer-review system. Every manuscript published in *AJCC* is reviewed by 3 experts in the field. These reviewers are anonymous. They receive no credit for the hours they spend making recommendations about a manuscript and they receive no payment for their work. It has never ceased to amaze me that the people we ask to do this unsung

About the Author

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work say yes. It is a reflection of an incredible professional commitment and a generosity of spirit.

So thank you to all the authors who have persevered through the peer-review process to publish in our journal, to all the reviewers who have said yes to the difficult task of reviewing, and to all the readers who have made my job worthwhile.

I will miss being an editor!

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

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None reported.

REFERENCE

1. Bryan-Brown CW. My first 50 years of critical care (1956-2006) [editorial]. *Am J Crit Care.* 2007;16(1):12-16.

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