SCCM: Progress and Promise

It is appropriate to take a moment to think about our members and friends that were so profoundly affected by hurricane Katrina and the events that followed in New Orleans. SCCM [Society of Critical Care Medicine] responded to the disaster by answering the call for medical volunteers and providing a way for individual members to connect with active relief organizations. The Society has a proven track record of responding to world crises including the Asian Tsunami and the earthquake in Pakistan and India.

Following Katrina, your Society directed volunteers to the NIH [National Institutes of Health] initiative to staff a mobile hospital that was deployed to Mississippi. Over 300 members contacted SCCM and registered their wish to help. The personal stories of several of our members who actually became part of the relief effort in Louisiana and Texas can be heard in their own words in SCCM Podcasts or streaming audio files from the SCCM Web site.

If you haven't already done so, I recommend you take advantage of listening to these interviews that you can find at the SCCM Web site. While the acute effects of the disaster are over, there are lingering wounds throughout the Gulf area that will continue for years. Some members and colleagues in the affected area have lost their homes and all their belongings. We have members who no longer have hospitals or ICUs in which to deliver their care. Continued support for members of the healthcare community will be necessary for a long time, and the New Orleans Medical Society has offered to be a clearing house for those who wish to help. Our continued good wishes and support will help recovery.

In many ways, this is a unique and important Congress for our Society. The success of this meeting is a testimony to the maturity and resilience of your Society. Following the hurricane, it was not clear that there would even be a Congress this year. The original plan for the meeting in New Orleans had to be changed. Thanks to swift work and advanced disaster planning, your professional staff was able to respond within days of Katrina, identifying possible alternative venues and dates in at least 20 locations. Having anticipated needing to make a change on short notice most of the information about the possible alternatives, such as size of meeting space and exhibit halls, was already known. In addition, the appropriate contacts had already been identified and personal relationships established. Based on availability and space, the alternatives were rapidly reduced to five or six potential venues. Your governing council was informed by E-mail about the problems and potential solutions for the annual Congress within 3 days following the hurricane strike. An E-mail discussion ensued, and the final choices were put to a vote within 5 days of the disaster. Your Council chose San Francisco with a slightly different date. The majority of the scheduled speakers were able to accommodate the change, and the rest of the program was completed with little difficulty and no kill of quality. I believe that this year's program is one of the best ever, as you will see in the next few days.

As I mentioned, while the emergency meeting move was being executed, SCCM was coordinating the Society's relief efforts and identifying and directing volunteers to help deal with the hurricane emergency.

You can be proud of your Society. It has matured and become a major player in the medical society world. SCCM is frequently being invited to actively participate in many important activities related to care of the critically ill.

To become the "Go To" organization in critical care was one of the primary motivations for our headquarters move to Chicago several years ago. We have unequivocally achieved this goal.

I am pleased to be given the opportunity to be your Society President. I would like to tell you about my early experiences in critical care medicine and why I love the field and Society today.

In 1977, while a fellow in anesthesiology at the University of Pennsylvania, I had a case of a family presenting with premature labor. The mother was a high school teacher and a primigravida. Her husband was just completing a professional education program. The timing of the pregnancy and anticipated delivery had been planned based on these parental activities. At the time of presentation to the University Hospital, the wife was at 27 wks gestation and she was in active labor. Her cervix was 4 cm dilated and her membranes, although intact, were bulging through the cervical os. The pregnancy up to that point had been uncomplicated.

The initial plan was to stop labor, allow further fetal growth and lung maturity, and possibly give steroids to help mature the lungs if delivery became eminent. She was started on iv alcohol, the tocolytic of the time, and contractions diminished. After several hours of this treatment, it was apparent that labor had progressed too far to arrest and the iv alcohol infusion was stopped. Several hours later, a premature female child was delivered whose weight was approximately 950 grams.

The family requested that intubation not be performed and the child be kept in the neonatal unit at the University Hospital rather than be transferred to the nearby children's hospital. There were no neonatal ventilators at the University Hospital at that time.

The attending neonatologist acceded to these requests, although there was much disagreement within the ICU team about the appropriateness of these decisions, especially among the house staff. Over the next few hours, the child developed increasing respiratory distress, demonstrating nasal flaring and abdominal paradoxical movement with respirations and hypoxemia on umbilical artery blood gas sampling. She was placed in an incubator with 100% oxygen. She was begun on gavage feeding with colostrum

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and then breast milk. Exchange transfusion of fresh O-negative blood obtained from her maternal grandfather was performed to improve oxygen delivery kinetics. The critical care team included the house staff, neonatal nurses, the attending neonatologist, therapists, and the family.

During the next 6 days, despite remaining in an Isolette with 100% oxygen, the baby's Pao_2 remained less than 50 torr. Respiratory failure worsened, and the $Paco_2$ gradually increased to 90 torr on the 6th postnatal day.

A family conference was held and a plan to intubate the baby for 24 hrs, employing gentle manual ventilation if the $Paco_2$ rose further, was proposed to and accepted by the family. However, the next blood gas demonstrated improved carbon dioxide, and intubation and ventilation was never needed.

She continued to improve and was a star in the nursery. She was discharged home approximately 3 months following her birth and did well.

As you may have guessed, this is the story of my daughter, Brandy. She is now a radiology technologist, a practitioner of Ti Kwon Do, and a joy in my life.

Her birth taught me many important things about critical illness and the ICU team. Critical Care Medicine is a team sport. The members of Brandy's team included Maria Delivoria-Papadopoulos (the neonatologist), the pediatric house staff, the neonatal nurses, the respiratory therapists, and very importantly her family—her mother, my wife Bertha, and me. Her excellent care and positive outcome resulted because of the integrated functioning of this multiprofessional team.

Communication with the family is essential and powerful. Knowing the members of the team and being told what to expect as part of the ICU routine was reassuring to us.

When Brandy's sodium fell to 120 and the diagnosis of sepsis was entertained, we had a bad day. How information is presented has a huge impact on the family. The most important contact person is the nurse, but the information from all caregivers is important and needs to be consistent.

Medicine doesn't have all the answers. Some things in medicine did not make scientific sense. Although Brandy spent more than 30 days in 100% oxygen, her lung function improved and is normal today. This was unexpected and surprising to me. We do not know all the answers. Science continues to evolve, and today's state-of-the-art will be found lacking tomorrow. Lifelong learning is essential if we are to best care for our patients today and tomorrow.

Do not expect medical personnel to remain objective when care involves their own family. The objectivity necessary for critical care practice at the bedside cannot be maintained when it is *YOUR* family member that is ill. Understanding may be better, but the feelings of hopelessness and helplessness are powerful and present in the family. Sensitivity to and acceptance of these feelings by caregivers is helpful to patients and their families. I am grateful for the outcome in my daughter's case and thankful for the understanding and support provided by her caregivers.

I wish to thank my wife and family for their support of my career. I missed some significant family activities but never felt anger from any of you at my absence or failures as a parent.

Thanks for being here today to celebrate this special moment of my career.

My first professional experiences with the Society of Critical Care Medicine occurred while I was an intern in Internal Medicine at the Baptist Memorial Hospital in Memphis in 1974. I went to a critical care conference in Pittsburgh, PA, that spring. Although it was not called the Annual Congress, this was the third or fourth meeting of SCCM.

I listened to talks by Ake Grevik, Peter Safar, and other great leaders of the young organization. What I remember clearly from that meeting was the enthusiasm of the group and the inclusive nature of the audience, which included all types of healthcare providers. I recently came across some of the handouts from that meeting, and surprisingly, many of the basic concepts of critical care medicine remain true today.

My real admission to the world of Critical Care Medicine was initiated by a former president of the Society of Critical Care Medicine, John Hoyt.

John had been recruited to the University of Virginia to be the first medical director and start an intensive care training program in the surgical ICU in 1978. I was a newly hired cardiac anesthesiologist who started the month after John had arrived. With my background in medicine, and my interest in the ICU, John encouraged me to join his growing ICU team. I was a bit afraid that I did not have enough critical care knowledge and would have little to contribute but was assured that it was a team effort and I would both contribute and learn in the ICU. John was and is a vigorous advocate for multiple professional collaboration in ICU management and patient care. His vision included strong partnerships with nurses, respiratory therapists, laboratory personnel, pharmacists, and various ICU support technicians. In my first months and years working with John, I learned from these and other colleagues about the value to the critically ill patient of this model of practice. I joined the Society of Critical Care Medicine in 1979 and helped found the Carolina/Virginia regional society of Critical Care Medicine in 1980. I have been a member of both organizations since. There have been many important changes in SCCM during this time. I would like to highlight a few of these. SCCM has always held that quality and safe care of the patient in the bed is our highest commitment.

We believe that a team of caregivers at the bedside devoted to providing critical care can do a better job of this than other models of care delivery. In order to communicate our beliefs and influence others, it was necessary to be identified as THE "GO TO" organization in Critical Care. The move of our headquarters to Chicago was essential to the execution of this plan. We accomplished the move despite the political and financial risks that attend such drastic changes. Although the average member is probably unaware, many inside SCCM predicted that we would not survive such a drastic change and outsiders were predicting that SCCM would dwindle. At the time of the move, SCCM had essentially no reserve funds and was spending every dollar on current operating expenses. Long range planning consisted of asking whether we could pay the rent next month.

The move marked a change in the way SCCM manages its affairs. For the first time in our history we have exerted enough financial restraint to begin to establish a prudent financial reserve. Your elected Council is taking the need to protect our future very seriously. We now live within our budget. We have brought our accounting and oversight processes to the point where they can meet the highest national standards. Protection of our charitable and educational missions requires this level of concern and oversight. We are now well suited to deal with the increasing scrutiny that the Federal

Government is applying to charitable organizations.

We have established and developed a highly dedicated and competent professional staff in Chicago. This allows the Society to continue to produce the high-quality products and programs you have come to associate with SCCM and, very importantly, investigate new initiatives to improve the care of critically ill patients.

The Annual Congress, the FCCS programs, our Journals, *Critical Care Medicine* and *Pediatric Critical Care Medicine*, and our Practice Guidelines from the College are known through out the world for their consistently high quality. In addition, this past year we have jointly held an international consensus conference on pancreatitis, a Summer Conference on mechanical ventilation, review courses for adult and pediatric critical medicine, held an advocacy conference in Washington, DC, a coding and billing course, a critical care pharmacotherapy conference, and produced and delivered the Fundamentals of Disaster Management course. We administered and scored our fellowship evaluation test and produced six issues of Critical Connections, 24 issues of our E-newsletter, and began distributing our first Podcasts. While most of the content of these activities are created by you, our members, they would not have been possible without the dedication and hard work of the professional staff.

To give you some idea of the quantity of work accomplished by your Society, consider that the Annual Congress alone is a 2.5 million dollar activity, which requires at least 16,000 hrs of our staff's time.

For this Annual Congress here in San Francisco there were 3,200 registration forms processed, 175 exhibitor applications processed for 300 booths, 1,200 exhibitor registration forms processed, 870 abstracts processed and printed (a new record I might add), 150 business meetings scheduled; seven hotel/center contracts negotiated, 30 onsite temporary laborers hired and managed, 350 speaker disclosure forms, expense reports, and A/V forms processed, five promotional pieces designed and mailed, $300,000 food and beverage contracted, $275,000 audio/visual services negotiated. In addition, in the past year, your Society held more than 25 educational conferences/courses and 20 additional committee meetings.

Your Society office is very busy. We have more than 13,000 members. Services for these members entail over 80,000 phone calls and more than one hundred thousand E-mails each year. This is just our "business as usual," but remember, we are changing and upgrading our electronic infrastructure and business software, which means this same level of activity must continue while the new system is being installed, tested, and taught to the staff.

The talents of our staff and its professional management are most apparent in this annual meeting. The almost seamless change of venue in a time of national crisis resulted from advanced preparation and effective decision making. The interaction between the Council and the profession staff was timely and accurate, resulting in this success. This is the model for your Society, professional staff and volunteer leaders working together to promote a common vision of improving care of critically ill and injured patients. Delivering the Right Care, Right Now, can be translated to doing the right thing when needed within the organization.

We have a group of very active volunteers within the Society, which we call the Creative Community. These more than 600 individuals serve on our many committees, taskforces, and workgroups.

As president, I hope to increase the membership in the Creative Community by at least 10%. Our Right Care, Right Now campaign is underpinned by our strategy of "Learn it, Deliver it, Measure it, and Improve it."

While the Society is extremely successful with delivery of educational content, we have been less successful at providing measurement tools to grade our success in changing practice at the bedside. As president, this is an area I will foster within the Society. We are moving toward making our educational products "learner" based experiences.

This year, there is opportunity to develop and test the tools needed to evaluate the impact these changes have on patient care. We recently underwent an accreditation evaluation by the ACCME and were awarded the highest level of accreditation; a 6-yr approval commendation, the longest awarded in our history and a level that only 8% of organizations ever receive. The emphasis we place on changing care helped achieve this accreditation status. Our forward approach and outcome concern was largely responsible for this remarkable achievement.

The 10% increase in members in the creative community I propose is measurable and achievable.

As a second goal, I challenge the creative community and our staff to move at least 10% of our education content to a form that creates active changes in the participants and their patient care. This will be evaluated by measuring the impact on process at the bedside. This is a new way of thinking and assessing success but is essential if patients are to benefit from your Society's educational efforts.

If you are not now involved in your Society, I ask you to seriously consider becoming active. Let me know of your interests and I will get you to the proper person. In addition to working within the Society, we have active members carrying our message and influencing others. We support active liaisons with over 50 outside organizations including volunteer societies, regulatory bodies, and government agencies. The American College of Critical Care Medicine continues to create and revise important practice guidelines, white papers, and surveys that influence the world of Critical Care Medicine.

In addition to improving the internal workings of SCCM, we have an important outward focus. We are an international, multiple professional, multifaceted organization. We have important ongoing relationships with other critical care groups inside and outside of the United States. We work on issues of common interest through out the world. Workforce issues are critical in the United States and with our sister U.S. societies, we continue to work with the Federal Government for financial support of healthcare students, loan forgiveness, and relaxed VISA requirements for those practicing in the ICU. Internationally, we are learning from our colleagues how different models of ICU care delivery can be effective and that the earlier resuscitation starts, the better the survival in the ICU. Rapid response teams or medical emergency teams may be able to prevent the need for our advanced skills and therapies by intervening earlier in hospitalized patients and avoiding the complications of late treatment.

Our European colleagues are taking this concept even further, suggesting that critical care should start at home and the delivery of critical care should be considered a continuum. Certainly, the recent work in sepsis treatment supports this idea, since critical care treatment and goal-directed

resuscitation performed in the emergency room affects ultimate survival from this critical illness.

As I said at the beginning of my address, I love the practice of critical care medicine and I love being part of the Society of Critical Care Medicine. Being part of a multiple professional team at the bedside, providing care to the sickest patients, delivering the Right Care, Right Now, giving these vulnerable patients the best chance possible is personally fulfilling and professionally rewarding. My family received such care and can vouch for its value. Being part of the Society of Critical Care Medicine, an organization with high ideals, cutting edge approaches to management and education, and working with such excellent people is much like being part of the critical care team at the bedside. Together in SCCM we can do much more than one person by themselves can achieve. I encourage each of you to rededicate yourself to the care of patients you see, learn as much as you can from this outstanding Congress, interact with your peers and support them, and take this new knowledge and rededication to our mission of caring back with you and share it with your colleagues at home.

My final comments and last goal relate to our Critical Care Education and Research Foundation.

SCCM is incorporated as an educational and charitable organization. We have excelled in our educational mission. Our members are very generous, donating money as well as time. Every year we encourage each of you to support the Foundation with an additional, tax deductible contribution submitted with your membership fees. I have just reviewed some of the many successful activities of SCCM, but there are many more excellent projects that we do not have the resources to complete. Over the past few years, your Foundation has received nearly $180,000 from our members for important programs that focus on improving care including research projects, clinical guidelines, and patient and family educational materials. These donations through the Foundation have also allowed FCCS courses to be delivered in indigent countries throughout the world. Foundation money is not used for routine activities or to support the general fund but allows these new initiatives to be launched and completed.

I have experience in fund raising charity work unrelated to the Foundation. Each year I participate in my community Multiple Sclerosis Society Bike Ride. I solicit support for the 150-mile bike ride that I attempt to complete. Those of you familiar with the Blue Ridge area of the middle Atlantic area where I live know how challenging the terrain can be. There are about 150 people that I ask each year for a small amount per mile that I ride. I do not ask for much, only a little from each person. Most people commit to this and because I do my part—train and complete the ride—they do theirs—send in the money. Last Spring, thanks to my many generous supporters, I was the top fund raiser in our local ride. I would like to make a similar appeal to each of you. Give at least a small amount to the Foundation and we will do our part—complete the projects you decide are most important. Since it is SCCM's 35th Congress, I suggest that each one of us commit to give at least 35 dollars to the Foundation.

Of course, some will want to give much more, and I encourage those who can to do so. We have some members who donate more than $10,000.00 each year. Equally important though, is that every one give something to the annual appeal. Our professional staff has an excellent track record of giving to the Foundation, but we, the volunteers, need to improve our participation. By achieving 100% participation, we create the credibility needed to allow our Foundation to approach outside organizations for additional support. We need to develop and demonstrate a culture of charity and an expectation of giving within SCCM to be able to show potential donors that we are committed to our charitable mission. This is another area where measurement can be used to judge our success. If half our members donate just $35 this year, we will have an additional $200,000 for research grants, patient and family support projects, FCCS courses, guideline development, and other activities. If you are in a giving mood, inside your registration packets, there is the CCERF brochure with a built-in envelope. Simply fill out this form to select the project you would like to support. Outside the doors to this auditorium, Foundation staff are waiting and will take your contribution today to help achieve this important goal.

In conclusion, I wish to thank you for your trust in me to help lead your Society this coming year. I will judge our success this year by measurable, achievable goals, some of which you have heard. I welcome your ideas and thoughts on how we can improve our services and programs. I encourage each of you to increase your activity within SCCM but, most importantly, rededicate yourself to your patients and your friends and colleagues working with you at the bedside to deliver the Right Care, Right Now. Find a way to measure what you have accomplished and set high standards for the next improvement cycle. Thank you for your attention and your extraordinary commitment to care of the critically ill.

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