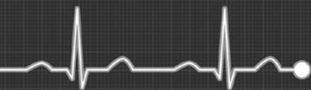

Presidential Address

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Society of Critical Care Medicine Presidential Address—49th Annual Congress, February 2020, Orlando, Florida

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MIND THE GAP

Thank you, Heather, for such a delightful introduction. We are indebted to you for the grace and skill with which you have artfully led our society. Notable accomplishments include new alliances, innovative programming, and successful public health education that honored your family's devotion to prehospital care. In sum, you have stewarded SCCM though a spectacular year. Very well done indeed!

Let us now look forward together. As Heather noted, this year's Congress is unique. For the first time, 30 organizations are collaborating with SCCM's Program Planning Committee to bring you a spectacular Critical Care Congress. None of this would have been possible without the dedication and tireless work of the SCCM staff. They are readily identifiable throughout Congress by their orange shirts. Join me now in thanking them for making Critical Care Week a resounding success.

Paralleling the ICU team-based structure that we embrace every day, these Societies craft a new team for SCCM. That team includes media partners to share the unique aspects of welcoming multiple critical care organizations in one place–the right place–and at the right time. We are expanding our collaborations to discover new knowledge and improve care across the globe.

Discovery is more than just inquiry. It is also the name of our increasingly successful research network. Addressing key clinical issues such as sepsis and organ failure, Discovery offers expert grant advice, research infrastructure, and clinical partners. Of course, Discovery relies on you and your team envisioning a critical question to be answered. It is this journey that often brings one to critical care, and for many, an essential aspect of being sustained within it. My journey began with a bullfrog as I reached the very advanced age of 8. It was the first pet that was uniquely mine–and I was in love.

As is the case for free-range bullfrogs, mine did not survive the season. Crestfallen at my pet's demise despite devoted care, I found refuge in medicine. It was the early 1970s and the heyday of cardiac surgery. Cardiopulmonary bypass was new–imagine that time. Bypass enjoyed triumphs in patient care and lay press notoriety with equal measure. With the naiveté of youth, a future repairing failing hearts charted my course, all with the certainty of pet immortality. My parents often told me that I was an unusual child! Swiftly learning that my childhood

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plan was less sound than desired, the novelty of evolving techniques for cardiac surgery sustained my enthusiasm from grade school through medical school. More importantly, every success led me to question how each one came to pass. These were my next steps along the path to Discovery.

In England, the subway system is known as the Tube, and presents travelers with a ubiquitous admonition–"Mind The Gap." Signs, t-shirts, and mugs alike remind passengers to avoid stepping into that perilous space lurking between the platform and the train. And yet, it is into this very space that I encourage you to delve. For it is here, in the space between what we know–and what we can imagine–that the answers lie.

One of those gaps relates to our partners. This year, in conjunction with our natural partner across the Atlantic, the European Society of Intensive Care Medicine, we are discussing filling a long-standing gap–durable collaboration that embraces more than just the Surviving Sepsis Campaign. Each year we will invite you to explore a different facet of the future of critical care. We intend to ignite your imagination! Our very first group manuscript, aptly titled, "Imagine…" appears in this month's editions of both *Intensive Care Medicine* and *Critical Care Medicine*. In fact, this year's joint SCCM-ESICM session exploring data science in and outside of the ICU flows directly from that collaboration.

The spark that ignited my passion for medicine and surgery would lead me to critical care and the OR. Initially as surgeon, and later, as a patient. A touch over 38 and a half years rushed me headlong into several life-altering discoveries. The pain of myocardial ischemia that stemmed from five-vessel stenosis. That 1 mg of midazolam is woefully insufficiently sedating in the catheterization lab (I required my own monitor, supporting the value of a non-pharmacologic management approach). And that despite a tightly wired sternotomy, effective analgesia eluded my grasp–and still does on rainy days. I extubated rapidly and promptly enjoyed widespread atelectasis and florid hypoxia. Forty-eight hours later, exhausted from breathing I asked my partner to reintubate me. Not your usual request. While assembling supplies, a Respiratory Therapist recently returned from a conference brought back a sample Positive Expiratory Pressure device; commonplace now, but new then. It was not very clean, but it was highly effective. I soon discovered what previously inspissated secretions looked like as well as the impact of reversing hypoxic pulmonary vasoconstriction on oxygenation. That one intervention rapidly eliminated all of my supplemental oxygen needs–a triumph of physiology. I had discovered the "why" of my clinical condition!

More importantly, neither my family nor I was spared the uncertainty and sense of doom that permeated those five days. My wife was a critical care nurse in that unit. It was the unit that I directed, and the one in which we met. Imagine if you will, two preschool-aged children, one autistic, presented with a very different image of a parent sprouting tubes, lines, and drains from seemingly everywhere! To this day, my daughter Kayla, who greets everyone else with a crushing embrace provides me with only the most gentle of hugs–an omnipresent reminder of that time–and her deeply connected understanding of it, in a way that she does not with other social circumstances. We had a robust introduction to what is now termed, and well investigated by SCCM–Post-Intensive Care Syndrome-Family. Indeed, our efforts in this space, launched in 2013 have borne fruit. THRIVE, ICU Liberation, and durable materials from the Patient and Family Committee abound. But our work is not complete. But then, neither was my discovery journey.

Embracing surgery as an avocation, I found joy in searching for the answer to "why" instead of only "what". My career delved into unexplored and somewhat atypical niches. Unmeasured ions, airway pressure release ventilation, non-hemorrhaging anemia transfusion thresholds, emergency general surgery–now known as Acute Care Surgery–and most recently, tactical emergency medical support are apt examples. With regard to deploying as a member of a civilian tactical team, my partners suggested a STAT brain CT. More than once. It was far off the well-trod path. But it was where I found answers, and from where I drew inspiration. Just like within SCCM where you will find unbridled opportunities to learn, collaborate, and discover your passion.

Passion benefits from being precisely channeled. In your SCCM Section or Chapter, or perhaps within the committee for which you volunteer, you are likely to find advisors, coaches, and perhaps, if you are fortunate, a mentor. Each of them plays a vital role in your professional as well as personal development. My journey to this stage reflects the influence of each of my guides. Each of you have my enduring gratitude. At the bedside, published research helps guide care, including that which flows from our flagship journal, *Critical Care Medicine* and its Editor-in-Chief, Timothy Buchman, a former SCCM President. You have likely noticed upgrades to the journal layout, content and appearance, all supporting *CCM* as one of the world's leading critical care focused journals. But *CCM* is not your only SCCM-related source for cutting edge research, clinical reviews and controversial viewpoints.

At last year's Congress we launched *Critical Care Explorations*, our rather successful open access journal that Dr. Buchman also leads. Within the pages of *CCM*'s partner journal, *Pediatric Critical Care Medicine*, and simultaneously published in ESICM's flagship journal *Intensive Care Medicine*, you will find our very first Pediatric Sepsis Guidelines. The Surviving Sepsis Campaign has been quite productive and has recently embarked on the next revision of the adult guidelines as well.

You may wonder what else SCCM has accomplished over the course of the year. I am pleased to report that this gap has been filled by an Annual Report posted on our website and available for download (www.sccm.org/annualreport). Finances, collaborations, publications, grants, presentations, and initiatives are all detailed for your review in an easily navigable format providing you tremendous detail.

Relatedly, this past year has been one of introspection as well as inquiry. Council has delved into three key areas: 1) who do we want to be as a professional organization, 2) with which partners do we wish to pursue that vision, and finally, 3) what strategies should we employ to achieve those goals? Look forward to learning the results of this year-long process through *Critical Connections*, the website, and the new Annual Report.

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This exploration uncovered important gaps in the Strategic Planning process. We want to more completely immerse you in the process of generating proposals. You have already started to receive requests for proposals (RFPs) targeting areas Council has identified as important in enhancing patient care. RFPs will come to you in the fall, providing sufficient time to craft successful approaches to the questions posed. Of course, member-derived proposals remain essential and are readily welcomed. While many of those proposals stem from committees, they also flow from the local Chapters. Like many of our leaders, my initial opportunity blossomed in my local chapter–Pennsylvania.

Your proposals have established new structures such as the wildly popular standing room only Women in Critical Care Knowledge Education Group–or KEG. This year launches six more–Data Science, Choosing Wisely, Ob-Gyn, Palliative Care, Coding and Billing, and Geriatric Critical Care. We continue to embrace critical care outside of the walls of the ICU as our founders intended. Indeed, outside of the ICU is where we want our patients to go. Stop by the ICU Liberation lab at the entrance of the exhibit hall which dovetails with our pre-Congress ICU Liberation course. These two offerings highlight the work of the ICU Liberation Collaborative from which we have garnered some of the most powerful data on patient and family focused bundle deployment in the ICU. They have resources available for you to take home and immediately implement.

You are undoubtedly familiar with our Fundamentals Programs including Critical Care Support, OB, and Disaster Management, all of which also address member identified needs. This year is no different as we pilot our first ever FCCS: Surgical course–derived–and well done by the way, in conjunction with our Surgery Section. As we expanded into new areas, members noted the need to teach life-saving skills in resource limited environments. Some of those may be austere and operational, especially those faced by our militarily deployed members. These challenging areas may also be found at home such as in the aftermath of firearm violence. Whether in a civilian or military role, or attached to a law enforcement tactical team, there is never enough of what you need when you need it to save lives. Accordingly, FCCS: Resource Limited is making its debut at Congress this year. This space is another gap we are filling by partnering with the American College of Surgeons Committee on Trauma–and more than 40 other professional organizations–to help address the firearm-related injury public health crisis. Indeed, this IS Our Lane and it is unfortunately rather busy.

Violence is not limited to urban spaces. It occurs in the workplace with great frequency in the Emergency Department as well as the ICU. At last year's Congress you learned about the Critical Care Society Collaborative's high impact work addressing Burn Out Syndrome. This year AACN, CHEST, ATS and SCCM–the four members of the CCSC–are delving into how to best address workplace violence. In parallel, the Program Committee has embedded sessions on Conflict Mediation in the ICU. They are designed to provide every member of your team essential de-escalation and management skills to prevent conflict and avoid workplace violence. Of course, these skills also help reduce moral distress–a key driver of Burn Out! Several years earlier, the CCSC helped develop the first five Choosing Wisely (ABIM) targets for critical care, a process in which I was privileged to participate. I am pleased to announce that our Quality and Safety committee is on the verge of finalizing the next five to share with your ICU as well.

It is clear that our society keeps evolving to meet new patient care and clinician education challenges. Moreover, we are doing so on a global scale with courses in multiple countries. If all of those activities seem like a challenge to manage and coordinate–you're right! It requires skilled leadership to ensure that all of the pieces seamlessly fit together. In 2005, *BusinessWeek* celebrated Peter Drucker, an Austrian-born American consultant, educator, and author as "the man who invented management". He counselled: "Only a focused and common mission will hold the organization together and enable it to produce." The glue that ties SCCM's mission to action is David Martin, our CEO who leads the SCCM staff, and advises Council. Drucker noted that "There is no procedure or checklist for managerial courage." Inspired and undaunted, courage underpins David's management decisions. Please accept our deepest gratitude for helping shepherd SCCM toward excellence.

Earlier you had a brief introduction to my shepherds. Allow me to properly share them with you. My middle child Kayla who struggles daily with autism. Travel and Kayla have different priorities. Fiercely supportive of one another, my family remains at home with her. Kayla has two bookend brothers who share a birthday as Kayla shares mine. My youngest son, Killian is 13, a fencer, and an unfailingly kind person. Aidan is my oldest at age 24. He is a successful game designer with a wry sense of humor and lightning wit. Most importantly meet Maureen, my far better half. We met in 1988 when I was a rather lost intern. I could not have done this without your love and support. I am indeed fortunate to have been graced with such an extraordinary family. My home is completed by our 4-legged managers, Bella and Cole, both of whom are Akitas.

As my family does for me, this Congress provides several pillars of support for you and your team. Novel education both basic and advanced, expert forums, and collaborative opportunities craft support for your teams and their patients. All of these are overlaid with late-breaking releases from industry leading journals such as *Critical Care Medicine*, *JAMA*, and the *New England Journal of Medicine*. Regardless of parent discipline, whether you are a trainee or faculty, in the community or academia, there is something in these halls and meeting rooms to bestir your passion for critical care. I ask that while coursing from sessions on ARDS to Critical Crosstalks to a focused Year In Review, you simply "Mind The Gap". It is my privilege and great pleasure to invite you to discover Critical Care Week 2020! Welcome to Congress!

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