

Programs, partnerships, and patient care: Moving Society of Critical Care Medicine and critical care forward

The Presidential Address from the 27th Educational and Scientific Symposium of the Society of Critical Care Medicine

In 1980, I arrived at Keesler U.S. Air Force Medical Center in Biloxi, MS, having just completed a pulmonary fellowship with minimal exposure to critical care. I arrived at an institution rich with the early pioneering spirit of critical care medicine: a medical-surgical intensive care unit; multispecialty physician interest and expertise in critical care medicine; intensive care unit (ICU) nurses and respiratory care practitioners actively offering input into patient management; medicine and surgery residents forming a common pool for ICU coverage. I learned critical care medicine primarily through "on-the-job training." It was a wonderful, novel experience. I had found my passion.

Today, no one would consider learning critical care as I did. Today, the physician aspiring to be an *intensivist* has access to high-quality, accredited fellowships. Today, we have 10 yrs of critical care board exams behind us. Today, we have the rich, accomplished, 28-yr history of the Society of Critical Care Medicine (SCCM) from which to draw information, innovation, and inspiration.

Today, nearly 20 yrs after I walked into that ICU in Biloxi, MS, I stand before you as the President of your Society, now over 9,000 members. SCCM has come a long way since 1970.

Despite our accomplishments, we are not there yet.

One of our great sportsmen and philosophers, Yogi Berra, said "You've got to be very careful if you don't know where you are going because you might not get there." When I look at SCCM, I see an organization that does know where it is going. I see an organization that looks at today's challenges and sees tomorrow's opportunities. I see an organization that is relying more on its members to guide its strategic plan. We must, however, remember that our first priority for strategic planning is the care of the critically ill patient.

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all scientific journals. Two newer programs are now poised to take off, and with these programs, you, the members of this organization, can make a difference.

Project IMPACT provides you with the capability to link your ICU database to a central repository for comparative analysis. We must be able to measure the quality of critical care before we can improve it—remember, "if you can't measure it, you can't improve it." Project IMPACT was developed and is administered by critical care practitioners like you—not by the government, not by a for-profit company—but by members of the critical care team. Project IMPACT belongs to you and you can ensure its success.

Fundamental Critical Care Support (FCCS) is a seminal, groundbreaking, standardized course which teaches the basic tenets of critical care medicine to nonintensivists and is designed to assure that the critically ill patient is well managed until care by the intensivist can be obtained. This is a course with great potential for physicians-in-training as well as for ICU nurses. Three international courses in 1997 and another 17 scheduled for 1998 gives FCCS the potential for global impact. FCCS has the potential to make an important difference in the care of critically ill patients. FCCS belongs to you, and you can make the difference.

I encourage you to invest your time and energy in these programs because Project IMPACT and FCCS can take us where we want to go.

But it's not enough to focus only on ourselves, only on SCCM. We must also communicate effectively with our colleagues and with other organizations. SCCM's increasing partnership with the American College of Chest Physicians and the American Thoracic

SCCM is about programs, partnerships, and, most importantly, patient care. Many of our programs are well-established winners. To establish that fact, one only needs to look at the success of this meeting and the ranking of *Critical Care Medicine* in the top 5% of

Presented, in part, at the 27th Educational and Scientific Symposium of the Society of Critical Care Medicine, San Antonio, TX, February 5, 1998.

Key Words: Society of Critical Care Medicine; Project IMPACT; Fundamental Critical Care Support; Coalition for Critical Care Excellence

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Society and our continued collaboration with the American Association of Critical-Care Nurses provide an opportunity to improve patient care and bring cost savings and additional benefits to our members. Our collaboration with industry, in general and especially through the Coalition for Critical Care Excellence, uniquely positions us to take the best of what we do today and make it even better tomorrow.

Our international partnerships facilitate the advancement of multidisciplinary critical care around the world. Our growing collaboration with the European Society of Intensive Care Medicine currently focuses on ICU databases and education. We plan on celebrating the 25th anniversary of the Mexican Critical Care Society by making their 1998 meeting a joint Mexican Critical Care Society/SCCM effort. Our growing collaboration with our critical care colleagues in Brazil and in Florence, Italy, are also signs that partnerships are good for all.

Achieving recognition of the value of critical care in today's healthcare system will take more than sheer technical and clinical skills. We need a heightened participation in the business and political sides of health care. For example, the time required by the onerous documentation guidelines established by the U.S. Health Care Financing Administration, which will soon be required in the ICU, is not in the best interest of the "guy in the bed."

To achieve recognition of critical care, we must commit to conveying the effectiveness and uniqueness of our Society to other healthcare professionals, administrators, and managed care organizations. We must engender in our medical students and residents an understanding of who we are, what we do, and why our organization brings added value to the practice of medicine. Preliminary studies suggest that superior outcomes can be achieved with our model of critical care delivery. However, we need additional clinical outcomes and cost-benefit research to show that our model of multidisciplinary critical care makes a difference; this should be a priority of this organization. To achieve recognition of critical care, we must educate the lay public—future critical care patients and families—on the merit of our multi-

disciplinary model. If the public recognizes the value of our model, they will demand it.

It will take something else for the continued success of this organization. It will take addressing controversial issues that affect critical care, as they arise, in a timely and responsible manner—issues such as how the intensivist will mesh with the hospitalist movement. While it is not clear how the hospitalist will interact or overlap with the intensivist, two things are clear to me. First, there is a level of critical illness for which patient care is best served through an intensivist-led multidisciplinary team. Second, although the hospital-based intensivist is by definition a hospitalist, the hospitalist is not necessarily an intensivist. I anticipate that SCCM will develop a positive and mutually beneficial relationship with the hospitalist movement, as we share a common interest in high-quality and cost-efficient care of the hospitalized patient. For the hospitalist who is also an intensivist, SCCM is a natural home.

As a diverse group of professionals, SCCM members bring their own unique perspectives to this organization. Now, I don't care if you believe in a closed ICU. I don't care if you believe in an open ICU. I don't care if the patient is seen by a hospital-based intensivist or by a consultant intensivist. I do care about three very important and indispensable elements of critical care delivery.

- I care that multidisciplinary patient care is provided with input from all members of the critical care team: the physician, the nurse, the respiratory care practitioner, the clinical pharmacist, and others.
- I care that an intensivist is the leader or co-leader of the critical care team and that decisions are made by the team and its leadership.
- Finally, to reiterate the vision of our founders, I care that a seamless path of critical care delivery is created that includes the prehospital area, the emergency department, the operating room, and the intensive care unit.

Programs, partnerships, and, most importantly, patient care—SCCM is

working hard to advance all three. Today, I'm asking all of you to help us: To step up your commitment to serving your Society and the care of the critically ill patient in some way.

Help us with our programs. Help us with our partnerships.

Help us find ways to deliver better care to the patient in the ICU bed.

Develop and enact care paths, guidelines, and protocols in your ICU to demonstrate your value and the value of the multidisciplinary model of critical care for which this Society stands.

Submit abstracts for the 1999 SCCM Educational and Scientific Symposium.

Continue to be a member and help us attract more members through the Critical Links program.

Bring Project IMPACT into your ICU and into your hospital.

Conduct an FCCS course.

Become involved in your SCCM Chapter and in your SCCM Section.

Invite your colleagues to the 1999 SCCM Symposium.

Communicate your ideas to SCCM leadership and staff. Use E-mail and the SCCM web page—we promise to listen.

Submit your best work to *Critical Care Medicine*, where it will be read by your colleagues around the world.

Only with you and your active involvement can we advance the cause of multidisciplinary critical care medicine.

As that other great American philosopher Barbara Mandrell said, "I was country when country wasn't cool." Well, the Society of Critical Care Medicine stood for multidisciplinary when multidisciplinary wasn't cool. What made SCCM unique in 1970 makes our organization a leader in critical care around the world today. A passion for our programs, collaboration with our partners, and an unwavering dedication to the capabilities of our model of critical care delivery. Join me and our entire Society in preparing to move multidisciplinary critical care to a higher plane in the new century.

It takes programs.

It takes partnerships.

It takes a commitment to patient care.

It takes the best that you and I can give to our patients, to each other, and to this Society.

R. Phillip Dellinger, MD, FCCM
1998 President
Society of Critical Care Medicine