

# Critical care in 1996: Doing too much? Doing too little? Keeping the patient in focus during a time of smoke and fire

The Presidential Address from the 25th Educational and Scientific Symposium of the Society of Critical Care Medicine

**W**hen I was 13 yrs old, my grandfather died of cancer in the small town of Ashtabula, OH. He had been cared for over the years at the Cleveland Clinic by Dr. Crile and Dr. Engles, names that some of the surgical members of the Society of Critical Care Medicine (SCCM) are likely to recognize. My grandfather had a history of many surgeries at the Cleveland Clinic for recurrent pyelonephritis secondary to kidney stones. In the spring of his final year, he was diagnosed with metastatic colon cancer.

The physicians who had managed my grandfather's chronic illnesses for many years took my mother into their office and told her that there was nothing more that they could do. They instructed her to take my grandfather home and make him as comfortable as possible before his death. As my mother put my grandfather in the car for the 60-mile drive home, he said to her, "They did not have good news did they, Orletta?" My mother answered, "No, they did not have good news." He replied, "Drive me home along the south ridge so that I can see it one more time."

Over the next few months, my mother administered morphine provided by the physicians, first by

mouth and then by suppository. I remember as if it was yesterday the summer day my grandfather received the first suppository of morphine. Temporarily free of pain, he got out of bed, went downstairs, and walked into the backyard to his garden, which had sustained the family throughout the depression. He returned to his bed a few hours later, never to leave his room again.

The physicians at the Cleveland Clinic managed my grandfather's illness. They informed and educated the family. They relieved pain and suffering. They did not back away from death. Critical care medicine at its best is like the care that the Cleveland Clinic physicians gave my grandfather. Critical care is patient focused. It uses technology to support life and reverse illness. It has close ties to the patient and to the patient's family. It recognizes and acquiesces when illness is irreversible and death is imminent. It relieves pain and suffering.

Recently, an article appeared in the *Journal of the American Medical Association*, suggesting the opposite about critical care (1). The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), as it is called, carried out in the intensive care units (ICUs) of five prestigious institutions in this country, suggested that ICU physicians did not listen to patients and families. They did not know when to stop treatment. They did not relieve pain and suffering.

It is not my intent to dispute this study but to discuss the aftermath, the headlines that were on the front page of every newspaper in America. The front page news was that ICU

physicians were insensitive louts, out of touch with patients and families and that treatment and life support persist well beyond any hope of recovery. These are chilling words for the members of SCCM, the nurses, physicians, respiratory therapists, pharmacists—the ICU team.

When I read these headlines, my first intent was to "shoot the messenger." I wanted to call George Lundberg, MD, the Editor of the *Journal of the American Medical Association*, and give him a piece of my mind. But then I had a second thought, a better thought. I remembered the old adage, "Where there is smoke, there is fire." Maybe there was some fire with this smoke. After all, one of our fellow SCCM members, Norman Paradis, MD, had told a similar story several years before on the "op-ed" page of the *New York Times* about the death of his father, a surgeon, from pancreatic cancer. The physicians described in that article entitled "Making a Living Off the Dying" did not seem to get it (2). They kept doing procedures. They did not know when to stop.

We may not like or agree with the SUPPORT study and the way the newspapers covered it, but the message is clear. Our patients and their families that we care for every day in the ICU want us to be in charge of their medical care, advocating on their behalf, listening to their needs and desires. They want us to relieve pain and suffering. They want us to be like the physicians at the Cleveland Clinic who educated my family and managed the death of my grandfather when nothing more could be done.

That is exactly what the founding presidents Max Harry Weil, MD,

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FCCM, Peter Safar, MD, FCCM, and William C. Shoemaker, MD, FCCM, had in mind when they met in 1971, 25 yrs ago, to incorporate, pass by-laws, and establish the Society of Critical Care Medicine. Their vision was of a multidisciplinary and multiprofessional team of ICU workers titrating therapy at the patient bedside and providing constant surveillance of patients with life-threatening illness. Their vision was of a team of healthcare specialists led by a fellowship-trained critical care physician. No longer were housestaff to be left unsupported by attending physicians to manage the sickest patients in the hospital.

This vision has served the critical care team and patients well for the past 25 yrs. But as we all know, health care is changing. There is an evolution in how we deliver care, where we deliver care, and who delivers care. SCCM's challenge, your challenge, and my challenge, is to take what is good from the original SCCM vision of quality patient care and move it into the new and constantly evolving healthcare system in this country.

To understand some of this healthcare delivery evolution, I again refer to the lay press. The January 22, 1996 issue of *Time* magazine included an article entitled "What Your Doctor Can't Tell You" (3). I shuddered as I read the story of physicians manipulated by a managed care company into providing less than honesty and full disclosure when discussing the treatment of metastatic breast cancer with a patient and her family.

The SUPPORT study was about a healthcare system doing too much. Fee-for-service medicine and cost plus reimbursement for hospitals have led to excesses in both cost and care over the last 20 yrs. Now, financial incentives to healthcare workers and hospitals are driving us at breakneck speed in the opposite direction. Managed care is a healthcare system that is at risk of doing too little. What about concern for the patient? What about concern for the family? Who is managing the care of the critically ill patient for the best interest of the patient? A for-profit insurance company with a chief executive officer making millions of dollars a year and hungry investors looking for a cut of the pie? It seems unlikely.

Many tough challenges and ethical dilemmas prevail in our era of healthcare evolution. Physicians are seeing limitations placed on their diagnostic and therapeutic choices. They are sometimes prevented by "gag" rules from disclosing to a patient a complete list of therapeutic options. Nurses are being asked to do more with less as hospitals "dumb" down their staff by hiring minimally trained individuals to replace registered nurses. In some places, there is consideration of eliminating respiratory therapists and shifting those duties onto the bedside nurse. Pharmacists are being asked to put tight controls on the ICU formulary in an effort to limit the pharmacy's annual drug expenditure.

Earlier, I referred to the SUPPORT study article (1) and the old adage "where there is smoke there is fire." In the smoke of the *Time* magazine article (3), there is real fire. Fire that will destroy the relationship between patients and healthcare workers. Fire that will sacrifice quality patient care for investor profits. Fire that will end patient-focused critical care as we have known it for 25 yrs.

We, the Society of Critical Care Medicine, must have a plan of action. Critical care must be delivered in a quality and cost-effective manner, cognizant of the wishes of the patient and family. I get angry when I see ICUs in Western Pennsylvania, one of the birthplaces of critical care, that are poorly organized, poorly supervised, and poorly managed. There must be an end to disjointed care delivered by an army of consultants marching daily into the ICU and rarely speaking to each other, except for illegible notes in the chart. There must be 24-hr and 7-days-per-wk coverage by intensivist physicians caring for a whole patient and not an organ system. This intensivist must coordinate the opinions and plans of the primary admitting physician and the consultants to weave a fabric of care that is focused on the best interest of the patient and family. Sometimes, that best interest will be care that is diagnostic and therapeutic, and sometimes it will be care that is focused on relieving pain and suffering as life support is withheld or withdrawn.

The intensivist must coordinate the care of all ICU patients, respect the

wishes of the patient, and communicate regularly and freely with family. There must be a multidisciplinary team led by a fellowship-trained critical care physician as ICU medical director, and a specialist as ICU nurse manager. There must be a recognition of futile situations so that life support can be used appropriately for patients who may likely benefit from that support. There must be relief of pain and suffering.

We have many challenges ahead of us. The SCCM is well positioned to help its members meet these challenges. From SCCM staff and financial stability to educational programs and exciting projects, SCCM is ready to serve. I would like to talk about this staff of which I am very proud. I have been involved with the staff and volunteer leadership of the SCCM for the past 10 yrs. We have had good times and bad times. We have learned a lot and built a firm foundation for the future. We are a strong, mission-driven organization committed to providing the highest quality patient care in the ICU. At the top of the organization is Steve Seekins, our new Chief Executive Officer and Executive Vice President. He had a previous career with the American Medical Association and SCCM is most fortunate to have recruited him. Janice Jensen is the new chief operating officer. Larry Hines is leading membership. René Arché is head of editorial affairs. Debbie Branch is in charge of education, and Marie Lent is managing marketing and public affairs. This staff is energized and eager to serve the membership. They are optimistic about the future of the SCCM.

I am also excited about a wonderful volunteer staff. Loren Nelson, MD, FCCM, is the new President-Elect. He has developed Project IMPACT, the ICU computerized database that is being unveiled at this meeting. This computer program will allow the SCCM to build a national ICU data bank to analyze the care of critically ill patients in a manner never before attempted. With this information, we can more clearly chart a course of quality patient care for ICU patients into the year 2000, as the SCCM maintains its position as the premier critical care organization in this country.

Joe Parrillo, MD, FCCM, the immediate Past President, will become

Editor-in-Chief of the journal, *Critical Care Medicine*, as Bart Chernow, MD, FCCM, steps down. I and the membership of the SCCM are deeply grateful to Dr. Chernow for his superb leadership with the journal, which has become an international voice for ICU medicine. Phil Dellinger, MD, FCCM, is the Treasurer of the SCCM. He has developed the Fundamental Critical Care Support (FCCS) course. This educational program is designed to improve the skills of first-responders with the objective that ICU physicians will receive better stabilized patients. Another FCCS instructor course was offered at this meeting (SCCM 1996 Educational and Scientific Symposium) and the provider course is ready to roll out in 1996. Finally, Robert Taylor, MD, FCCM, joins the Executive Committee as Secretary and will be working with the Coalition for Critical Care Excellence on important projects for the future of critical care. I am particularly proud of and grateful to Dr. Taylor, a well-organized and tireless worker for the SCCM. He managed the search process for the new Editor-in-Chief of *Critical Care Medicine* and then managed the search process for the new Chief Executive Officer.

Finally, there are three important committees that I would like to discuss. First, I have asked Michael DeVita, MD, to co-chair the Ethics Committee with Marion Danis, MD, and to address ethical issues

associated with managed care and its impact on the ICU. Second, I have asked George Sample, MD, to continue to chair the Reimbursement Committee but to rename the group the Reimbursement and Managed Care Committee and to address the business side of managed care in the ICU. In particular, they are to look at how managed care impacts on the hospital and healthcare workers. I am hoping these two committees will have strong liaison activity and report back to the SCCM membership before the 1997 Symposium in San Diego.

Finally, I have asked my partner, David Crippen, MD, FCCM, to chair the Electronic Communication Committee and to make SCCM the voice of international critical care on the Internet. If you are not a regular computer user and facile with obtaining information from the Internet, make it a high priority in your life for 1996. I can promise you that the SCCM will have a major presence on the Internet. It will be the mode of communication that will propel us into the next millennium. It will be one of the tools that the SCCM will use to deal with the smoke and fire of 1996. We will use it to continue the patient-oriented vision of our founding members.

SCCM has a great staff, impressive programs, and a bright future. We need not be gloomy about the changes in health care. We know the principles of quality patient care in the ICU that we support. We are on a firm

foundation with SCCM to be the voice of critical care and the source of knowledge for patient safety in the ICU.

I am reminded daily of the purpose of our specialty and its value to our patients' lives. My reminder is a poster that hangs on the wall in the outer office of the Critical Care Department at St. Francis Medical Center in Pittsburgh where I practice. The poster was created in 1986 by the Foundation for Critical Care in memory of Jacob Javits. It reads, "In critical care it strikes me that the issues are three: realism, dignity, and love." Now that is what critical care is about. That is what the physicians at the Cleveland Clinic provided to my grandfather and to my family. That is what we owe our patients in the ICU, whether it is 2:00 in the afternoon or 2:00 in the morning. That is what combats the smoke and fire of a changing healthcare system.

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