

Critical care: On target

About twenty years ago, I was seriously injured. My wife received the awful call—that I had been taken to a hospital after a car crash. Fortunately, with proper care from professionals, such as all of you, I recovered. My entire family is in your debt.

During the twenty years that have elapsed since my injury, many others have been treated by, and owe their lives to, intensive care professionals. Unfortunately, there are not nearly enough of us. The statistics provided last year by SCCM member Peter Pronovost suggest that during these twenty years, about three million people have died in the United States for lack of proper critical care. That is more than the entire population of the St. Louis metropolitan area; it is about twice the population of the greater San Antonio area. Each week, more Americans die from this lack of critical care than were lost at the World Trade Center on nine-one-one.

America can fix this—with more intensive care professionals—but, few Americans know who we are. . .and what we do.

So, when I am asked these questions, here are my answers.

We are physicians. . .and we are nurses. We are respiratory therapists. . .and pharmacists. . .and dietitians. You will find us serving side-by-side in every ICU worthy of the name—because that is what intensive care professionals do. We are men. . .and we are women—each of us lending our expertise to the patient in the bed. . .and none of us quitting because the stress is too rough or the job is too tough—because that is what intensive care professionals do. We are white. . .and black. . .and brown. . .and yellow and red, and when the sweat flows from our brows, it never separates by race or title and never stops, until we have done our collective best for the sickest of the sick, because that is what intensive care professionals do.

We are Jews and Christians and Buddhists and Muslims, and so many other religions, performing our sacred duties to sustain life when possible. . .and to comfort always. And when our knowledge and skill prove inadequate to defeat death, we grieve with the survivors because that is what intensive care professionals do. We leave our families each day and each night—24/7, 365 days a year—to fight against diseases with fearsome names, to stand watch over those patients already in our units, and to prepare for those who will soon come. And when the pressure is greatest, we find strength in each other and meet the challenge, because that is what intensive care professionals do.

Yet, despite our intentions, despite our efforts, despite our successes, we intensive care professionals are in trouble. Our trouble comes in two flavors—numbers and quality. There are not enough intensive care professionals, not enough nurses, not enough doctors, not enough pharmacists, or respiratory therapists, or even dietitians who want to work in our critical care units. The training is available. The jobs are out there, but none of these professions are fully subscribed.

More importantly, those who are joining the ranks of health care are choosing to work somewhere other than our ICUs. Unless we act, the gap between how many intensive care professionals we have and how many we need will grow. Unless we act, our parents, our partners, and our children will not receive critical care from trained professionals. That scares me. That scares me a lot. It should scare you. I think we can fix this problem.

I visited the websites of several hospitals last month to read about their critical care units. Each web page trumpeted “state-of-the-art” care. Each web page focused on “high-quality.” Two-thirds talked about patient safety. That is great PR [public relations]. But I knew something that the rest of the web visitors did not. None of those critical care units that I visited electronically uses even the most basic protocols, such as sedation or weaning, protocols that are known to improve

outcomes—and reduce costs. Those units either do not know about the evidence (hard to believe)—or decided to ignore the evidence—or their staffs are so gifted that their performances take them beyond the evidence.

So, I asked some staff members to explain their claims of excellence. They told me: “We’re too specialized—the evidence doesn’t apply to our patients”; “We do just as well as the protocols”; “It’s too expensive to create and follow protocols”; and my all-time favorite response: “We are a “state-of-the-art unit delivering high-quality care.”

But I knew something that the rest of the web visitors did not. Not one of those critical care units maintains a registry. Not QuiC, not APACHE, not homegrown, not even the SCCM’s own Project IMPACT. Not one of those critical care units prospectively collects data! So, I asked how they knew that they worked in a “state of the art unit delivering high-quality care.” Again, they told me: “We’re too specialized—the statistics don’t apply to our patients”; “We do just as well as units that have registries”; “It’s too expensive to purchase and use a registry”; and, once more “We just know that we are a state-of-the-art unit delivering high-quality care.”

Ladies and gentlemen, they may choose to believe their hospital’s PR. They may choose to believe that they can assess and improve quality without data. They may choose to believe that they have better than average outcomes, with fewer than average problems. But deep down, you know that it is not enough to deliver intensive care. You know that great intensive care has to be delivered right. You know that great intensive care has to be delivered right now. Intensive care professionals have to strive to be on target. . .every patient. . .every time. Why? Because that is what the public expects and because that is what intensive care professionals should do.

I believe that the underlying problem is that we are ambivalent about excellence. More precisely, we are ambivalent

about the commitment required to achieve excellence. That commitment requires that we do the tough job of introspection—to look at our practice and our performance. Sure, it costs money to buy the hardware. . .and the software. . .and the personnel to populate. . .and use a critical care database. It also costs money to buy drugs, monitors, and ventilators. But hospitals understand that you cannot take proper care of patients without drugs, monitors, and ventilators, so those purchases are made.

Why do not hospitals understand that registries are just as critical to critical care?

Because we have not done our jobs. We have not clamored for the data. We have not demanded the tools necessary to collect and analyze the data. We have not made the case that patient safety and cost-effectiveness require that we have the tools and the time to analyze our local data and our total performance.

Fortunately, many vendors are trying to simplify this aspect of our job. For example, Project IMPACT has developed registry modules—modules that make data collection and data analysis easier and less expensive than ever before. But no matter what the vendors offer, the databases will not be put into place unless all of you—the community of intensive care professionals—collectively say to your supervisors, to your administrators, and to your hospital presidents: “show me our data.”

Getting the data is only the first step. But once you have data, you can compare your performance against relevant benchmarks. You will be able to apply the principles of quality improvement to your patients, your staff, and your unit. You will improve patient safety and save money in the process. But you cannot even make a commitment to excellence until you can measure your performance, and performance is also the key to solving our manpower problem.

We're meeting in San Antonio, one of the military centers of our great nation. Every branch of the service has to recruit personnel, and sometimes it is hard to make the quotas. What is never hard is to recruit into the elite, performance-oriented units within the armed services. Do you want to become a Navy SEAL? So do hundreds of other sailors. The physical qualifications are grueling, and many who pass the entrance requirements wash out during initial training. It is no different for the Army RANGER pro-

gram—many aspire, but few achieve. Yet, there is never a shortage of applicants. Why? Because excellence—becoming the best of the best—is a most powerful of motivators.

The world of health care is full of talented people. Yet, much of the world of health care lacks such identifiable excellence. Providers, practices and hospitals are mostly perceived as generic—interchangeable. Colleagues and associates, when people are really sick, when the risk is greatest, and when life itself hangs in the balance, few want “generic.” Few want “ordinary.” Our patients, their families, and their friends want the very best. It is up to us to deliver that best. . .and to make it known that we intensive care professionals do deliver the very best health care available anywhere, at any price. If we make excellence a goal for which we are willing to make any sacrifice, those talented people will flock to join us.

Excellence is never easy. Preventing problems that should never have occurred in the first place is uncelebrated work. Invisible achievements rarely lead to promotion. Holding oneself—and one's unit—accountable for doing the right thing, at the right time, for every patient means accepting tough critique. That accountability demands a willingness to do what is needed, not what is expedient. That, I believe, is what SCCM members are all about.

Today, I ask each of you to renew your personal commitment to uncompromised excellence. The arena is patient safety, one of the three pillars of the SCCM strategic plan. As you listen to the lectures, as you confer with delegates, as you view the posters, I ask each of you to consider how new information can be translated into safer patient care in your institution. Do not just consider the possibilities; I ask you to act, to make a change in the way you practice and in the way your unit practices. I am not asking you to make ten, or five, or even two changes—just one—one that you can stick with for the next year. Maybe it is perfect adherence to isolation procedures, or 100% compliance with hand-washing, or institution of a glycemic protocol that tightly controls blood sugar. Perhaps it is adoption of a daily wake-up for every sedated patient or a meaningful peer-evaluation program. . .one that gives every member of the critical care team timely and accurate feedback on individual performance. Perhaps you will

develop a bereavement program that not only supports grieving families but also solicits their input on how to make comfort care better. When each and every SCCM member commits to making a single change, there will be more than ten thousand changes to celebrate this time next year. Critical care will be closer than ever to being “on target,” every patient, every time.

Finally, I am asking each of you to make a commitment. . .right here, right now. The Society of Critical Care Medicine is leading research into patient safety in the ICU. Research costs money. A lot of money—big time. A few months ago, I asked every member of the SCCM executive committee to support research in ICU patient safety. Every member of your executive committee responded by making a contribution. I asked every member of the SCCM Council to make a contribution to this patient safety research effort. One hundred percent of the Council said, “Yes”!!! Every single Council member sent a check. The Past Presidents of SCCM have been approached and asked to support patient safety by making their contributions. They too have responded to the appeal. The SCCM staff—the people who answer the phone and answer our needs—answered my call for support.

Now I come to you—SCCM members and our industry partners and friends of critical care—and ask you to join us in making a commitment and a contribution to support patient safety. Everyone can afford to make a contribution of some magnitude, right here, right now—whether it is a few dollars or a few hundred or a few thousand. And that is what today's drive is all about—to get as many SCCM members and friends to show their support for research in patient safety by making a contribution right here, right now.

Here's what I'm asking you to do. Take the donor envelope out of your registration packet. Write your name and registration number in the upper left corner of the envelope. Put in some cash, write a check made out to SCCM, or put your credit card information on the form. Drop your envelope in the box that you will see on your way out of this hall. At that time, you will receive a special acknowledgement sticker. Attach it to your badge. Wear it proudly. Then, double your contribution. That is right—double! Our colleagues at Ortho Biotech will match your contribution, dollar for dollar, when you stop by their booth,

show them your badge with the sticker, and sign the "donor wall." They will match every dollar all of us contribute, up to \$10,000.

Finally, if you'd like to add to your donation, stop by Critical Care Central anytime during the Congress to drop off your contribution. You will be personally acknowledged in the next annual report, appreciated by those of us who see you

wearing the donor badge during the next few days, and rewarded in your own sense of pride at having supported the worthy cause of patient safety research.

Ladies and gentlemen, I invite you to work hard and play hard during this annual meeting. Join us at the educational sessions and at the social events. Visit the industry exhibits and view the posters. Renew old acquaintances and make new

contacts. Above all, renew your personal commitment and dedication to excellence in critical care. Take your new knowledge back to the bedside and save another life. Because that, my friends and colleagues, is what intensive care professionals do.

Timothy G. Buchman, MD, PhD

2003 President

Society of Critical Care Medicine