

It's an honor to serve as your president in this coming year, and I'm eager to accept the challenge.

It's a special honor to follow Pam Lipsett who has been a friend for over 25 years. Pam has a unique ability to analyze things and see what the rest of us have missed – and that's never been clearer to me than during this past year as I've prepared to become your president. I also have to credit Pam with helping me overcome a prejudice that dates back to my childhood. As a lifelong fan of the New York Yankees, I was raised to believe that all Red Sox fans were intellectually limited. Pam has helped me to see that there are exceptions. And, of course, that tells you a little bit about me.

As I look around this room, I see so many friends. It's one of the best things about having been involved with the Society of Critical Care Medicine (SCCM) for a while, starting when it was young and small. I've gotten to work, grow, develop friendships with so many of you. But for those of you I've yet to meet, who don't know me, here are a few bullet points.

I practice in the surgical intensive care unit at the hospital of the University of Pennsylvania in Philadelphia. I trained in Gainesville, Minnesota, and Baltimore, but I am and will always be firmly rooted in New York: the city of my birth, those Yankees, of the Super Bowl champion New York Giants, and of course, the only place on earth you can get a real bagel. It's also the home to my first alma mater, the Fieldston School, a unique institution established in 1878 by Felix Adler, the founder of the New York Society of Ethical Culture. He envisioned a school committed to diversity of class, race, and gender, and graduates who were competent to change their environment. Graduates of Fieldston include J. Robert Oppenheimer, the father of the Manhattan Project; my classmate Jill Abramson, the newly appointed Executive Editor of *The New York Times*, the first woman to hold that post; and my friend Gary Cohen, who some of you may have heard of. Gary's the acting

director of the CMS Center for Consumer Information and Insurance Oversight, which is to say, he's the man whose job it is to try and make the third-party payors do their job and behave. What's really most important to know about Fieldston is that it's always been a place that placed a high value on cooperation as opposed to competition—pretty good incubator for a future intensivist and I want to bring that sense of cooperation and respect for diversity to the SCCM presidency.

As you know, critical care is a specialty that in many ways was born out of the inadequacies of other specialties. It demanded an unconventional approach, required us to think a little bit differently, and most of all—and most beneficial to our patients—it required a commitment to cooperation, that we pool our professional expertise and check our egos at the door.

My wife Chris likes to give me a hard time about watching TV. Guilty. So I caught an episode or two about that medical drama, *House*. You all know it: the one where the crazy doctor swoops in, shoves everyone else out of the way, does something that's probably illegal, and saves the dying patient—all in 60 minutes, less commercials. It seems the TV scriptwriters haven't gotten the message; in this day and age, critical care practice requires a team, not an individual. Medicine may have at one time been practiced by cowboys, but today's critically ill patient requires a committee of professionals, a coalition of diverse experience and expertise, to laser focus on the complexities of critical illness.

And the people who founded the SCCM knew that. They understood that they were starting something brand new, something medicine had never seen before; a specialty where the issues to be faced—and the problems to be solved—were so complex, the patients' needs were so great, that dealing with them exceeded the capacity of any traditional branch of medicine and certainly of any individual caregiver. Critical care medicine required that we abandon the traditional medical hierarchy because it was insufficient. And the SCCM knew that. They understood that they were starting something brand new, something medicine had never seen before; a specialty where the issues to be faced, the problems to be solved, were so

complex, the patients' needs so great, that dealing with them exceeded the capacity of any traditional branch of medicine and certainly of any individual caregiver. Critical care medicine required that we abandon the traditional medical hierarchy because it was insufficient. The SCCM founders provided us with a new type of professional society that fit our new specialty, one designed to provide a voice for all the different groups of professionals whose input is essential to the care of our patients.

I've served on an Executive Committee led by Judith Jacobi, a pharmacist. At this time next year, I'll proudly turn the presidency over to Carol Thompson, a nurse. Pam Lipsett was one of the first women to finish the surgical residency at Johns Hopkins. In fact, our current Executive Committee consists of two men and three women—very unusual in traditional medical organizations. As the father of three daughters, I'm especially proud to be an officer in a medical organization that doesn't have a glass ceiling.

But there are some other things that our founders knew that some of us seem to have forgotten, and that's what I want to talk to you about today. First, I'm afraid we've lost track, both individually and institutionally, of the relationship between patient care and basic research. In fact, it often seems that keeping up with the science behind critical care practice is no longer considered a vital part of our daily job description. I think I understand why this has happened, where we began to lose contact with our scientific roots.

We work in institutions that seem to grow bigger and more complex every day. Our work is continuously scrutinized by regulatory agencies and review boards, each with its own complex set of requirements. To make that work, we've come up with systems, rules, protocols, guidelines; and these are more or less good things because they can assure that really sick patients get the essential care they need, and they can simplify life, bring order to places where chaos might otherwise reign. But the danger from these approaches, especially when they are increasingly dominated by an inflexible bureaucracy, is that they don't leave much room for innovation. At best, they stifle it; at worst, they kill it. Innovation gets done in by the daily

demands of providing consistent, top-level patient care by insurance and safety committees, HIPAA and OSHA, lawyers and liability, prevention and protocols, and paperwork. Wouldn't critical care be the perfect job if you didn't have to write notes every day? With all these demands, it's easy for the scientific underpinnings of critical care to get lost. But just as the practice of critical care medicine arose out of a clinical imperative, most basic and translational research starts at the bedside.

Now I've been involved in laboratory research for most of my career. I use animal models and molecular techniques to study sepsis and organ failures, stuff that at times seems pretty far removed from bedside critical care. But the interest that's been so central to my professional life started when I was in Minnesota, as a fellow under Frank Cerra. It seemed that too many of our patients died when they developed unexplained dysfunction in multiple organ systems all at once. When I went to search the medical journals, I discovered that some really smart people had done a great job of describing what I was seeing and that they had uncovered some of the aspects of the underlying pathobiology—but overall, the cause of what was killing my patients and what we ought to do about it was unknown. So to try and find some answers, I went to the lab. That was 28 years ago. And I'm still going to the lab pretty much every day.

But surprisingly, what's been most beneficial is the effect that the involvement in research has had on my clinical practice. It's taught me to be skeptical of conventional wisdom; to read the paper, not just the abstract (to look at the methods) to consider the unconsidered; and not to take anything at face value. And my patients are better for that. So my first challenge to each of you in this coming year is to make a personal commitment to increase your familiarity with the scientific foundation of our specialty, and to contribute whatever you can to our understanding of the science behind our daily jobs, even if it's something as simple as sharing an observation with a colleague. In fact, great discoveries most often start with simple observations. One of my favorite quotes comes from Isaac Asimov, the prolific science fiction writer who also happened to be an accomplished biochemist. He said, "The most exciting phrase to hear in science, the one that heralds new discoveries, is not 'Eureka!' but 'That's strange....'"

Now I realize that for many of you, there's not a research lab down the hall or across the campus—but we all have access to each other: clinicians, scientists, academics, private practitioners, in this room and elsewhere. We are all part of the same critical care family. And I promise you—promise you!—that someone will think that what you've observed is fascinating and will be interested in helping you take the next step.

Your SCCM is doing its part to make it easier for you to commit to keeping up with research. In conjunction with our colleagues in the other organizations that make up the Critical Care Societies Collaborative (CCSC), we convened experts and developed a comprehensive agenda in critical care research. A paper detailing this agenda was just published simultaneously in the official journals of each of the CCSC organizations. And we've begun the next step by opening a dialogue with some of the key program directors at the National Institutes of Health (NIH) to find a way to advance investigation into critical care medicine. Even more importantly, in response to the most recent survey of your needs and aided by the work of a member task force, we've been examining ways to reinvigorate the basic and translational science presented at this meeting. We are developing sessions that will place this type of research in a clinical context so that each of us can see just how these findings are directly relevant to our clinical work and better understand how to use that information to improve the care of our patients.

So I ask that each of us take a few moments away from the art of caring for critically ill patients and renew our commitment to the science of critical care, and welcome it as an essential component of our daily job. That way we, as committed professionals, can take responsibility for our own growth and for the advancement of the discipline. Providing our patients with improved care requires that we do all that we can to better understand the disorders that make them critically ill.

It's this requirement that leads me to a second key issue that I want to raise. Where it starts, to put it bluntly, is money. Research of any type is expensive and, in some cases—for example, large scale randomized controlled trials—really expensive. We need to think about where that money is going to come from.

I don't think we can count on the government—the NIH budget seems to be shrinking and science too often becomes

politicized. Recent experience would certainly suggest that critical care is not going to be a high priority with the pharmaceutical companies. So what are we to do?

Well, for starters, we need to think about what the public at large understands about who we are and what we do. Most lay people know what an ICU is; they have some sense that at some point it will impact on them or someone they care about. But the notion that critical care is a distinct specialty that requires specific knowledge may not be obvious, and this lack of clarity carries over to research. Later in this meeting, our next secretary, Craig Coopersmith, will present a study demonstrating just how underfunded critical care research is. He found that while between 5% and 11% of our healthcare budget, the money we spend on patients, pays for critical care, research related to critical care accounts for somewhere between 1% and 3% of the NIH budget. That's a disparity that makes no sense. Consider, by way of contrast, the public view of cancer or heart disease; the public is acutely aware of both of these. People freely give money to support research into cancer and heart disease. There's a National Cancer Institute with a budget of \$5 billion a year, 16% of the NIH budget. In contrast, donations to defeat critical illness are pretty rare. There are no walks for the cure for ARDS, no NIH-designated critical care centers; in fact, there's no NIH entity of any kind dedicated to critical care. Yet we know that sepsis kills more people in the United States each year than any single form of cancer and may actually be responsible for more deaths than the four most common forms of cancer combined.

So what's the difference? Well, cancer and heart disease are in the public eye. The researchers and providers involved with these disorders have made a compelling public case for support. While somehow, the patients we care for, the disorders we treat, critical illness doesn't loom large in the public consciousness.

And I think that a big contributor to our visibility is that we ourselves, the people who care for the critically ill, haven't spoken up. So my second challenge to each of us is this: it's time to call attention to ourselves and the patients we care for. Let people know about what we do and why it's so important to them. Make the case for public support of critical care medicine. Call in the press when something unusual happens. Connect with

community leaders and politicians. When the opportunity presents itself, step up and help with the dollars, fund raise. Do it for your unit, your research, your colleagues, your patients. Craig's study may be just what we need to approach and convince the government, the private agencies, maybe even Bill Gates, that it is essential for them to support critical care research.

And once again, SCCM will do its part. I've asked our professional staff to begin examining options to increase the visibility of critical care medicine and to help us enhance funding for critical care research. Count on hearing about this in the near future. And remember in addressing this and many other important issues, what makes critical care unique is our ability to work as a team.

Now I've got my own personal team: my wife and best friend, Chris; my kids, Cate, Nicki, and Beth, who really aren't

kids anymore; my friends and colleagues, many here today. I've been part of a team of remarkable people on Council and the Executive Committee: Phil Barie, Fred Ognibene, Mitchell Levy, Judi Jacobi, Pam Lipsett. The SCCM professional staff, led by David Martin, is an amazing team, people I've come to really appreciate in the last year. But we should remember that we, the people who care for the critically ill, are also a team and we all have access to each other.

And that brings me to my final point: access, and in particular, your access to me and the rest of us who have the privilege of leading our society. The SCCM is here to help us solve problems. We recognize that sometimes the leadership has appeared to be removed from the membership. In an age where communications technology grows every day, access should never be an issue. As your

president, I'll make a personal commitment to each of you. You can contact me through the SCCM Web site. If you have a question, if you have a problem, get in touch. If I can help, I will; if I can't, I'll find the colleague or staff member who can. I'm committed to do whatever I can, whatever it takes, to make the SCCM work for you. I look forward to working with each of you in this coming year, to advance toward achieving the goals we set for ourselves, for our society, for our critical care colleagues, and most of all, for our patients.

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