



# Society of Critical Care Medicine Presidential Address—42nd Annual Congress, January 2013, San Juan, Puerto Rico

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I thank you for the honor and the opportunity of representing you in the coming year. I've often felt that honor from peers and colleagues is the highest honor, and with it comes a special responsibility: not only to represent, but to lead; to help both an organization and its individual members move forward; to pick an aspect of our profession that is of special interest and needs urgent attention, and then give it an extra focus as your President.

We have a tradition of that in our Society. Last year, Cliff Deutschman urged a reemphasis on bench and traditional research. The year before, Pamela Lipsett challenged us to learn new “stuff”. And before that, Judy Jacobi focused on quality measures. This year, a happy coincidence, the challenge for those of us in critical care and my passion are one and the same: comfort strategies, especially pain management; changing in a significant way how we manage comfort in our patients.

Now, I'm not a big fan of “Dancing With the Stars,” but I've seen it a few times, I admit. And I've noticed that when the music changes, so must the dance. Critical care's music has indeed changed dramatically—you might say from a waltz to “Gangnam Style”. But too many of us are still doing the same old steps. When I first began working as a critical care nurse, and for many years since, conventional wisdom was that our patients needed complete bed rest and quiet, needed to conserve their energy, to keep immobile, sedated like zombies. Hollywood could have shot “Revenge of the Zombies” on most of our units. Today, current research and our colleagues in physical therapy have shown that thinking is faulty. We have learned that the body responds best to a program of activity. Today, we get our patients up and active often only hours after major surgery. We know now that better restoration is a body in motion—an awake, aware body in motion.

Critical care has moved from zombie level sedation to daily wake-ups to assess ventilator readiness for weaning. We're kicking them off the ventilator sooner. And we're learning better

ways to restore mobility. Last year at Congress, we saw presentations of pictures from Johns Hopkins' patients walking in the halls, accompanied by their ventilators. Many of you have read the work of, or even attended, the conferences of Jean-Louis Vincent in Brussels. He employs a team of physical therapists 24/7 to keep his patients mobile. Research is showing us that mobility is key to restoring to a normal level of physical activity. And that's the good news.

The bad news, as we all know, is that an awake patient feels pain. Now, most of us have been taught to ask our patients to rate their pain on the old 1-to-10 scale. But intubated patients can't talk, and many others can communicate but are in such a state of delirium that I'm not sure they comprehend what we're asking. My patients at University Hospital tell me that pain was the worst part of their ICU experience. But we're learning that it didn't have to be. The International Pain Society really helped when it broadened its definition of pain to include patient responses. That action laid a foundation for the College to update our guidelines. Today, we know which measures best serve our patients in assessing and treating their pain. From the Confusion Assessment Method for the ICU (CAM-ICU) and ICU pain scales, facial grimacing, fist clenching, ventilator synchrony, to morphine dose equivalents and other comfort strategies, we have a lot of tools at our fingertips. And what's more, we know they work.

But it's not enough to know best practices. We must be willing, as professionals, to abandon our old ways and embrace the new standards of care, no matter how expert or accomplished we are at the old ways. When I began working as a critical care nurse, stripping was the accepted standard of care to maintain chest tube patency, keeping the tubes open and allowing them to drain. I was delighted to discover that I had a real knack for it. Soon, I became so proficient that I was teaching others how to do the stripping. I could strip three different ways. Imagine my horror and alarm when I learned that sucking out the clot did keep the tube open, but it caused more bleeding. I was causing my patients harm. Not only was I not helping my patient, I was actually hurting them. It was a defining moment when I understood that critical care isn't a cookbook set in stone. Critical care demands that we constantly revise and update our care. That's the challenge to us as professionals: not only to keep up with the current best practices, but to embrace, adopt, and put them into practice.

Now comes the best news. Our Society's leadership is already on the case and has developed tools we need to better address

and treat pain. And that's my challenge to you in this year ahead, specifically when you return to your ICUs. Do three things: standardize routine pain assessments to every 4 hours, include as-needed orders for pain management, and address pain management adjustments on daily rounds. Let's work to take pain off the top of our patients' memories of their stay in our ICUs.

Now, I've talked a lot about pain management and patient comfort, because that's a priority of the Society and obviously a passion of mine. But they are by far not the only items on our plate this next year. You may already know that you can expect to hear from SCCM on details about our expanding Surviving Sepsis Campaign, assessing strategies in under-resourced environments, our expanded international programming, and our study mission to South Africa, where you will have an opportunity to see severe complications from infectious diseases that are less common in industrialized countries.

One of the neatest and terrific things about being a leader in SCCM is how much you come to know and appreciate about our Society. I was surprised that we draw membership from more than 100 countries. And more than 60 of those countries send professionals to our Congress. The world is looking to us for critical care education and standards, and in turn, we're learning a lot from our colleagues around the world as we find

opportunities to explore their critical care systems. Truly, the world of critical care is a global one and a fast-changing one. And our patients and our colleagues are better for that change.

I know from a very personal experience that change can be hard, very hard. In the past 2 years, I've lost over 102 pounds – on purpose, dropped more dress sizes than you can count on one hand, and I feel great. And I'm told I look great. I'm ripped and ready to champion the cause of critical care medicine. I didn't get here in this dress and on this stage alone. Like many of you, I've had wonderful family, friends, and role models along the way, sources of inspiration and encouragement. I'd be remiss if I didn't recognize my sisters and their families; my University of Tennessee faculty colleagues and students; professional colleagues Dr. Kathleen Puntillo of the University of San Francisco, Dr. Ken Leeper at Emory University, Dr. Sheila Melander and Dr. Amado Freire at the University of Tennessee; from our Society, Cliff Deutschman, our Council, and staff; and so many friends I see in this room today. You've been and continue to be a great team for me, for our Society, and for our critical care patients.

I look forward to working with you in our coming year, and to another successful year in providing quality care for our patients. Muchas gracias.