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Ruth M. Kleinpell, RN-CS, PhD, FCCM
Director
Center for Clinical Research and Scholarship
Rush University Medical Center
Professor
Rush University College of Nursing
Chicago, Illinois, USA

Good morning and mahalo. It is so good to be here with you in lovely Hawaii, and it's certainly my great honor to serve as your next president. I am proud to serve as your 46th president. I realize I am standing here today because of the monumental work of our former leaders. We stand on the shoulders of the giants in the field. Since the Society's founding in 1970, we've been privileged to have amazing leaders who, in one way or another, helped develop and mentor all of us.

In reviewing some of the historical documents that were obtained from Dr. Max Harry Weil's archives, which were donated to SCCM this past year, I was struck by the words in his first inaugural address as SCCM's first president. He highlighted that the Society was formed to address a single commitment—service to critical care medicine. He shares his reflections on the discussions that served to form the Society. He said, and I quote, "We discussed the problems that stem from segmentation of patient care, particularly at the time of life-threatening illness. We were very much concerned with the role of nursing and paramedical personnel." He said, "We recognize the need of a new venture in medical technology so that we could get information more rapidly, yet competently." He said, "We saw about us the need for setting standards of performance in the profession in this field and, most of all, the need for training." He goes on to say, "We had tentatively talked about the American Society of Critical Care Medicine, and there was strong opposition to that name because, along with a multidisciplinary commitment, we also have a strong international representation." The Society holds true to these tenets today, with programs and key partnerships that span the globe. Along with Dr. Ake Grenvik, president-elect, Dr. David Allen, secretary/treasurer, Dr. William Shoemaker and the other initial officers, our early leaders created an organization whose sole purpose is to improve the care of patients with acute, life-threatening illnesses and injuries and to provide for optimal facilities for this purpose. These individuals led the way in our field, and I am no different than you in that I too have worked hard to follow their example.

I have had an exciting career in critical care, starting as a clinical staff nurse, working for over 15 years in medical/surgical ICUs, followed by practice as an acute care nurse practitioner since 1995, a role I am still active in today, along with experiences as a critical care researcher and as a professor of nursing. Critical care has afforded me numerous opportunities, including national and international committee work, research study section involvement, scholarship and truly collaborative work and networking in my years of service to SCCM. I would be remiss this morning if I didn't also mention Maurene Harvey and Carol Thompson, who were both nurses and presidents of the Society and proved to me that all members of the critical care team could hold our highest office.

Issues in the Profession

Mentoring and developing the young professionals in our field is so important to ensuring an adequate critical care workforce and this remains a priority—a high priority—for SCCM. But

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at the same time, we are losing too many of our professionals in the prime of their careers. All of us gravitated toward a career caring for critically ill patients because of the fast-paced, high-tech and challenging work it provided. While the life-and-death struggles can be exhilarating, you know as well as I do that they are also physically and emotionally draining. With ongoing workforce shortages and pressures to do more with less, this fast-paced, demanding and stressful environment we know also can lead to burnout. So I work closely with our partners in the Critical Care Societies Collaborative, AACN, ATS and CHEST, focusing on this challenge. Together we have made the prevention of burnout syndrome a priority for each of our organizations.

In July, we simultaneously published a call to action, which includes strategies for prevention, including promoting healthy work environments, stress reduction techniques, mindfulness training and meditation. The call to action has spurred many articles, blogs, tweets and a development of other focused interventions to promote a healthy work environment in the ICU, which can mitigate and help to prevent burnout.

As a next step, our organizations will also host a summit to prioritize the most promising interventions that help prevent burnout in the field. The summit will bring together multiprofessional experts from the fields of medicine, psychology, sociology, occupational health, nursing and allied health. We also seek to develop a research agenda to further identify causes, solutions and actionable tools to better address this challenge that threatens our workforce.

One tool that has been increasingly employed to help reduce burnout is the use of advanced practice providers, who can help shoulder the load in the ICU. Diversifying the workforce has proven beneficial in many ICUs, and we are also working to help these individuals to transition successfully from training into practice. Professional diversity has also been a strength of SCCM, and we continue to fully embrace this concept, set in motion by our founding fathers. But as you may have noticed, our founders were all fathers, not mothers. So, today, I am pleased to announce that SCCM is increasing our focus on diversity by broadening that thinking to include more racial and ethnic diversity, greater gender and geographic diversity, and a more varied mix of individuals from a broader range of workplace settings.

With the formation of the new Diversity and Inclusion Committee, we are seeking more diverse participation at every level of the Society—on faculty of our programs and in the authorship of our publications. While we will continue to ensure the highest level of scientific expertise, we will also aim to better represent the broad range of members of varying religions, sexual orientations and nationalities, to name but a few. So when you receive a request to update your profile, to provide this demographic information, know that this is so we can better diversify our various activities.

Patient and Family-Centered Care

Equally, we are also developing a plan to include much more patient and family involvement in all that we do. Hawaiians are especially known for their strong link between culture and family. They embrace the family as the basic unit of society. The Hawaiian term *ohana* signifies the emphasis on family. Unlike the English language, the Hawaiian language can say many things in one word. *Ohana* identifies that the family is a central force—building, bridging, binding the spirit of a community. The Hawaiian emphasis on family is truly reflected in several important SCCM initiatives and soon will be embedded across the culture of our organization.

In addition to the THRIVE initiative, which Todd highlighted earlier, SCCM was supported by a patient-centered outcomes research or PCORI grant to bring together more than 60 ICUs seeking to engage patients and families in care during a loved one's stay in the ICU. The collaborative started last September and focuses on promoting family engagement through a number of activities, including integrating patients and families on rounds, the use of family diaries, open visitation, establishing a patient and family advisory group, and structured care conferences to mutually establish goals of care. This initiative was informed by an advisory group that includes former ICU patients, family members and members of the clergy. This new project provides the Society with a truly unique opportunity to advance our knowledge in patient and family engagement in the ICU. It stemmed from our work with the Agency for Healthcare Research and Quality to develop and enhance communication and educational strategies for integrating patient-centered outcomes research into practice. These types of projects allow the Society to engage and learn from your ICU teams and then to share these best practices with our worldwide membership, thereby enhancing care. As ICU clinicians, we know the impact that critical illness can have, not only on the patient, but also on the family. Many times, ICU hospitalization is a sudden event that disrupts life.

Recently my family was personally impacted by critical illness. We came home one night to find a phone message indicating that a family member in another state had been hospitalized for what was reported as a sudden seizure after presenting to an emergency room with chest pain. I immediately called and was told that she had been transferred from that hospital to a university medical center for emergency surgery and that she was in the ICU. I called that hospital and told them I was a former surgical ICU nurse and currently an acute care nurse practitioner. Her ICU nurse relayed that she had just returned from surgery for repair of a ruptured descending thoracic aortic aneurysm. I immediately knew the severity of the situation, and my husband began his 600-mile drive to be at her bedside while I connected with the ICU clinicians by phone. These individuals, who did not know me, took the time to give me a report as if I were a member of their team. Over the next several days, her condition worsened. She remained ventilated, sedated, and on full vasopressor support. When the surgical team rounded each day, I was invited to participate via speakerphone, as well as to receive updates to review the goals of care. As a family member, the experience of participating in rounds long-distance is an experience I will never forget.

A significant portion of adults will experience an ICU hospitalization during their lifetime and, as ICU clinicians, we may find a family member or ourselves needing ICU care. The Hawaiian word *kuleana* signifies right, privilege and responsibility. *Kuleana* is not just a word that says "responsibility" but it's much deeper and richer than what I can express. It speaks of a value, a way of thinking. As critical care clinicians, we have the privileges and responsibility—*kuleana*—for ensuring family-focused care in the ICU, as we are truly the visitors in our patients' lives. Pick up your *kuleana* ribbon as you leave the room today to show that you accept this right and responsibility.

New Opportunities for the Society

But sharing best practices isn't really enough, is it? As we endeavor to improve the ICU experience for patients and their families and provide even better clinical care to our severely injured and critically ill patients, there is still so much we don't know that only scientific research can reveal. Over the past several years, the Society has increased its focus on research. The number of research grants, both given by and to the Society, has increased exponentially. Research submissions for presentation at this Congress alone grew by 50% over last year's already record number. Our quality improvement programs have gone from basic collaborative learning projects to data collecting, analysis and publishing. Later this week, we will hold a meeting with key leaders from the United States Department of Energy to discuss how we can utilize the National Strategic Computing Initiative to leverage the nation's high-performance supercomputers to better find ways to identify and treat sepsis.

So it seemed only logical that, at our recent Council meeting, we approved an additional $3.5 million expenditure to launch the Society's latest research endeavor, our own critical care research network, which we will call Discovery. Discovery will foster collaborative research around our global membership and promote the advancement of critical care, leading to improved patient outcomes. Our research network will support team-based innovation by fostering investigator-initiated, multidisciplinary research activities, including informatics, surveillance, point prevalence, hypothesis generating and hypothesis testing, and epidemiologic as well as interventional research. Discovery's activities will span the full spectrum, from basic science to translational and clinical outcomes and operations research. Supported by a full professional staff and research infrastructure, we will seek to increase research in the field and use SCCM's existing broad base of programs to disseminate these findings into practice. I am pleased to say that USCIIT, the United States Critical Illness and Injury Trials Group, and CCPTN, the Critical Care Pharmacotherapy Trials Network, will merge with the Society in this endeavor. As we move forward, other research networks may also choose to join with us, and they too are most welcome. This is a major Society investment and will significantly advance our knowledge base and improve outcomes for critically ill patients as it develops and expands over the next several years.

I know I've talked a lot this morning about SCCM's various new programs, but if there's one thing I want you to take away from my talk today, it is this: SCCM is doing so many great things, from our core programs, including the journal, Congress, review courses, and Fundamentals training to all the new activities I mentioned, together, we are making a difference. It is truly an honor to be deeply involved at the Society at this juncture. All of this is possible, not because of one small group or individual, but rather because of our collective efforts. With nearly 2,000 members volunteering their time, talent and, often, money, it really does take a diverse community to make progress in our field. If you serve on any of our task forces, committees or work groups, please stand up. Please stand up, come on. Wonderful! Stand up. Thank you so much. Look at this. Wonderful!

And did you know that, every year, many individuals make financial contributions to the Society? Last year alone, SCCM received over $200,000 in donations of all sizes, which were never solicited. They simply dropped a check in the mail, contributed on our website or called and asked if they could give to support the cause. Truly amazing dedication and very much appreciated. These gifts make our many new programs possible, and I can't thank you enough for all of your contributions.

It is also my distinct pleasure and privilege to chair the SCCM Council, who are your elected board representatives. This is a highly talented, extremely dedicated group of diverse critical care professionals. I have enjoyed serving the past nine years as a member of Council and can attest to the many contributions that each member of our Council makes. I'd like to take time to recognize and thank the current members of Council. Could you please stand, members of Council? Let's give them a big round of applause. Thank you so much! Thank you, all of you.

There's another group that I also must mention. They are the glue that holds everything together and makes everything work. They partner with each and every committee and work group to achieve a long list of goals and objectives. They answer our phones, they maintain continuity from year to year. They, of course, are our staff partners, led by CEO David Martin. Please join me in thanking them.

Finally, I want to introduce you to my family and to publicly thank them for their tremendous support over the years. Without my husband, Horace Nowell, and my son, Horace, I would not have been able to accomplish all that I have done. They are here today, and I'd like to acknowledge them. I am also joined by my work colleagues from Rush University Medical Center in Chicago and Vanderbilt University Medical Center in Nashville, where I have served as a visiting professor for the past three years. I'd like to also recognize them for their commitment to critical care excellence.

Thank you for being with us here this morning and giving me time to talk with you and share the many new things that are going on at SCCM. I look forward to seeing you throughout Congress this week and talking with you about many ideas for yet new endeavors. Your dedication to the SCCM mission is key to our long-term success. Thank you so much.