Thank you for the honor of serving as your president in this coming year.As a young girl growing up in Milwaukee, WI, never in my wildest dreams did I see myself as president of our Society of Critical Care Medicine (SCCM). Back then, my dreams were more likely to be about ice cream sodas, sundaes, and all the penny candy to be found in my grandfather's corner store, Horky's Pharmacy.

Everybody knew my grandpa. His customers relied on him, and he responded to their needs 24 hours a day, opening at night for an emergency. Like today's pharmacists behind the counter at Walgreens, he dispensed patient care and concern along with the little paper envelope of pills. I loved the esteem in which his neighbors held him and am sure visits to Grandpa Horky's store began my interest in pharmacy.

What led me to critical care was a professor at Purdue University and the luck of the draw. That professor sent me to shadow a pharmacist who worked in a hospital. I was not yet aware of that potential role for pharmacists. I watched that pharmacist interact with a team of professionals and – more impressive to me – the bonus of giving direct patient care. Later on, in the Doctor of Pharmacy graduate program, our rotations were assigned by lottery and my first draw was critical care.

On my first clinical day, my preceptor, Dave Angaran from the University of Minnesota, told me to go observe a patient who was dying. It was my first lesson in understanding that just because we can do something for a patient doesn't mean we should. There is a time to let go. In addition, I learned much from the critical care nurses and gained so much respect for them, especially for their patience in never being too busy to answer my questions. I learned from them the process of taking care of patients and their families.

Key Words: teamwork; safety; pharmacists; adverse drug events; daily goals; communication

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That critical care rotation opened my eyes to the world of medicine, the bigger picture, and the role I could play in it. In the hospital I could practice pharmacy – which I love – and also make a difference for complex patients and work with a team of highly trained professionals. What a rewarding way to spend a day.

What led me to SCCM were the leaders and opportunities – leaders like Max Harry Weil, our founding president. He said in 1972 in his inaugural address that the success of our society hinged on a leadership made up of the diverse viewpoints of our multidisciplinary organization (1). He further pledged his commitment to developing an inclusive society at all levels of leadership. Dr. Weil and successive leaders have been true to their word. Ake Grenvik stated that "the best possible care of critically ill patients can be rendered when physicians, . . . nurses, and allied health professionals join forces and treat problems together" (2).

Though founded by male physicians, in our brief history, SCCM has been led by three women physicians, one nurse, and today its first pharmacist. I know it's not just about me personally but about the Society's recognition of the valuable role my pharmacist colleagues play, not only in our hospitals as members of the critical care team, but also in this Society. What started with a handful of pharmacists, led by Debi Armstrong and Joe Dasta, grew into the very active section we have today.

Pharmacists are the third largest membership group in SCCM, behind physicians and nurses, and the Clinical Pharmacy and Pharmacology Section is now the second largest. This group of passionate practitioners found a home in SCCM. We have pushed the envelope more than once, always while striving to find new answers to common problems or new ways to involve our members.

But those of you who work with pharmacists – and I hope it is most of you – recognize that there are many contributions made every day: streamlining care, preventing adverse events and errors, and educating on new products and processes. Having more pharmacists, especially pharmacists at the bedside, is associated with lower mortality rates (3). Our work to prevent adverse drug events is well documented, and it will save almost five times more in healthcare costs than is spent on our salaries (4). I love being a pharmacist, at the bedside, making a difference.

I'm sure you all have similar personal stories that led you to SCCM. Let's talk about this meeting and the year that lies ahead for critical care. I need a show of hands. I'm going to be traveling around the country a lot this year as your president. If I get critically ill in your region, which hospital would I want to go to? Yours? Let me see the hands of those who think your critical care program is the best. I thought so. My hand is up because I think Methodist Hospital in Indianapolis is the best in my state. But do I know it? Do I know my teams provide the best critical care in the state? Perhaps yes; Methodist Hospital in Indianapolis has been recognized as a top-performing hospital by the University HealthSystem Consortium 2 years in a row. Do you know if yours is the best in your state? Can you prove it, show your track record of quality measures and regular review? I'm going to guess that in most cases, the answer is no. Quality is not a bit like pornography; it's not a matter of knowing it only when you see it. Quality can be defined, components can be measured, and it can be tangibly proven. And that's what this year's meeting is all about, with more than 100 sessions and 300 expert presenters, all with the underlying theme of quality.

Demonstrating quality is not the same as being perfect; it takes work every day as new challenges arise. Ten years ago, that infamous Institute of Medicine (IOM) report – the one that said as many as 100,000 hospital patients die each year of medical errors at the hands of physicians, nurses, pharmacists, and other healthcare workers – that report landed like a well-aimed water balloon (5). Many of us were distrustful of the report, thought the estimate way too high, but none of us could deny the accuracy or the intent.

The number of deaths and injuries is unacceptably high. Five years ago, my hospital made national news. We administered an adult dose of heparin to six neonates; three died before we recognized the error and corrected it. The ba-

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bies got the wrong dose because of similar product labeling, improper stocking, and failure to do a proper double check. We acknowledged our mistakes very publicly, spending time with the families and the press. This disclosure process was important, as was our focus on the system errors. There was a series of mistakes that were made, lots of contributing factors, a system problem. This has been described as a *Swiss cheese alignment*, where all the holes allow an error to pass through unimpeded. We thought we had a good system, but we learned differently. We'd been reacting to problems and individual events rather than prospectively planning for all that could go wrong. It was a costly, costly lesson, but it changed the culture of safety in our hospital.

Has it changed your hospital? Here we are, 10 years after that IOM report, but the pace of change has been dismally slow in many hospitals. There are several tools to measure the culture of safety in your hospital or intensive care unit (ICU) (6). Have you used them? Measurement often reveals a very different perspective among team members; the view from the top can be very different than the view from the trenches (7). Have you asked your colleagues for their assessment of the team or patient safety? Do you assume, or do you know, that your patients are safe?

My safety focus is obviously on medications and therapies. I want a seamless process, so I need to understand the needs of my nurses, their processes, and their concerns. When we sought to reduce the rates of bloodstream infections and ventilator-associated pneumonia, our team banded together: nurses, physicians, respiratory care specialists, and pharmacists. It has been a long process. We measured and tested new interventions, had setbacks, but kept at it. We have been successful; we have celebrated these infection rates at an all-time low. For example, our neurotrauma unit has gone over 6 months without a ventilator-associated pneumonia and 4 months without a bloodstream infection, and other ICUs have similar results. This was a team effort that included all adult ICUs. Peer pressure and competition: it worked for our ICUs. We generated collaborative enthusiasm. What does it take for your hospital and staff to challenge the status quo?

We had all team members present and engaged. Identifying where your team needs help is the first step to making positive change to improve patient safety. Start with your team. Do you have everyone present, have common goals, know what needs to be done? Focus on care at the bedside. Make sure the daily goals are identified and clear to everyone (8, 9). Some units put these goals in writing every day, and success has followed. Evidence-based care is provided more routinely and systematically when caregivers are focused on a goal. Some units have implemented bundles and developed tools to maximize adherence. It takes the team to make it happen: every patient, every day, everyone on the same page. Our bedside nurses have to know the plan and the goals, and have to share our passion for patient safety.

Part of our job as professionals is to face the issues of quality and safety head-on. Patients, families, and payers expect it and, in truth, so do we. It is a challenge to develop the tools needed to measure outcomes and then – and most importantly – implement the guidelines and protocols necessary to achieve that quality.

Publications like the Surviving Sepsis Campaign database results are important to demonstrate the potential impact of what we do every day (10). Teams from ICUs just like yours and mine developed a structure, followed a plan using the sepsis bundles, and measured the results. These were volunteers doing the extra activity to measure the impact of their team. One of the most important tools you have is your team. Where does your team stand, together or apart?

One of my passions is sailing, where team work is essential. Every crew member has a job and must be able to execute the task. We are only successful if everyone works together and trusts everyone else. We each have to know our role, but also the roles of others. If someone needs assistance, we must be able to provide that support. When sailing, we need to chart our route, or we may miss our destination. We arrive at the next island with reason to celebrate. I see parallels between my time on the water and my time in the hospital. We need the same kind of training, planning, goals, unified effort, and trust. But they don't come automatically. These strengths only come with time, practice, and willingness to be persistent. Teams and team leaders need to develop skills and improve communication and trust. It's like a family; there will be new challenges and setbacks. Trust must be earned and demonstrated often. One of our new respiratory care managers just asked me how I, a pharmacist, knew so much about their processes and needs. I learned from the team: from other therapists at home, and from those within our SCCM network.

There is so much to learn here and so much to share among us. That's why SCCM continues to work so hard to provide the tools and support you need. You have the opportunity to use our resources to help your team. Consider hosting a Fundamental Critical Care Support, Pediatric Fundamental Critical Care Support, or Fundamental Disaster Management course at your institution. Explore SCCM's LearnICU Web site, or incorporate the Surviving Sepsis Campaign bundles. Access all of the many resources your Society offers you. Most of all, remember that you are not alone in this process. Your colleagues in this Society and in hospitals throughout the world are working toward the same goals. Many of you have been highly successful in making your ICUs safer, better places for patients and for staff. Please be eager to share and learn. That is what membership in SCCM and attendance at this Congress is all about.

You just saw an amazing introduction to our new Paragon Critical Care Quality Improvement Program. This new SCCM product provides support for your team and your ICU to make the changes that you need or want, that your patients need and want. Be sure to stop by the Paragon booth located in the Sky Bridge above the Exhibit Hall. Talk with the peer-to-peer coaches, and learn how they can help you and your team improve your critical care quality. While there, sign the *Commit – Transform – Improve* board to demonstrate your passion for quality patient care. How many signatures will we get? One thousand? Two thousand? More? Can we? Is now the right time? The answer is yes. I have signed that board, and I hope you will too.

Much may change in the future of U.S. healthcare; the details are still evolving. But no matter what else changes, quality will remain a healthcare mandate. Government, insurers, and the public are demanding as much transparency and efficiency in their healthcare as they already get from their grocery stores, Netflix, or UPS tracking systems. Payers have put us on notice that they will no longer pay for mistakes and iatrogenic complications.

My charge to you today is twofold. First, take advantage of all this Congress has to offer. Bring an open mind to the sessions, a willingness to consider that

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there might be another way – a better way – to do something. Learn how you can reduce infection rates, eliminate medication errors, slash the number of patients who develop pneumonia, and make other improvements. This meeting is a great place to think about ways your critical care team can improve quality and patient safety. Second, take what you learn home with you. Go back to your hospital and your critical care units with a willingness to change the way things are done. Don't start in a few weeks or a month. Go home and start the conversations and activities necessary to make change happen now. Today, tomorrow, together: the time is right for change. One patient at a time; every patient every time.

Let's quantify quality with a goal not to be as good as we think we are, but to be even better because our commitment does matter Transformation is crucial and it is expected. We need to make the ICU safer for our patients and a better place for our staff. It's an achievable goal, and I look forward to working with you this year to make that goal a reality.

I wouldn't be standing here today without the help of family and friends. Most important is my husband of 27 wonderful years, Jim Mowry: my best friend, my sailing partner, and the person who keeps me grounded. My parents, Anne and John Jacobi, taught me the value of independence, hard work, generosity, and good food. I am also thrilled to recognize my sisters and their husbands: Jo and Doug Kaempfer, Jan and Mike Seebruch, my sister-in-law Lynn Mowry.

Many of my medical family are here from Methodist Hospital and Clarian Health, as is my pharmacy family headed by Tate Trujillo. I think we have a great and unique team and, while everyone could not be here, I hope the folks back home know I thank them also.

Finally, I am grateful for the ongoing support of the SCCM Council and Executive Committee and, of course, the SCCM staff, led by David Martin, who are as dedicated to this organization as you are to your patients. Please join me in thanking them for all they do for me, for SCCM, and for our patients.

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