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The Society of Critical Care Medicine, its history and its destiny

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It is my privilege to have this opportunity to address you regarding the state of the Society of Critical Care Medicine as its first year draws to a close. I feel that an assessment of the present position of critical care medicine as well as its potential direction and scope for the future benefits this occasion.

It is the purpose of our Society to improve the care of patients with acute life-threatening illnesses and injuries and to provide optimal facilities for this purpose. We commit ourselves to these ends by creating a good hospital environment with qualified teams of physicians, nurses, technicians and medically oriented engineers. We commit ourselves to specific duties and obligations that will bring increased orderliness and expertise to the management of the critically ill.

Our foremost commitment is to develop educational programs to provide basic training for the physician-trainee, subsequent fellowship programs and broad based experience for those who will serve as directors of facilities. These

programs would instill dedication to continuing education for our society. Our dedication to these ends is already evident; we have co-sponsored two national symposiums and today we had our first annual meeting. The doors of our meetings and scientific sessions are wide open to all, quite independently of membership in the Society.

Our second commitment is to standards of practice, i.e., professional qualifications and the performance of those who make decisions affecting the survival of potentially salvageable patients. Organizational guidelines for critical care units were drafted by the guidelines committee, chaired by Dr. John J. Downes. These guidelines were adopted by the Society a year ago and are to be published in the *Journal of the American Medical Association*.** This singularly constructive project spelled out the purposes and set standards for staffing and organization of clinical facilities for the care of the critically ill.

At the present meeting, we extensively deliberated over the proposed guidelines on education of critical care physicians drafted by Dr. Peter Winter and his committee. These guidelines focus on the qualification of candidates prior to entry into the training programs, the basic curriculum and duration of training. We

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must insure that the critical care specialist is not only well trained as a clinician, but also oriented in operational management, optimal utilization of professional and supporting staffs, functional designs of physical facilities and the selection, operation and maintenance of instrumentation.

HISTORY OF THE SOCIETY OF CRITICAL CARE MEDICINE

The purposes, present state, and future potential of the Society might best be considered in the light of recent struggles which have made our achievements particularly significant. The Society arose from a growing awareness of the need to have a common meeting ground for multidisciplinary efforts in the fledgling ICU field. An inciting letter from Dr. Burton Waisbren as well as discussion with Dr. Will Shoemaker and many others led to the determination to organize this society. On February 10, 1970, a group of thirty physicians came to Los Angeles, largely at their own expense, to combine thoughts, experiences and plans with the single commitment of bringing some order to the care of the critically ill. Observers from federal services and from professional societies participated in that day-long conference. We discussed problems stemming from segmentation of patient care along traditional medical specialties particularly at times of life threatening illnesses. Of utmost concern was the role of nursing and allied medical personnel. We recognized the need for new levels of expertise in crisis care, at the bedside and in the application of laboratory technology and more rapid analyses. We recognized the urgent need for setting standards for the professional performance for training programs in critical care medicine. We all agreed there was great need for pooling resources and for developing operational guidelines for facilities. We also expressed concern that the role of emergency medicine in relation to critical care medicine be defined.

Five months later we met again; this time we invited adversaries. As expected, a lively debate transpired over whether it would be most efficacious to regard the practice of critical care medicine exclusively as a specialty or as an area open to all physicians and surgeons responsible for acutely ill patients. We left that meeting without answering this seemingly basic question, but with a commitment to establish a peer group which would carefully examine these issues.

In November 1970, in Philadelphia, we de-

cidated to form a society with multidisciplinary commitments. The name, "Society of Critical Care Medicine," was suggested in my report as acting chairman. We rejected the concept of organizing along national boundaries and we agreed that membership was not to be restricted to physicians, but would include nursing, medical scientists and paramedical specialties including engineers, technologists and inhalation therapists. Initial drafts of a Constitution and By-Laws were hammered out.

In February 1971, the Constitution and By-Laws of this Society were formally adopted by the 54 founders. It was also suggested at this time that the Society initiate publication of a journal.

In May 1971, in conjunction with the annual course sponsored by Dr. Peter Safar and his colleagues in Pittsburgh, the machinery of the more formal organization was set in motion. A membership office was established in Pittsburgh for Dr. Ake Grenvik, whom I appointed as the first membership chairman, and a Secretary-Treasurer's office in Chicago for Dr. David Allan, the first Secretary-Treasurer of our Society. Legal moves were initiated to formalize the Society as a corporation in the state of Illinois.

At this, our first official annual meeting, a full day was also allowed for presentation of scientific papers. I am grateful to the Scientific Program Committee for having made this an obviously successful undertaking. Our highly functional Council displayed substantial independence in thought and action as it examined controversial issues. Today we agreed that we would accept the proposal of our sister societies to develop a federation to include the American College of Emergency Physicians, the University Association of Emergency Medical Services, and the American Association of Critical Care Nurses.

THE HERE AND NOW

Having over 100 members, we have become legally incorporated and have adopted guidelines; we have officers and offices. The aforementioned represents our dedicated effort to establish appropriate standards of practice, education and research. We have sought association with other organizations that share common interests in acute patient care.

The substantial inroads into community and public relationships that we have made thus far reassure me of the important role of our So-

in national policy making. Responsibilities previously carried by committees of the National Academy of Sciences/National Research Council have been shifted to external professional organizations, and the government has already communicated with us in regard to the possibility of filling some of the void that has resulted from the discontinuation of the NAS-NRC Committees on Shock and Trauma. We have met with representatives of the Joint Commission on Accreditation, the National Academy of Engineering, the National Institutes of Health, the National Center for Health Services Research and Development, the Veterans Administration, and with each of the military medical services. These organizations have maintained liaison with our Society and have acknowledged the need for substantial guidance as more and more critical care services have evolved and the teams responsible for patient care have expanded.

FUTURE DIRECTIONS

We must continue to define the role of critical medicine in relationship to other medical specialties. Does it constitute a specialty discipline? Are partial commitments on the part of physicians, nurses or engineers feasible, and under what conditions? If critical care is to be a department, is it to be in competition with the conventional departments in hospitals and medical schools? Can we afford to set up our units in a maverick fashion so as to challenge the function of more traditional specialties? If we are to regard ourselves as a service specialty responsible for relatively brief periods of patient care, can we evade overt opposition by giving service first and letting other issues follow in due course? Or, to the contrary, should we demand the recognition that comes with a new specialty: a new specialty board, a department in a university medical school and exclusive prerogatives therein implied?

We must also ask ourselves, what is our commitment to the community which we serve, as well as to our society and its government? Are we to knock at the door of our congressmen and our state legislators for funding programs of research and training? Are we a political action group?

Must I escape from the realities on the negative side of the ledger, let me also hasten to point out that we also have some major dilemmas. We've discussed hard and long whether we

should be an elite organization with membership restricted to accomplished leaders in the field in order to maintain that close rapport that comes with small groups. If we do, we will not have the number of members needed to be politically potent nor to influence national policy as it affects our field. We all share enthusiasm for that political action which would assure adequate grant funds for those who are operating training and research programs in emergency and critical care medicine. But, how effective is the lobby of an organization with a hundred members?

On the other hand, to what extent should we be a political action group? At this moment, we are not at all sure that the issues are so clearly defined that the Society can or should speak out on major issues. We are not ready to propose departments of critical care medicine, and we have not crystalized our relationships to departments of emergency medicine. Our internal relationship to the health delivery system is insufficiently defined to allow for the formulation or presentation of a definitive policy. Thus, for the coming year, our task is clear. We must seek understanding of the problems, examine potential means for resolving these problems, define and test our hypotheses and, only then, call for political action.

I welcome the current controversies within our Council. Out of those hard fought, soul-searching sessions the real issues emerge with greater clarity. If we spend our efforts on propagating positions that had not gone through this discussion, we would surely compromise the potential of our Society and threaten its long-term viability.

It is my earnest hope that the dedication to patient care will remain as the central purpose of our Society. Professional expertise should continue to be the principal criteria of membership; a large membership is not our purpose. I also caution against the implied role of the Society as a synthetic umbrella which replaces board certification. The Society is not a certifying body and should not be constituted as such. Maintenance of high standards will afford us the maximal opportunity for leadership in the field of critical care medicine. The Society will inevitably grow, but it should grow as more and more qualified professionals are attracted to the field, without downgrading admission criteria. Since quality is not geographically restricted, it is important to be responsive to those in foreign lands who seek membership. In any event, all are invited to participate actively in the Society's

scientific and training activities without the test of membership.

With respect to matters of organization, there is no doubt we shall have to overcome some traditional barriers. A surgical patient with pneumonia or atelectasis is not fundamentally different from a medical patient with the same illnesses. Not every physician or surgeon is either temperamentally or professionally qualified to assume general responsibility for the care of the patient with life-threatening illnesses. In my experience, he welcomes dedicated aid, particularly in the community hospital. If we are to provide community hospitals with dedicated and skilled professionals, we must insure that a comfortable place is made for them.

Who is likely to attend the patient in a teaching hospital when there is a massively bleeding peptic ulcer at two in the morning, or even at three in the afternoon? Until now, the care of the critically ill has been largely an enterprise of the intern and resident. Those who are most experienced are likely to be giving a routine anesthetic, doling out digitalis pills in their offices, or doing an elective surgical procedure with an overall mortality of less than 1%; while patients face 60 to 90% mortality with conditions such as cardiogenic shock, infarcted bowel, bacteremia, or pulmonary embolization, and often two or three of these are present at the same time. Our job is to change this by developing an operational approach which involves the experienced senior men, not in lieu of the intern, resident, or fellow, but with him.

I personally do not believe that we must extract from a critical care specialist a resignation from his initial specialty. It is perfectly reasonable that he remain a competent surgeon, anesthesiologist, cardiologist, or an infectious disease specialist. However, he should apply his specialty skills to the care of the critically ill and build bridges to the conventional specialties. This is an ideal opportunity to break down the barriers that isolate traditional departments. For

the present, I look to conventional board certifications in internal medicine, pediatrics, surgery or anesthesiology as a basis for entry into our field; though in time, a critical care specialist might have sub-speciality certification. Our role is that of a service, to some extent akin to that of anesthesiology, or radiology, where for some relatively short period of time, and for very special purposes, the service is directly responsible for patient care. As service specialists, we are obligated to maintain close liaison with the referring physician who has continuing responsibility for the patient. We would do well to accord the referring physician membership on the team during the interval of critical illness.

Our Council, which is made up of accomplished, dedicated and uniquely responsive men, represents the diverse viewpoints of our multidisciplinary organization. But, we do not have non-physician Council members. I hope our multidisciplinary commitment will soon be evident by leadership roles for non-physicians.

Finally, I do not know of any one enterprise of the Society which is more important than the development of our policy statements in the guidelines. To paraphrase the statement of Dr. Lou Del Guercio, "Let's not be so afraid of making a mistake that we paralyze ourselves with inaction. If we wait for the perfect solution, we shall accomplish little when the accomplishment is most meaningful." Critical care services are highly disorganized in most institutions, and we cannot deliver the life-saving care that we are capable of delivering because we are not sufficiently efficient. Rather small improvements in efficiency bring substantial gains.

In closing, let me say that I have never been so proud of any enterprise than the Presidency of this Society. I am deeply grateful to you who have given me this honor and supported me through many a blunder. In the years to come I shall take very great pride in having been the First President of this Society.