

Essential Intensive Care



The backbone of in-patient care is the hospital ward, and I believe that this will remain so in the future. Shortcomings in the staffing, organization and layout of the conventional ward have been recognized for a long time, but there have been few changes and not all these have benefited the patient. The evolution of specialized treatment centres for poliomyelitis, thoracic surgery, burns and so on, showed the need for a new staffing structure—a re-organization of patient care and of secondary importance, new forms of accommodation. These regional or referral centres serve large populations or areas and are collectively known as specialized intensive care (or therapy) units. The idea of using similar principles of staffing, organization and facilities to serve each large district hospital came much later (1959) and was first applied in the United States. Thus, the general intensive care unit was born, a unit which would treat critically ill patients irrespective of the nature of their disease, in sharp contrast to the specialized intensive care unit. The staffing structure and technologies of the two are however similar. Specialized intensive care consists of a single speciality or two specialities, for example thoracic surgery and thoracic anaesthesia. General intensive care cannot be a speciality because it embraces the whole of acute medicine, acute surgery, accident surgery, toxicology and many more individual specialities. This very diversity makes it difficult to organize, but interesting to perform.

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