

Historical Development of Intensive Care Nursing at Vancouver General Hospital

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Purpose

In this chapter I will outline the history that led to the construction and design of the ICU at VGH, the first of its kind in BC. First, I argue that although intensive care nursing was practiced at VGH for many years prior to 1967, it was a nurse-initiated practice that was carried out in a rather disorganized and scattered fashion in the absence of centralized leadership or formal education. When the Intensive Care Unit was established at Vancouver General Hospital in 1967, there was generally very little nursing knowledge, technology or physical space to guide the care and management of a new kind of critically ill patient with complex needs. The nurses who worked there pioneered specialized knowledge and developed nursing skills to care for this patient population, many of whom were so ill that they were in the process of dying. There was no other therapy to offer them except for intensive care. Second, this chapter will address the effect of the creation of a designated Intensive Care Unit within a hospital on nursing practice. Specifically, the first ICU nurses created a culture or ‘therapeutic landscape’ⁱ from scratch that combined the physical and geographical features of the hospital layout, established nursing techniques, and emerging medical knowledge. As the means by which nurses cared for this new kind of pathologically complex patient evolved in this therapeutic landscape, they developed a professional identity that reflected a particular meaning and purpose. In the process, they distinguished themselves from other kinds of nurses and healthcare professionals.

Finally, this chapter will demonstrate that the designation of physical locations and spaces in hospital structures play an important part in the development of hospital culture as a whole. Specifically, the creation of an ICU at VGH determined the purpose of the work done in

that space and how that work was structured and enacted over time. Moreover, an exploration of the ICU sheds light on the formation of professional nursing identities and the kind of knowledge that was generated and communicated between the nurses who worked in the ICU.ⁱⁱ

The chapter is organized according to the historical time line of the three ICU's at VGH. The first opened in 1967. In the years to come, the foundation for intensive care nursing and intensive care culture was established at VGH. The second ICU opened in 1985 at the back of the CP emergency department and was the site where the expansion of nursing knowledge and introduction of medical technology really began. The third and final ICU was opened in 1989. It was intentionally designed for professional intensive care nurses who possessed their own body of knowledge to provide formalized intensive care. The chapter will describe the physical layout of the units. Then, changes that occurred in them will be discussed in order to comment on advancements in nursing practice that provided better care to the burgeoning ICU patient population. Finally, an analysis of the meaning that nurses who worked in the ICU ascribed to this particular place and space will be provided.

ⁱ Wilbert M. Gesler. *The Cultural Geography of Health Care*. Pittsburgh: University of Pittsburgh Press, 1991, p. 170.

ⁱⁱ Wilbert M. Gesler and Robin A. Kearns. *Culture/Place/Health*. London: Routledge, 2002, p. 5, 7, 120.

Introduction

Today, nurses, doctors and the general public commonly believe that intensive care units **evolved from** the technological explosion of medical science in the late 1950s and early '60s and that intensive care nursing was developed because nurses were needed to operate this new technology on behalf of doctors.ⁱⁱ It ⁱⁱis also believed that nurses were given specialized training to integrate the new sophisticated medical technology into their caring practices. However, new

historical analyses contradict these popular notions. Nurse historian Julie Fairman (**cite**) found that designated intensive care units and intensive care nursing **had their own tradition separate from technology. It was recognized by the hospital administration and ICU nurses were given space to direct the development of a specialty nursing practice.** The story of the creation of the ICU at Vancouver General Hospital **is congruent with Fairman's finding in that it** was constructed literally from the ground up. However, Fairman did not emphasize the places and spaces where intensive care developed, as I will do in this study.

The VCH ICU was housed in **three** temporary locations: it started out in the Basement of the Heather Pavilion, **then moved** to the back of the old Centennial Pavilion Emergency department), and in **1989** it finally assumed occupancy of its permanent home **adjacent to** the Operating rooms, Cardiac Surgical Intensive Care Unit and Post Anesthetic Room (Recovery Room). **Further**, the nurses who worked **in the ICU for the first 20 years created the** body of critical care nursing science through trial and error while working at the patient's bedside.

1967 VGH actually had very little physical space, limited medical or nursing knowledge, and **even less** technology to guide the care and management of the critically ill patient. An examination of the evidence provided by the oral histories of the nurses and physicians who worked at VGH **prior to 1967 and from 1967 to 1983** (when the ICU was relocated) illustrates how the ICU was established and the physical geography that became the nurses work space. **The way in which healthcare workers organized and used physical space** may have in part been responsible for grassroots nursing practice evolving into a specialty nursing practice at Vancouver General hospital.

Historical Background

VGH **was** the main treatment referral centre for British Columbiansⁱⁱ and it was the main teaching hospital for the University of British Columbia (UBC). Aiming to maintain this status, in June of 1964 the VGH administration presented a proposal for a construction project which included an ICU to city, provincial and federal governments. The need for an ICU had been expressed by Ms. King, the Director of Nursing, in March of 1964: “The other area that gives us great concern is the post-anesthetic room in Heather Pavillion. This area is grossly overloaded because patients remain when their condition is such that they need intensive care and the equipment available for that care. . .we need more space, but where?” (cite) This was only one of the problems facing VCH in the 1960s. Not only was there a nursing shortage, but the 1600 beds the hospital provided to serve the population within Vancouver’s city limits were adequate because population growth substantially increased since WWII and there was a chronic shortage of nurses in hospitals.

At that time, VGH was also experiencing financial trouble.ⁱⁱ The polio epidemic of **19__** **[?]** required many nurses to provide 24-hour care to incapacitated patients and **further strained** the hospital financially. Finally, the hospital realized that many of its buildings were now obsoleteⁱⁱ due to inadequate space and equipment, forcing **its directors** to appeal to the Provincial Government and the City of Vancouver (as well as the federal government) for funding in 1964. However, before any funding would be allocated to the hospital, the Minister of Health, Eric Martin, requested that a study be conducted to identify its needs and asses the cost of upgrading its facilities in order to improve services.ⁱⁱ

The consulting firm hired by the hospital, Agnew, Peckham and Associates, produced a 355-page report outlining a master plan and it was presented to the Minister in early March of 1966.ⁱⁱⁱ The report stated VGH could no longer afford to be a ‘general’ hospital serving the

needs of the whole community. The consultants recommended that VGH develop its diagnostic and treatment capabilities to provide ‘progressive patient care, a new system of grouping patients on nursing wards according to their medical diagnosis and ranking them by the severity of their illnesses.’ⁱⁱ According to this model, patients ranked as critically ill would receive intensive nursing care, which was defined as care “for those patients who are acutely ill and require constant nursing and ready access to the best in bedside equipment.”ⁱⁱ Patients requiring intensive care were **further** categorized as “post-operative, surgical... crushed chest, acute cardiac, and comatose or other medical emergencies” (no infectious cases or patients with incurable diseases would be admitted to intensive care since they were already housed elsewhere in the hospital)^{ii ii}. As the severity of the patient’s condition **worsened** they **would [might]** be shifted to another nursing ward to receive the appropriate level of care.

The report **concluded** that VGH would benefit from a designated **ward** called Intensive Care where patients could be isolated in private rooms. The creation of an ICU fit into the hospital’s master plan to develop and support the now expanding medical specialties and subspecialties. According to the plan, specialized medicine would enhance the hospital’s reputation as a health care centre of excellence, increase the value “of the Hospital for undergraduate medical and other teaching,”ⁱⁱ and improve its research program. As such, it would generate much needed revenue for Hospital. The report also suggested that if the patient wards in the different hospital buildings of the hospital (spread over two city blocks) could be consolidated, “more skilled nurses would result”ⁱⁱ and more efficient organization and use of equipment would save money.^{ii ii} VGH proceeded to make plans to improve its reputation and generate money, but there were barriers to implementing these plans, **particularly [OR including]** internal resistance to the creation of an ICU.
