Invisible excellence

The Presidential Address from the 31st Congress of the Society of Critical Care Medicine

One constant in my 35-year critical care career is my commitment to the intensivist model. Near the beginning, I was fortunate to practice in a hospital with a critical care fellowship program directed by one of the giants and founding fathers of critical care, Dr. Max Harry Weil. After I left, I became a full-time vagabond instructor, a role that brought me into a number of intensive care units (ICUs) each year. I was immediately and am continually astounded by how few units have intensivist-directed multidisciplinary teams and how this negatively affects patients and their families. I began to wonder why everyone is not clamoring for intensivists.

If you were to walk through your emergency room right now and then walk through your ICU, which would have more vulnerable, unstable patients? Which would have more devices, drugs, tubes, and disorders not seen anywhere else? Which would have the highest mortality rate if patients were left unattended for a few hours? Yet, for which does the standard of care dictate the 24-hour presence of a specially trained physician? In this country, unlike in most developed nations, medical care of the ICU patient is often left to critical care nurses. One of the biggest secrets in U.S. health care today is that the medical care of our most vulnerable patients is being managed by nurses. Only about 30% of our patients are even seen by attending physicians with intensive care training, and fewer than 5% of our units have intensivist-directed teams. Two thirds of the medical orders in our ICU are written or coached by nurses. Thankfully, critical care nurses are highly trained and committed to their patients. Why doesn't this cause all nurses to clamor for intensivists?

Nurses struggle to make sure that an adequate number and appropriate mix of novice and expert nurses staff each shift. They will not permit nurses new to the ICU to care for patients until they have both didactic courses and precepted clinical experience. Why do they tolerate the delivery of their patients' medical care by physicians with little or no training and experience in critical care? The standard of care requires that critical care nurses be trained and present in adequate numbers. Why are physicians allowed to be untrained and absent? All patients deserve highly trained and present nurses, intensivists, pharmacists, and respiratory therapists. Why do we let patients suffer needlessly?

Nurses are in a unique position to see all of the problems the currently predominant system of critical care creates. So why aren't all nurses clamoring for intensivists? The probable reason is that many nurses have never worked with an intensivist-led team. They have only experienced the more typical model of multiple medical consultants intermittently present, most without formal training in critical care and each focusing on only one of the patient's systems or problems. Therefore, when most nurses picture a unit with increased physician presence, they do not picture one with rich, respectful bedside collaboration and a system that promotes topflight care. They picture increased confusion and interference. They cannot conceive of how much more organized and less fragmented the delivery of care would be. They cannot imagine a physician-led team that is tightly focused on the care of the whole patient and the patient's family. They cannot visualize a unit in which physicians are present to advocate for the needs of the patients, their families, and the staff. They cannot dream of a day when a fully trained ICU physician would be immediately available whenever needed. With an intensivist model, nurses do not have to take the risk of initiating emergent therapy without physician orders. The intensivist is immediately available to manage emergencies. Nurses do not have to waste their time juggling conflicting medical orders. The intensivist is there to prevent that. Nurses do not have to devote time and energy to begging for the transfer of patients who no longer need critical care to make room for those who do. The intensivist is there to ensure appropriate bed utililization. Nurses do not have to keep up with medical advances and to convince physicians to apply them to their patients. Intensivists are devoted to the field of critical care and keep abreast of the relevant research. They take responsibility for the medical management of ICU patients so nurses have more time for giving high-quality nursing care. Nurses can practice nursing!

So why isn't everyone clamoring for intensivists? Because intensivists practice invisible excellence. This is a phenomenon I have long observed, and it is easily described in nursing. The better they are, the more invisible they are. Good nursing is invisible. Good nurses see a little skin redness before the skin breaks down. Good nurses pick up on tachypnea before the patient has a respiratory arrest. Good nurses recognize orthostatic hypotension before the patient goes into hypovolemic shock. Good nurses know the potential complications of disease and interventions and prevent them from occurring, etc. The better they are, the more invisible they are. When I walk through a unit full of invisible nurses, I see the nurses vigilantly standing and watching and thinking and the patients cruising. Because the nurses are protecting them, the patients are doing well. When administrators walk through a unit like this, what do they see? They see nurses stand-

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ing there and the patients cruising. They wonder why they are paying high-priced personnel to stand around when the patients are clearly doing so well. They try to figure out how they can decrease the number of nurses to cut costs when, in fact, the high standard of care is saving money. The same misguided conclusion can be reached by any untrained observer, including families, payers, regulators, and consultants. The same scenarios can be described for intensivists, for pharmacists, and for respiratory therapists. Sometimes, even we do not recognize our worth. What we do is critical. We are in the practice of critical but invisible excellence.

The Society of Critical Care Medicine (SCCM) has been devoted to making the ICU team more and more invisible over the years. Our journals, our educational programs, our research, and our guidelines attempt to improve our practice, to promote excellence, and thereby, to decrease our visibility. We have not been trying to hide. The truth is quite the contrary. We have promoted the value of the intensivist-led multidisciplinary team since our founders first described the mission of the SCCM in 1971. We have been promoting this vision for 31 years; however, until recently, the politics of health care have made this a difficult battle, and headway has come in significant but small steps. Last year, in her presidential address, Ann Thompson described how SCCM suddenly found itself at the "tipping point." She described how outside forces are now pushing our agenda and vision forward, making our model and its excellence more widely visible. A body of research has accumulated that documents how outcomes improve when ICU patients are cared for by expert intensivists, critical care nurses, pharmacists, and respiratory therapists. The COMPACCS study published in *JAMA* predicts a dramatic increase in the demand for intensivists for the next 10 to 30 years. The Leapfrog Group (a forum made up of several Fortune 500 companies), ensuring tens of millions of employees, searched for ways to make dramatic improvements in health care while decreasing the cost. They have determined that one of the three most important strategies they can promote is the utilization of intensivists present in the ICU during the day, with the immediate availability of an appropriately trained alternate the rest of the time. Leapfrog is promoting the intensivist model. The media has helped keep up the momentum. There have been articles in *USA Today*, *US News & World Report*, *Modern Healthcare*, the *LA Times*, and the *Chicago Tribune* touting our value. These steps are contributing to the unveiling of our invisible excellence.

This year, several more steps have been taken by outside forces to promote our vision. The Advisory Board, a national firm with long-standing clout among hospital administrators, sent 500 hospitals a best practice implementation kit on why and how to establish an intensivist-led team. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), in collaboration with Leapfrog, is planning to develop a measure set for ICUs. The National Coalition on Healthcare selected intensive care as its third focus in their search for examples of excellence and innovations in quality care. Most of the top 11 stories selected from the 180 submitted showcase the spectacular impact of the intensivist-led team or team member. All their stories take your breath away. The Institute for Healthcare Improvement is working to identify and promote best practices in critical care. They are sold on the intensivist-led team. What all these outside forces have done is shine the light on our invisible excellence.

On September 11, every critical care practitioner's thoughts turned to colleagues in the ICUs nearest the disaster scenes. Soon, the media searched out and told their heroic stories. Even President Bush, while touring the ICU in Washington Hospital Center, was overcome by the reality of what critical care units face on a daily basis. After September 11, the government began to ask whether the country would have enough critical care personnel to handle a disaster that caused many more casualties. The President and the government have a sense of our critical excellence. Some of you not may be aware of how impressive our members' response was on 9/11. By mid-morning, the SCCM office had received numerous calls from members wanting to help. By that afternoon, we had several multidisciplinary teams lined up nearby in New Jersey ready to help. According to officials, they were not needed. According to reports heard later from our members on the front lines in the ICUs, they were needed. Clearly, this needs to be addressed.

So, what is SCCM doing to make our excellence more apparent? What our founders did was critical to the development of the field of critical care. SCCM began with a focus on education and research. Our Congress, our journals, and our research efforts are still our most highly valued and prized pursuits. All are continually improving. But, what we do next is critical.

This year's Congress, as each of those that preceded it, promises to be the best ever. The program, the faculty, and the attendance are strong. In addition, for the first time, six sessions will be Web-cast. Along with our other ongoing educational programs, we conducted an international consensus conference on sepsis last December. 2002 will see the addition of two more programs: a seminar for administrators and payers on why and how to establish an intensivist-led team, and an annual summer symposium on disease management in collaboration with the European Society of Intensive Care Medicine (ESICM). Fundamentals in Critical Care Support (FCCS) courses continue to be provided worldwide, and we are planning extra FCCS courses in areas populated by Leapfrog companies. The first module of the Pulmonary Artery Catheter Education Program, self-paced and interactive, is now available via the Web sites of the SCCM and other participating organizations. Module two will be available soon. Our journal, *Critical Care Medicine*, continues to make us proud. This year it is available online. Our new journal, *Pediatric Critical Care Medicine*, a joint effort with the World Federation of Pediatric Intensive Care Societies, has already exceeded expectations for quality and growth. Its abstracts are being published in Chinese, Japanese, Spanish, and French.

Research continues to accumulate building the case and increasing the visibility of the excellence of the multidisciplinary intensivist-led team. These findings became the stimulus and substance for SCCM's Models of Critical Care Delivery published in *CCM* in October. Last July, the Agency for Health Care Research and Quality (AHRQ) published its summary of 73 evidence-based practices for making health care safer. Seven of their top 11 recommendations are critical care practice strategies. This year, SCCM has demonstrated its ongoing commitment to research by reestablishing funding for some of our research grants. Next year, we will be able to do more. Our newly established Foundation for Critical Care Research and Education is committed to raising funds to support research and programs that promote the theme of

patient safety. They are focused on philanthropy, and one source will be our committed members. They will need support from each one of us. In addition, the SCCM is a co-recipient of a seven million dollar AHRQ research grant with Johns Hopkins School of Medicine to study error reporting in the ICU. Thirty units have been enrolled, and 100 others have been asked to participate.

But today's rapidly changing healthcare scene requires quick and nimble responses. Our new home in Chicago, a hub of organization activities, has proven to be one important strategy toward this end. So far, our new and well-qualified staff is proving to be highly productive and agile. Goethe said that "boldness has genius, power, and magic in it." Our strategic plan for 2002 is bold. However, we are already well on our way. Much of the credit goes to the staff we are bringing together. What they do for us is critical. You will be able to read the 2002 strategic plan on SCCM's Web site, but let me share some highlights.

Advocacy continues to be one of the areas of highest interest to our members. Funding for our advocacy efforts was reinstated in 2001 and doubled for 2002. SCCM has fewer than 10,000 members yet speaks for practitioners in 5000 U.S. ICUs that spend 1% of the gross national product caring for five million patients per year. Our patients need a voice in government. In advocating for the ICU patient, our voice is stronger when we stand with others with similar interests. We continue to build strong partnerships with the ESICM, the American Association of Critical Care Nurses (AACN), the American Association of Chest Physicians (ACCP), and the American Thoracic Society (ATS). Our combined focus recently has been on manpower issues. All of our efforts depend on continued adequate supplies of highly trained personnel. The current demographic and workforce trends not only threaten the maintenance of the current level of intensive care, but also quite likely will lead to a decrease in the quality of care if the looming shortage of intensivists and nurses is not addressed. What we do here is critical. Two of our strategies are to mine the COMPACCS data and to write a White Paper on manpower. You can read this impressive position paper on any of the organization's Web sites. This information will be disseminated through a public relations campaign to legislators, payers, and the lay press. Very soon, we plan to meet with the Secretary of Health and Human Services, Tommy Thompson, to present our credentials, vision, and tools. What direction Secretary Thompson and the government choose to take is critical to our patients.

JCAHO's recent interest in ICU gives us an opportunity to improve care for critically ill patients, and we are working hard to establish a strong relationship with them. Input from intensivist care clinical experts will be critical to JCAHO's hitting the right targets. To move the agenda even further, SCCM, AACN, ACCP, and ATS are joining forces to establish an ICU verification program. The core of the program will be the intensivist-led expert multidisciplinary team. Dovetailing with the JCAHO measure sets and the ICU verification programs is our long-range planning for disaster preparedness. We are creating a database designed to identify ICU teams willing to respond to emergencies by location and by specialty. We are adding a chapter on disaster response to our FCCS manual. We have applied for a twelve million dollar government grant to fund our efforts to organize and educate the nation's ICU personnel for the possibility of terrorist attacks. Your role in such an event would be critical.

Project Impact has become a for-profit entity, PI CCM Inc, with SCCM retaining a 50% share. This change, along with the new version of PI, will allow it to grow and develop a large ICU database to better meet our imperative for measurement. You cannot improve care unless you can quantify it, qualify it, and describe it.

Working with the Coalition for Critical Care Excellence and the American College of Critical Care Medicine, SCCM is creating tools to help you in your practice. To date, the College has published approximately 30 guidelines, and all are available on the Web site. But these, along with many of the initiatives I have mentioned thus far, serve to make you better and, therefore, more invisible. However, we also have several new tools to help you promote your visibility by explaining your value to your institution. The Resource Guide for the Intensivist-Directed ICU has been developed in response to the Advisory Board and Leapfrog recommendations. It will be available to you. SCCM's Coalition for Critical Care Excellence has just finished a Cost Primer designed to help practitioners make the case for a new technology or process to administrators. It can be downloaded from the SCCM Web site. In addition, the Coalition is developing a model for making the business case for establishing the intensivist model. In brief, a modest estimate for a typical ICU shows that the return on investment over a 5-year period is in the tens of millions of dollars. The cost of establishing an intensivist is so trivial, it is fiscally irresponsible not to do so. These three tools will help you convince the hospital administration and insurance providers of the value of the intensivist-led team. There will also be a media kit available with talking points for interactions you may have with your local press. All of these tools will help make you more visibly invisible.

Critical care at its best saves lives and reduces suffering; and at its worst, it prolongs suffering. Seventy percent of Americans die in institutions, many of them in the ICU, and the majority of those after a decision has been made to withdraw life support. Socrates said that the greatest way to live with honor in this world is to be what we pretend to be. As critical care practitioners, we have told society that we are going to work in the gray zone between life and death. We need to be just as good at caring for the dying patient as we are at saving lives. And what a privilege that is. It can be one the most rewarding aspects of being a critical care practitioner. It is during care at the end of life that our excellence is most critical, and most visible. SCCM is working for you in this arena. Our new Patient/Family Support Committee is creating a page on our Web site with resources and information for patients and their families. Next year, we plan to work with Robert Wood Johnson's End-of-Life Work Group to help them develop and achieve their ambitious goals. In addition, SCCM is a major sponsor and collaborator with ICU-USA, a beautiful and well-developed Web-based resource for the public. SCCM has worked with industry to develop two videos on end-of-life care—the one created last year for caregivers and a new one created this year for patients and families.

There is so much going on as we begin this year. It will be important to keep you informed as more issues, projects, and tools develop. Efforts to improve communication will include E-mailed advocacy alerts and a bimonthly electronic newsletter. Chapters, Affiliates, and Sections will be able to identify and communicate with members using our new database and Web site. But communication is two-

way, and I will look forward to hearing from you. You can also contact your section chair, council members, and the staff. We are all here to help, hear, and heed your advice. There is much good work yet to be done. To paraphrase Franklin D. Roosevelt, "Far and away the best prize that life offers is the chance to work hard at work worth doing." He must have been talking about critical care. What you do every day is hard work worth doing. It is critical excellence.

I have devoted my life to two passions. First, I have had the privilege of teaching thousands of critical care nurses over the years, striving to arm them with knowledge and skills that enable them to provide a higher level of excellent invisible care. Second, I have had the pleasure of working with the members of the SCCM, promoting the intensivist-led multidisciplinary team and revealing its invisible excellence. These passions were instilled in me and nurtured by several people, many of whom are here this morning. I want to thank each of them because, for me, what they did was critical. My parents, Ed and Irene Antus, gave me values and drive that led me to become a nurse. My husband, Bill, gave me the support and courage to stretch, to dream, to do more. Max Harry Weil gave me deep roots in multidisciplinary critical care done well. Norma Shoemaker gave me the opportunity to try my wings and to find my home in SCCM. Barry Shapiro taught me to teach critical care. Phil Dellinger, Rob Taylor, Carolyn Bekes, and Ann Thompson prepared me for the coming year.

I am braced for the responsibility but buoyed by possibilities and bolstered by your support. Together, we will make your invisible excellence so visible it will dazzle the beholder.

Maurene A. Harvey
2002 President
Society of Critical Care Medicine

A collective task force of the American College of Chest Physicians, American Association of Respiratory Care, and the Society of Critical Care Medicine have published "Evidence-Based Guidelines for Weaning and Discontinuing Ventilatory Support." They appear in the supplement to the December 2001 issue of *Chest*.