

INTERCHANGE

Society of Critical Care Anesthesiologists Newsletter Volume 33 | Issue 3 | October 2022

PRESIDENT'S MESSAGE

Colleagues, next year's annual meeting will be in Denver, Colorado, on April 14, 2023. We have received many excellent submissions for next year's annual meeting, and now the education committee has the difficult task of putting together the program. Some panels not selected for the annual meeting will be shifted to SOCCA webinars in 2023. More to follow.

SOCCA has many events and opportunities coming up in the next few months. To help keep track of these and get better organized we have added a calendar tab to the SOCCA website.

You can access it by clicking on the "news" tab and then clicking on the calendar in the drop-down menu. August and September have been very busy months! Eventually, this calendar will be populated with dates and links for committee meetings, task force meetings, and more.

SOCCA will host a Critical Care Anesthesia Meet-up at the ASA Meeting this year. The Meet-up lounges will be set up as casual, comfortable networking areas. **Ours will be on Sunday, October 23, from 4:00-4:45 pm (CST) in Connection Lounge 2.** Please stop by and say hello to your colleagues and




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President, SOCCA
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friends. Some committees and workgroups may be having informal get-togethers during the ABA meeting, and dates and times will be placed in the new SOCCA calendar.

SOCCA will also be holding a call for volunteers this fall. We have many new workgroups and taskforces open for members to engage with in their areas of interest. These include the Early Career Workgroup; the Medical Student, Resident, and Fellows Workgroup; the Physicians

and Practice Workgroup; the Women in Critical Care Workgroup; the Diversity, Equity, and Inclusion Workgroup; and the Service Chiefs Advisory Council. If you are interested in joining any of these workgroups, please attend their open meetings and webinars. Check the calendar for dates and times. This a great way to get involved in SOCCA!

If you have any other ideas or suggestions on improving the value of SOCCA to our current and future members, please do not hesitate to let me, the Board of Directors, or the Committee Chairs know.

I hope you all have a safe, healthy, and happy season, and I look forward to seeing you on a Zoom call or in person soon. 

SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS

ANNUAL MEETING 2023

SAVE THE DATE
APRIL 14 – 15, 2023
DENVER



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COMMITTEE ON RESEARCH

Nationwide Clinical Practice Patterns of Anesthesiology Critical Care Physicians published in *Anesthesia and Analgesia*

Two years ago under the leadership of Drs. Robert Stevens and Matthew Warner the SOCCA Research Committee formed the SOCCA Data Subcommittee which was charged with expanding the portfolio of survey information that would be of interest and utility to our membership.

This month we are glad to showcase some work recently published in *Anesthesia and Analgesia* highlighting the first of these surveys as key deliverables from the Research Committee.

We felt one of our first tasks was to gain an understanding of contemporary clinical practice of our subspecialty for a multitude of reasons—to recognize the opportunities and challenges facing critical care anesthesia, optimize staffing patterns, assess sustainability and satisfaction, and strategically plan for future activity, scope and training.

Therefore, after appropriate IRB approval, this study invited members of SOCCA sourced through our membership distribution list to evaluate practice patterns of critical care anesthesiologists using a voluntary online survey between May and June 2021. Respondents were asked to describe practice patterns at their respective institutions, and provide information about their demographics, salaries, effort in ICUs as well as other activities.

490 participants were invited to take this survey and 157 (response rate 32.0%) surveys were completed and analyzed. In terms of key findings, the majority of respondents were white (73%), male (69%), and under 50 years of age (82%). The cardiothoracic/cardiovascular ICU was the most common practice setting, with 69.5% of respondents reporting time working in this unit. Significant variability was observed in ICU practice patterns.

Respondents reported spending an equal proportion of their time in clinical practice in the operating rooms and intensive care units (median 40%, IQR 20-50%). Female respondents reported salaries that were \$36,739 less than males; however, this difference was not statistically different and after adjusting for age and practice type, these differences were less pronounced (-\$27,479.79, 95% CI: -\$57,232.61 to \$2,273.03; $p = 0.07$). Some other key results are also depicted here graphically.

These survey data provide a current snapshot of anesthesiology critical care clinical practice patterns in the United States. In the future, additional granular information about factors affecting compensation, temporal trends in ICU coverage and clinical practice patterns can help inform decisions on staffing, clinical organization and compensation. We wish to thank all authors for this contribution, the SOCCA Board of Directors for their guidance and support in this endeavor and of course our Society's membership for taking the time to contribute. 🏥

continued on page 3



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Clinical Practice Patterns: Figure 1

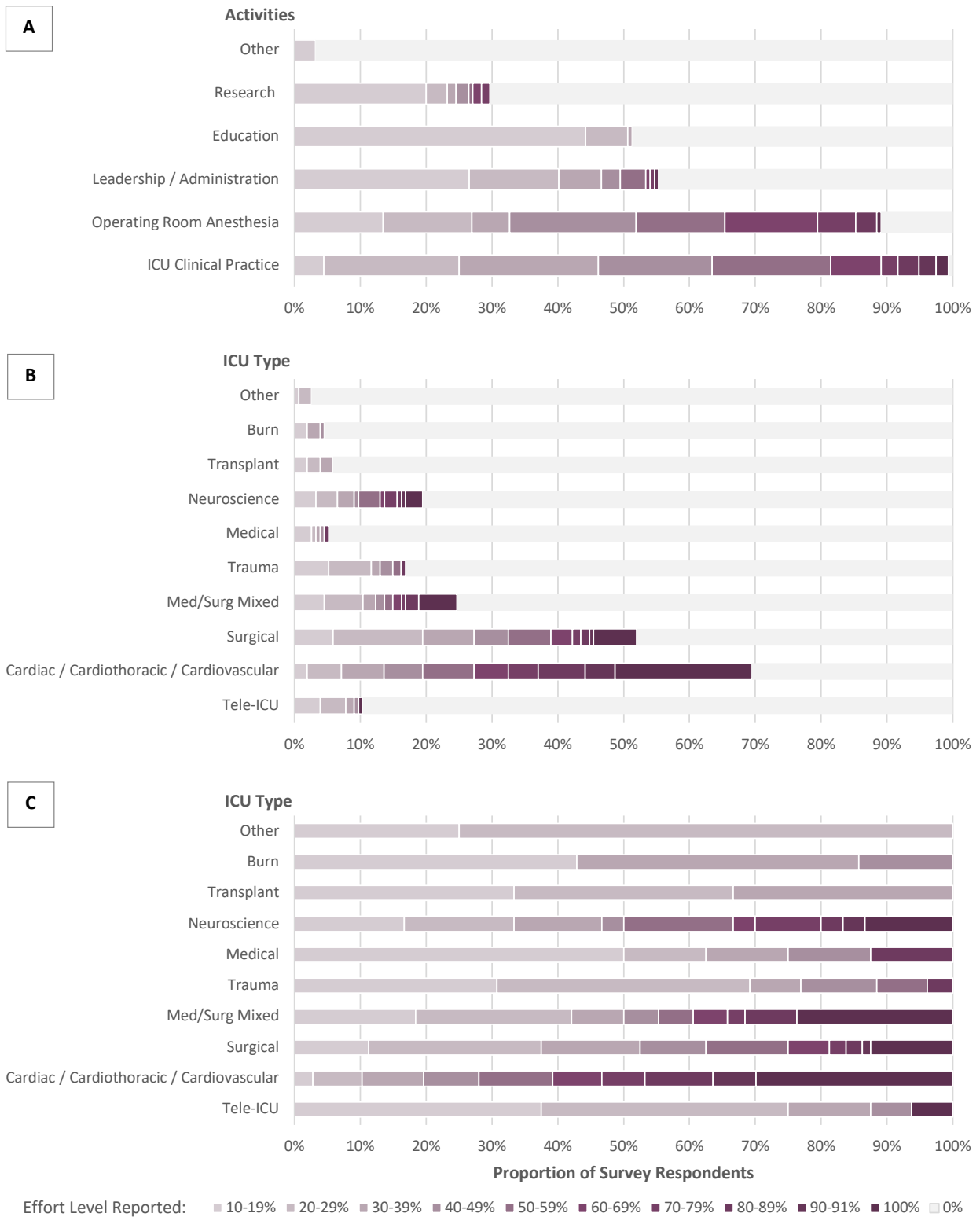
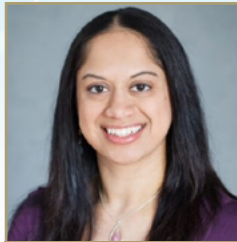


Figure 1. Analysis of Effort Levels

A breakdown of respondents work activities are described in Panel A. In Panel B, ICU units that respondents indicate working in are described, along with the effort levels reported. Respondents primarily reported working in a cardiovascular unit. Further, in Panel C, the breakdown of ICU type is reported among those who report working in that unit. Participants who did not report working in a unit are excluded from Panel C.

Committee on Membership Update

The SOCCA Membership Committee has been hard at work putting together a variety of programs for all of our members at various stages of their careers. For our graduating fellows, we put together a new “SOCCA Fellowship Exit Brochure” to make sure all of our newly minted intensivists are aware of everything SOCCA has to offer to them. This brochure was distributed with the help of the Program Directors committee. Our fellowship subcommittee also planned our annual Job fair, which occurred on October 5.



Alisha Bhatia, MD
*Chair, Membership
Committee*
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We started hosting Membership Meetups last May and will continue to do so on a regular basis. See the SOCCA website for a full calendar of events! In early summer we had a meetup for our members in private practice. Several topics were discussed, and great conversation was had by all participants. The event was well received, and we are currently planning another meetup for this group in the fall. Our most recent meetup was put together by our DEI subcommittee. We initiated several discussions with

members about how best to incorporate DEI into our society, and we look forward to turning these discussions into action later this year.

Our Early Career Group subcommittee hosted an event on September 22, 2022 at 5pm CST. The topic was “Maximizing Networking Opportunities as an Early Career Intensivist” and featured a discussion with senior members Brigid Flynn, Liza Weavind, and George Williams.

Please visit the newly created [Early Career section](#) on the SOCCA website to stay up to date on resources and meetings.

Last but not least, our mentorship program continues in its first year. Thus far we have received positive feedback from both mentors and mentees! We look forward to enrolling more matches in the program and we appreciate everyone’s thoughts and suggestions about how to ensure this program continues to be a success. 🏛️

SOCCA EARLY CAREER INTENSIVISTS

The SOCCA Early Career Intensivists working group provides new members and members who are early in their careers with the resources needed to ease the transition from trainee to practicing intensivist.



SOCCA Nominations

The strength of SOCCA is the wealth of talent and energy of its members. One of the ways to serve the Society is through volunteer activities. The SOCCA Nominations Committee annually evaluates nominees and develops an election ballot for available Officer and Director positions. This election cycle we will be electing 3 members for the Board of Directors (3-year term). Further details about the governance structure of SOCCA are described in our Society Bylaws.

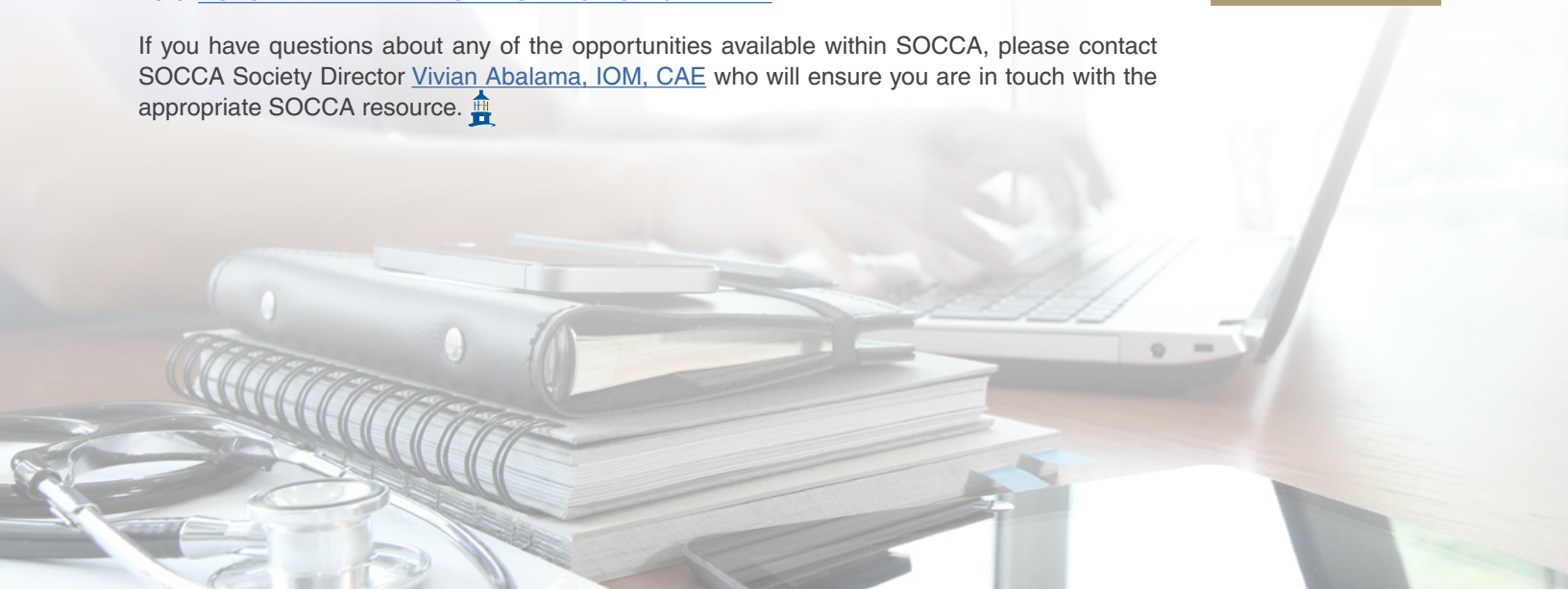
Information about additional opportunities to serve the organization, such as committee involvement, will be shared in future communications. This year, we will be looking for committee volunteers for our communication, education, membership, and research, as well as the new clinical practice committee.

Those interested in elected positions will be asked to submit a letter of interest, photograph, and curriculum vitae in November. Criteria by which volunteer leaders are evaluated are available here: [VOLUNTEER LEADERSHIP SELECTION CRITERIA](#).

If you have questions about any of the opportunities available within SOCCA, please contact SOCCA Society Director [Vivian Abalama, IOM, CAE](#) who will ensure you are in touch with the appropriate SOCCA resource. 🏢



**Miguel Cobas,
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*Immediate Past
President, SOCCA*
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JOB BOARD

Read members-only job posts—including roles with: University of Minnesota in Minneapolis, Minnesota • Indiana University Health in Indianapolis, Indiana • Emory University School of Medicine in Atlanta, Georgia • Penn Medicine Lancaster General Health in Lancaster, Pennsylvania • Dartmouth-Hitchcock in Lebanon, New Hampshire • Maine Medical Center in Portland, Maine. [Visit SOCCA's Job Board](#)

If you would like to post a job, please email a short description and/or PDF flyer including location, contact information, and closing date to SOCCA Society Director, Vivian Abalama, IOM, CAE at vabalama@iars.org.

SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS INNOVATORS AWARD

SOCCA is pleased to announce the debut of the Innovators Award.

Created through a generous anonymous donation, we plan to award one deserving recipient \$10,000 for a **true innovation**, that is, something that introduces a new device or technique, changes clinical practice, or could improve clinical outcomes.

The purpose of the grant is to promote:

- the advancement of medical technologies
- innovative clinical solution ideas
- safe and effective uses of existing technologies
- next-generation innovators & leadership
- translational research
- academic promotion

This award is an extension of the SOCCA's growing interests in research, education, and engagement. We encourage interested members to apply.

The award will be given to a medical student, fellow or clinical faculty member at an accredited North American training program, who is also a member of SOCCA.

Required elements for application include:

- Background of the problem being solved
- Expected final product of the research
- Expected expense budget
- Expected impact from implementation
- Relevance to the field of critical care anesthesiology

Applications will be judged by an awards committee, and finalists (up to three) will be asked to present their proposals at a SOCCA meeting. Travel grants will be provided.

A full description of the award is available here: [About SOCCA Innovators Award](#).

[Application](#) opens September 30, 2022 and closes November 30, 2022.

Please review the [Award Guidelines](#).

We expect to announce the winner at the [2023 SOCCA Annual Meeting](#) in Denver, Colorado.



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SOCCA Research Spotlight

I was exposed to research early in my training as an anesthesiology resident at the University of Maryland in the late 1990s, where I had the fortune of training with Dr. Jane Matjasko, our department chair. As a pioneer in neuroanesthesia, she worked diligently to understand the complexities of anesthetic effects on the brain. She was one of the inaugural members of SNACC (Society of Neuroscience in Anesthesiology and Critical Care) and among the first graduates of the Women's Medical College of Pennsylvania (now Drexel University). She inspired me to become an academic anesthesiologist who was passionate not only about patient care but also about asking questions, being industrious, and finding the answers through research.

Dr. Mary Njoku was another amazing role model who inspired me to pursue critical care and become a woman intensivist. She highlighted the importance of bringing a humanistic aspect to the care of patients and families in the ICU. During my Critical Care fellowship at Columbia University, I had the opportunity to work amongst amazing scholars and clinicians such as Dr. Robert Sladen (the fellowship program director and Vice Chair), Dr. Margaret Wood (Chair), and Dr. Desmond Jordan. Having them as mentors and advocates during a fellowship year in New York when 9/11 devastated the world was very special to me. With their support and encouragement, I published my first peer-reviewed manuscript and have been hooked ever since.

I continued my journey in academic medicine in Asia (following my husband's jobs) where I worked as an intensivist and anesthesiologist. I completed a Master's degree in medical ethics from the National University of Singapore. I was touched by the predicament of families of elderly patients in the ICU and wanted to understand the perspectives and dilemmas that these tensions hold. I was also fortunate to receive national grants on multiracial genetic aspects of sepsis in critically ill patients. While living abroad, I continued to be actively involved in various academic societies here in the US, including SOCCA, the Society of Critical Care Medicine (SCCM), and the Critical Care Medicine committee of the ASA. I returned to the US just before the start of the pandemic under the leadership of Dr. Daniel Talmor at Beth Israel Deaconess Medical Center (BIDMC). I was especially attracted to BIDMC given its history of research excellence and limitless opportunities. Since then, I have continued to focus on scientific investigations centered on humanities, compassion, cross cultural ethics, racial injustice in end of life care, and women in medicine and critical care.

As an ethicist and anesthesiologist-intensivist, I have incorporated my interest and training in medical ethics in the social and clinical aspects of family and patient care in the ICU. I spearheaded the creation of ethics rounds for our trainees in the ICU and created an interprofessional module for nurses, residents, and students to discuss real life case vignettes with important ethical and moral dilemmas. At BIDMC, I am currently conducting a study in collaboration with representatives from SCCM, SOCCA, the Schwartz Center for Compassionate Care, and ESICM on compassionate care in the ICU. I am also working with SOCCA on a member survey regarding professional fulfillment and burnout amongst intensivists. My work is currently supported by BIDMC Healthcare Delivery Science and John Hedley Whyte grants, and a complete list of my publications may be found [online](#). I currently serve on the Board of Directors of SOCCA and co-chair the SOCCA Women in Critical Care Working Group. I look forward to collaborating with SOCCA members for the advancement of humanities research in critical illness.



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Don't forget to follow SOCCA on Twitter!

 @SOCCA_CritCare



FEATURED ARTICLE

Results and Trends in the Anesthesia Critical Care Medicine Fellowship Match

INTRODUCTION

Anesthesia Critical Care Medicine (ACCM) is the oldest ACGME board-certified subspecialty within Anesthesiology and has seen tremendous growth over the past decade. In an effort to organize, streamline, and create a fair and equal process for fellowship recruitment, ACCM fellowship programs have participated in the SFMatch process since 2014. Over the past nine years we have increased the number of fellowship programs offering positions in the match by 35% and increased the number of positions by 58%. Despite the expansion at the programmatic level, the interest in the field has yet to catch up to the need, and we remain with unfilled positions throughout the country.

RESULTS OF THE MATCH

After seeing a slight uptick in the 2021 cohort that was attributed to increased interest due to involvement in critical care rotations and the visibility of anesthesia-intensivist leadership revealed through the COVID-19 pandemic, we witnessed slight decreases in applicant registrations, the number of applicants that submitted a rank list, and the total number of matched applicants. While many were hopeful that the sharp increase in applications in 2021 would be a continuing trend, it instead may be an outlier, and the interest in the field of ACCM has a slower rate of rise than previously anticipated. The silver lining is that the interest is rising and we recruited a strong cohort of future intensivists across the country.



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Highlights of the Match

The 2022 match process was smooth and collegial despite 29 programs remaining unfilled on Match Day. The match process is designed to be resident-centric, allowing resident preferences to drive the process, and 90% of applicants matched with their first-choice program. SOCCA has sponsored a match-exception agreement process for special circumstances such as residents matching to their home fellowship program and applicants committing to a two-year training agreement (full details regarding the policy around match exceptions can be found on the [SOCCA website](#)). Up to 58% of the applicants used the match-exception agreement process to secure their positions. The most common reason (42% of applicants) for using this process was for the two year-training programs. Those pursuing two-years of consecutive training in ACCM followed by Adult Cardiothoracic Anesthesia (ACTA) represented 20% of the entire applicant pool and 35% of those solidifying their positions through the match exception process. Emergency Medicine (EM) residents are required to complete two years of training and therefore utilize the match exception process as well. EM applicants make up approximately 17% of the applicant pool and accounted for 30% of those utilizing the match exception process.

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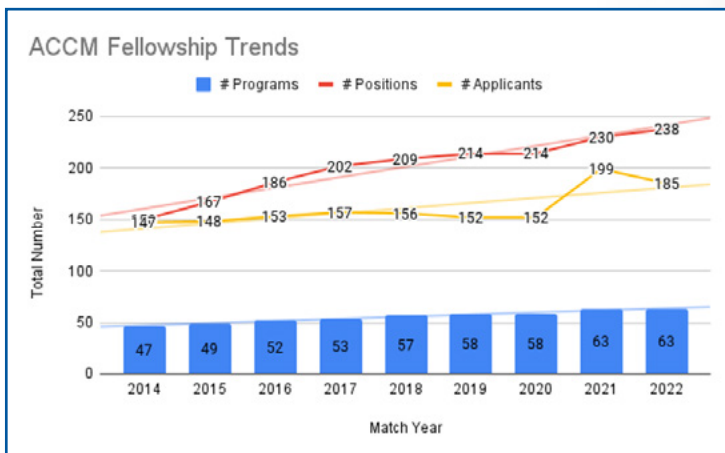


Figure 1

TRENDS IN ACCM COMPARED TO OTHER SUBSPECIALTY PROGRAMS

Interest in Anesthesiology Fellowship Training Programs

A common theme at the subspecialty update session at the annual Association of Anesthesiology Subspecialty Program Directors (AASPD) is the applicant to position ratio for individual subspecialties. While all fellowship programs have increased their offered positions over the past year, only ACTA and Pain Medicine continue to have more applicants than positions offered. ACTA, ACCM, and Pediatrics all had a slight decrease in applicants in 2022 (data for Regional and Acute Pain Medicine and Obstetric Anesthesia are not publicly available). Combining the number of fellowship positions available across the board, as seen in Figure 2, shows that the total number of positions approaches the total number of graduating residents in Anesthesiology training programs in the United States. This does not take into account non-ACGME accredited fellowships that are also increasing in number. Without an increase in the applicant pool, anesthesiology fellowship programs will continue to go unfilled across the majority of subspecialty programs.



Figure 2

Interest in Critical Care Medicine Across Specialties

Even prior to the COVID-19 pandemic, discussion of intensivist shortages throughout the nation loomed over our specialty. As a contributor to the workforce for critical care medicine, we join our colleagues in Pulmonary Critical Care Medicine (PCCM), Critical Care Medicine (CCM), Neurocritical Critical Care (NCC), and Surgical Critical Care (SCC) to fulfill the need to train adult critical care physicians to address the public health shortage. All programs saw an increase in applicants during the first recruitment cycle after the pandemic. However, only

NCC (34% increase from previous year) and PCCM (15% increase from previous year) reported a continuous uptick in applicants. PCCM and CCM remain the only programs to have more applicants than positions offered which is demonstrated in Figure 3. In order to increase intensivist coverage across our nation, our multidisciplinary specialty will need to support expansion in PCCM and CCM medicine positions to accommodate the increased demand in those specialties and/or develop ways to attract applicants into the surgical, anesthesia, and neurocritical care training programs.

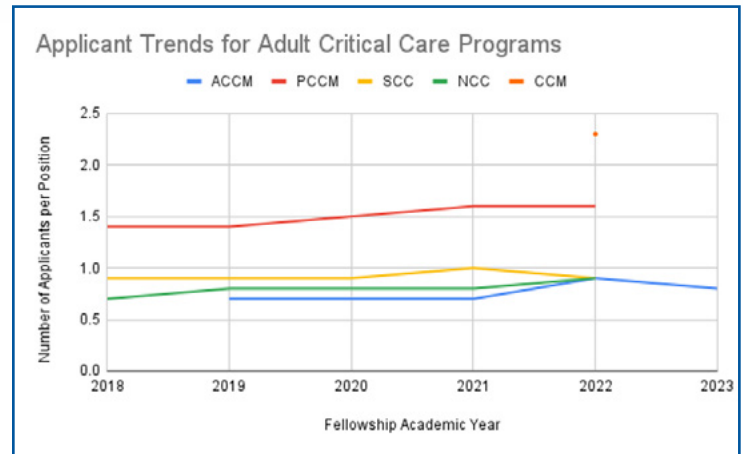


Figure 3

Using Trends to Enhance Recruitment Strategies and Interest in ACCM

As mentioned above, attracting more applicants into our training programs is a goal of the current SOCCA Program Director’s Advisory Committee (PDAC). Analyzing the current trends in applications, highlighting unique pathways, and focusing on innovative curriculum are ways in which our committee will be leaning into these efforts.

Two-Year Fellowship Tracks

The most common match exception used amongst programs and applicants is for those pursuing ACCM and ACTA fellowships in a consecutive structure. This allows the applicant to focus on programs that can offer both positions, minimize moving twice, and allow longitudinal growth at the same institution. A joint task force between SOCCA PDAC and the Society of Cardiothoracic Anesthesia (SCA) is actively improving the application process and joint efforts for program innovation and structure. The PDAC also recognizes that critical care medicine is not limited to a combination with ACTA but also lends itself to those interested in maternal health and obstetrical anesthesia, regional and acute pain management, perioperative medicine, trauma anesthesia,

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and research. Designing innovative two-year programs can attract candidates that are developing specific academic or scholarly interests and improve interest in our specialty.

American Board of Anesthesia Sponsored Emergency Medicine Pathway

Emergency medicine physicians are able to train in critical care medicine through multiple pathways, including a formalized two-year training program associated with ACCM ACGME approved programs. In 2013, the American Board of Anesthesiology created a pathway for training programs to develop a second year of training to fulfill board certification requirements for EM trainees. We now have over 32 of the 63 registered ACCM fellowship programs approved with more programs working on their applications. Advertising our training program as a good fit for EM physicians is another way to increase our applicant pool for our fellowship training programs.

Obstetrical-Gynecology Trainees

Obstetrical and Gynecology (OBGyn) residents have shown an increased interest in critical care subspecialty training. With the current rates of maternal mortality in the United States and a global need to improve maternal health nationwide, providing an avenue for OBGyn physicians to train and become board certified in critical care medicine can help this mission. While the current interest is small, we have seen a slow increase in interest over the past three years in cross-specialty applicants. ACCM is a program well-fitted for OBGyn residents given our cross-specialty nature and collaborations within our obstetrical anesthesia divisions.

Critical Care Ultrasound Training and Certification Options

The National Board of Echocardiography (NBE) now offers a certification exam in Critical Care Echocardiography. ACCM programs have been leaders in Critical Care Ultrasound Training and continue to lead the way. Improving resources for programs to adequately train fellows in this area can attract candidates to the fellowship program. The NBE offers both a training pathway and a practice pathway for certification and both require fellowship training and/or critical care practice and billing time to acquire certification.

Return to Fellowship for Practicing Physicians for Community Needs

Given the overall need for a larger applicant pool beyond current trainees, creating avenues and limiting barriers for practicing physicians interested in the specialty to return to training is another way in which the PDAC is hoping to recruit

into our programs. The COVID-19 pandemic put a lot of stress on community ICUs and many community anesthesiologists stepped up to staff and cover critical care units. We have seen physicians return to fellowship training with the goal of going back to their community hospitals to provide more formalized services to the ICU. Creating a space for private practice physicians to become involved in SOCCA and learn more about opportunities is another way to increase exposure to the benefits of formal fellowship training.

Integrated Critical Care Residency-Fellowship Training

In the last copy of SOCCA Interchange, the group at OHSU shared their positive experience with an integrated critical care training program. In this program, medical students match with the program directly and are set up to spend a total of five years at the same institution in which the critical care fellowship rotations are spread out over the last 24 months. Integrated programs like these are a way to recruit early and mentor residents for success in our specialty.

Call to Action for SOCCA Members

Consider these top five ways to help expand our applicant pool and recruit trainees into our amazing, rewarding, and innovative subspecialty.

- 1. Mentor a student** — Start recruiting earlier!
- 2. Recommend and sponsor a resident** — We need 20% of the current class to apply to ACCM!
- 3. Retweet the Program Spotlights during Recruitment Season:** Follow SOCCA on Twitter and help us spread the word!
- 4. Highlight open fellowship positions when discussing anesthesia job searches:** Send current CA3 residents to our [website](#) listing of programs or to the [SFMatch listing](#) of open 2023 fellowship positions when discussing their job search.
- 5. Collaborate with interdivisional and multidisciplinary colleagues:** Discuss opportunities to provide dual-training programs within your department or support an emergency medicine or OBGyn resident to pursue ACCM as their preferred training pathway for critical care medicine.

**All data extracted from publicly available sources from SFMatch, NRMP, and AAMC. RAPM fellowship numbers extracted from asra.com. *

ORGAN TRANSPLANT

FEATURED ARTICLE

A New Partnership in Transplant Critical Care & Transplant Anesthesiology

A milestone in transplantation was recently announced by United Network for Organ Sharing (UNOS) commemorating the completion of over one million transplants in the United States.¹ This achievement reflects a steady increase in annual transplant volumes with over 400,000 transplant recipients alive today. It is commonly understood that anesthesiologists are instrumental in peri-operative care of both organ donors and organ recipients. Less widely recognized, but equally important, is the involvement of anesthesiologists in patient selection, risk assessment, coordination of care for pre-operative optimization, and post-operative care. This includes the provision of critical care services for potential transplant candidates with end-stage organ failure, care of high acuity post-operative patients, management of post-transplant complications, and supportive care for organ donors.²

SOCCA and Society for the Advancement of Transplant Anesthesia (SATA) have formed a working group to collaborate on projects involving transplant critical care and transplant anesthesiology. Both societies are dedicated to the support and development of anesthesiologists in their respective sub-specialties. These focused societies can foster the formation and maintenance of a tightly knit community with others. Anesthesiologists with an interest in critical care and transplantation are encouraged to become active members in this collaborative effort.

Many aspects of transplant care that are vital to the continued success and growth of transplant programs occur behind the scenes and may not be apparent to patients, our colleagues, or institutional leaders. As an example, for liver transplantation in the United States, the Organ Procurement and Transplantation Network, a public-private partnership which falls under the U.S. Department of Health and Human Services, has specific mandates for the involvement of transplant anesthesiologists.³



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These include peri-operative consults and participation in candidate selection, morbidity and mortality conferences, and development of intra-operative guidelines based on existing and published knowledge. More extensive participation is specified and required of the Director of Liver Transplant Anesthesia. Of note, fellowship training in Critical Care Medicine, Cardiac Anesthesiology, or a Liver Transplant Fellowship are required for this position, formally highlighting the intersection of multiple fields in the care of transplant patients. Despite this federal guidance, support for these activities is not uniform across institutions, nor is a


standard funding mechanism in place. Obtaining resources to back the essential work of anesthesiologists outside of the operating room which enable transplant care remains a challenge.⁴

The proposed collaboration between SOCCA and SATA is meant to be broadly inclusive and address the needs of those involved in all transplant care. This includes those clinicians caring for all organ recipients including, but not limited to, heart, lung, liver, pancreas, and kidney, as well as those involved in donor care in the ICU and OR. As the field of transplant medicine evolves, the role of anesthesiologists in organ transplantation will likely continue to grow in the ICU, the OR, and via multidisciplinary collaboration.

Possible areas of focus for this initiative, to be determined and driven by members, include formal and informal education; facilitating clinical discussions across institutions, regions, and countries; and development of clinical statements and guidelines. Examples of recent efforts include work to define fellowship competencies and milestones in a variety of organ transplant fields.⁵⁻⁷ As multiple fellowship training becomes more common in anesthesiology, one avenue for collaboration is the exploration of the integration of critical care and transplant anesthesiology training. As mentioned, the practice of transplant anesthesia is heterogenous across

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institutions, but is largely uncharacterized. Similarly, we know little about the practice of critical care anesthesia in the United States, but the role of member-driven societies is essential to help understand the environment in which we work. A recent survey of SOCCA members shed light on demographics, training, practice characteristics, compensation, coverage models, and practice environment.⁸ Such work is essential to support our field as we must understand our practice to effectively advocate and promote the role of anesthesiologists and intensivists in the care of transplant patients in all phases of their clinical journey.

More immediate avenues of cooperation could include opportunities for presentation of critical care and transplant topics across both SOCCA and SATA, allowing members of each society to gain access to materials developed by colleagues. This can occur via multiple platforms. SOCCA offers a webinar series, a board review course, and a spring annual meeting. SATA has an online platform with a lecture series, multiple regional meetings, and a spring annual symposium. Both societies have options for either discounted or free membership for medical students, fellows, and medical residents. Those interested in the care of transplant patients are encouraged to participate to help drive the field forwards. Membership information can be found at socca.org and transplantanesthesia.org. Members interested in getting involved in the transplant collaboration between SOCCA and SATA are encouraged to email the author at akacha@dacc.uchicago.edu. 

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SOCCA drip

SOCCA Drip is a new online platform that offers member-generated content, spotlights member achievements, and delivers relevant news and updates from the broader critical care community—more frequently than ever before.

- Our newsletter, *SOCCA Interchange*, will continue to highlight features from our members and news from within the organization.
- To reflect these changes, SOCCA's Main Menu has changed to include "Drip" under "News" on the main menu.

- All back issues of *SOCCA Interchange* are available [here](#).
- To explore contribution opportunities or share relevant professional or programmatic accomplishments, please email SOCCA Society Director Vivian Abalama, IOM, CAE at vabalama@iars.org

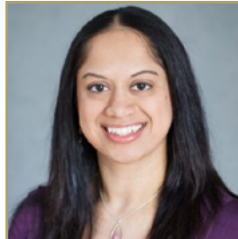
PREPARE II TRIAL FINDINGS: A REVIEW

Does Fluid Administration During Induction and Intubation Prevent Cardiovascular Collapse?

Russel DW, Casey JD, Gibbs KW, et al. Effect of Fluid Bolus Administration on Cardiovascular Collapse Among Critically Ill Patients Undergoing Tracheal Intubation. *JAMA*. 2022;328(3):270-279. doi:10.1001/jama.2022.9792

Nearly one in five patients suffers from cardiovascular collapse while undergoing intubation in the intensive care unit. This is defined as severe hypotension necessitating vasopressors, cardiac arrest, or death. The PREPARE II investigators sought to determine if the administration of a 500ml bolus of intravenous crystalloid solution prior to induction might prevent this collapse. The study was conducted at Vanderbilt University Medical Center in Tennessee, University of Alabama at Birmingham, Louisiana State University School of Medicine and Ochsner Medical Center in New Orleans, Lahey Hospital and Medical Center in Massachusetts, Hennepin County Medical Center in Minnesota, University of Mississippi Medical Center in Jackson, Wake Forest Baptist Medical Center in North Carolina, Oregon Health and Science University in Portland, University of Washington in Seattle, and Baylor Scott & White Medical Center in Texas.

This prospective study randomized patients to either receive a 500ml bolus prior to intubation or receive usual care. The primary outcome was cardiovascular collapse – defined as death within one hour of intubation, cardiac arrest within one hour of intubation, new systolic blood pressure of < 65 or a new or increased vasopressor requirement between induction and two minutes after intubation. The secondary outcome was 28 day in-hospital mortality. Additional outcomes measured included lowest systolic blood pressure between induction and two minutes after intubation, change in systolic blood pressure from induction to lowest systolic blood pressure, ventilator-free days, ICU-free days, lowest oxygen saturation and arterial oxygen saturation from induction to two minutes after intubation,



Alisha Bhatia, MD
Chair, Membership
Committee
Rush University
Chicago, IL

incidence of hypoxemia (oxygen saturation < 90%) and severe hypoxemia (oxygen saturation < 80%) between induction and two minutes after intubation, oxygen saturation at 24 hours after intubation, fraction of inspired oxygen at 24 hours after intubation, positive end expiratory pressure at 24 hours after intubation, systolic blood pressure at 24 hours after intubation, additional intravenous fluids initiated between induction and two minutes after intubation, time from induction to successful intubation, Cormack-Lehane grade of glottic view on first attempt, difficulty of intubation as reported

by operator, incidence of successful intubation on first laryngoscopy attempt, number of laryngoscopy attempts, and need for additional airway equipment or second operator.

Of the original 1576 patients screened, 1067 patients were randomized over two years. Inclusion criteria were as follows: age at least 18, undergoing endotracheal intubation routinely, plan for sedation, plan for positive pressure ventilation between induction and laryngoscopy (bag mask or non-invasive). Incarcerated patients, pregnant patients, urgent intubations, and patients who could not tolerate fluid boluses were excluded from the study.

For patients randomized to the fluid bolus administration, the operator was able to induce any time after initiation of the fluid bolus, and the entire 500 ml were given during the immediate peri-intubation period. Fluid infusing prior to induction and intubation was not altered. For patients randomized to the other arm, no additional fluid boluses were initiated prior to induction. Fluid infusing prior to induction and intubation was not altered. Clinicians were able to initiate fluid boluses for cardiovascular collapse at any time. Additional fluid administration to the non-fluid bolus group was only considered a protocol violation if it occurred between randomization and two minutes after intubation, in the absence of cardiovascular collapse. All other aspects

continued on page 14

of the intubation, including anesthetizing medications and vasopressor selection were up to the discretion of the treating physician.

The published results were as follows:

Among 1067 patients randomized, 1065 (99.8%) completed the trial and were included in the primary analysis.

Cardiovascular collapse occurred in 113 patients (21.0%) in the fluid bolus group and in 96 patients (18.2%) in the no fluid bolus group (no significant difference).


New or increased receipt of vasopressors occurred in 20.6% of patients in the fluid bolus group compared with 17.6% of patients in the no fluid bolus group, a systolic blood pressure of less than 65 mm Hg occurred in 3.9% vs 4.2%, respectively, cardiac arrest occurred in 1.7% vs 1.5%, and death occurred in 0.7% vs 0.6%. 218 patients (40.5%) in the fluid bolus group died before day 28 compared with 223 patients (42.3%) in the no fluid bolus group (no significant difference).

The investigators also looked at different parameters surrounding the intubation, including indication for intubation, comorbid conditions, preoxygenation method, induction agents used, type of positive pressure delivered between induction and intubation, and neuromuscular blocking agents

used. No significant findings were noted between the bolus and non-bolus group for these parameters as well.

The major previous trial on this idea also found that fluid administration prior to intubation did not reduce the risk of cardiovascular collapse overall but may have decreased the risk of cardiovascular collapse among patients receiving positive pressure ventilation, thus setting the standard recommendations for administering fluid prior to induction and intubation in the intensive care unit. This trial was conducted to further evaluate the impact of fluids in patients set to receive positive pressure ventilation.

The investigators concluded that the administration of an intravenous fluid bolus prior to tracheal intubation did not significantly decrease the incidence of cardiovascular collapse.

Though contrary to previous beliefs, these findings are in line with many recent studies that have re-evaluated how we administer fluids in the operating room and in the intensive care units, and whether they are beneficial. These findings support the idea that we need further studies looking at other interventions that may prevent cardiovascular collapse in the peri-intubation setting, including choice of induction agents and vasopressor usage. 

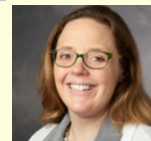
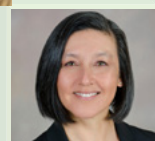
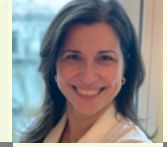
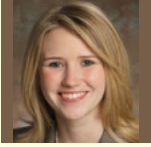
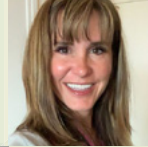
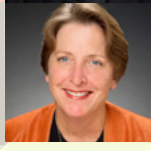
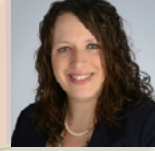
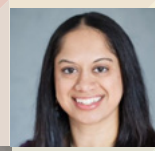
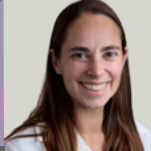
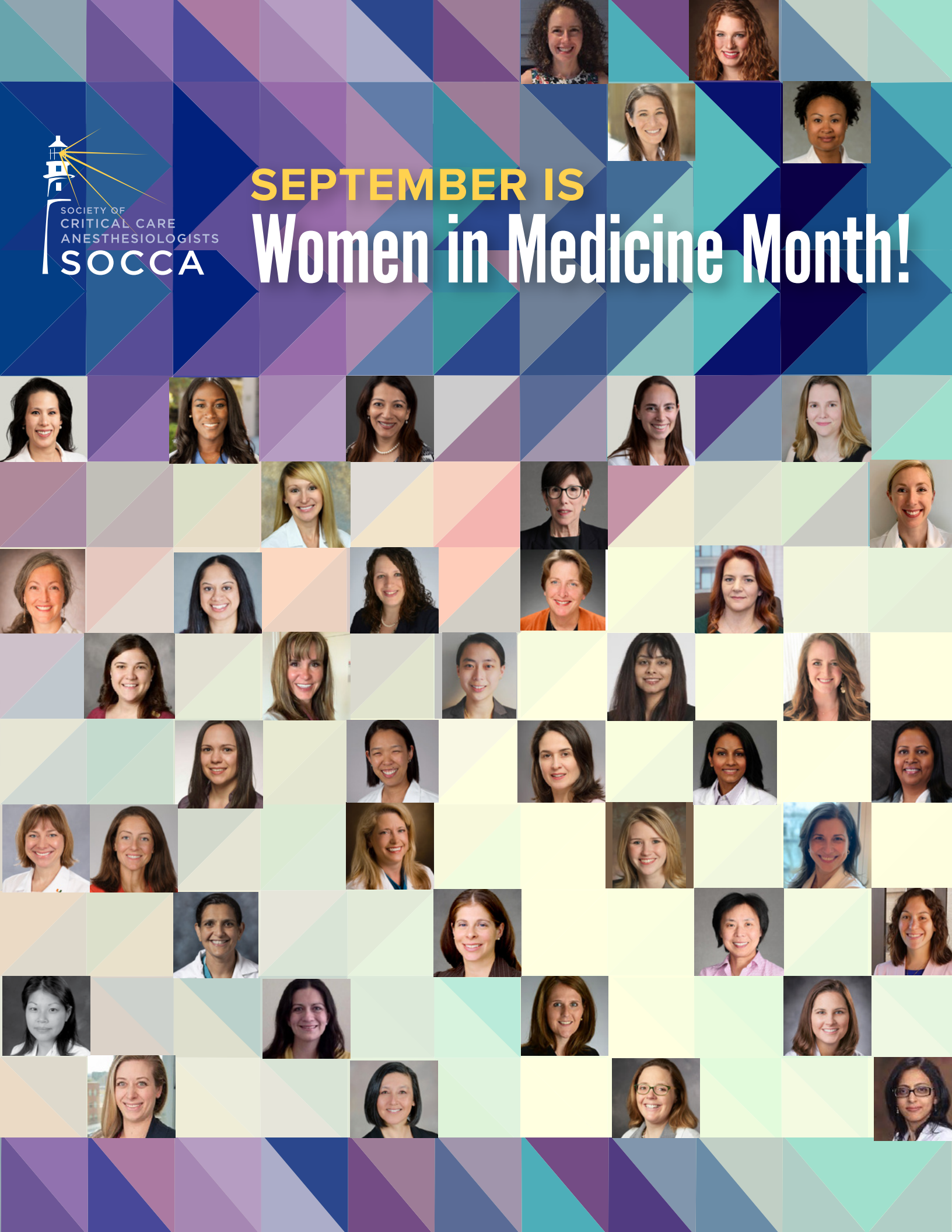
SOCCA INTENSIVISTS IN PRIVATE PRACTICE

JOIN US FOR AN ONLINE MEETING

October 13, 2022 | 6:00 PM ET



SEPTEMBER IS Women in Medicine Month!



Women in Medicine Month

Where We Are & Where We Want to Be

Where We Are

Over the past decade, the need to promote gender diversity in medicine has been embraced by several medical societies. In the USA in 2017, 33% of critical care trainees and 26% of ICU physicians were women. There are many reasons for this disparity and work is being done to understand these reasons to some extent. It was noted in literature that an explicit focus on “eliminating gender inequity will help to gradually change societal views of the roles played by women and men critical care physicians so that it will become the norm for women and men to be both critical care physicians and leaders in critical care.”

In 2018 SOCCA leadership held a facilitated Strategic Planning retreat. At that time, it was recognized that SOCCA could do better in terms of diversity and inclusion. Leadership and administration noted that there was a need to address this better within the SOCCA bylaws, mission statement and strategic planning. These underwent major enhancements with this in mind. Women Directors on the Board increased threefold from two to six from 2017 to 2022.

In 2018 SOCCA added two additional seats on the Board of Directors to work on increasing diversity of the SOCCA Board. In addition, a set of guidelines was created to encourage diverse members to apply (<https://socca.org/wp-content/uploads/2021/01/Criteria-for-SOCCA-Volunteer-Leadership.pdf>). Within the Board, both the Secretary and Treasurer are women, in line for future further leadership roles.

SOCCA currently has four committees, with two led by women (Education and Membership committees). There are two new working groups (Women in Critical Care and Early Career Intensivists) both envisioned and led by women. Training and mentorship programs for women and men intensivists have been developed within all committees to enable equitable promotion of women to higher academic ranks, gain research opportunities and leadership positions.



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Where We Want to Be

Seeing how SOCCA has evolved, these efforts have been associated with considerable improvement in this arena. In the words of one past President, “We need to maintain focus and continue to track how the Society evolves but I think we have a strong foundation to further build upon.”

There is still a long way to go to address the reasons of disparate numbers of women joining critical care anesthesiology and assuming roles in leadership and research roles. It is not enough to believe that women may choose not to achieve the same metrics of success as men do, due to personal or life factors. Perhaps these metrics need reimagination and reinvention, with greater support and sponsorship from both men and women who have achieved these accolades. Flexible scheduling, and promotion criteria, accommodation of mid-career or older women to achieve research mentorship, funding and research or educational tracks, (so they can balance childbearing and relationship responsibilities with academic roles, and not have to sacrifice either one in order to be judged successful) are examples of such ‘out of the box’ viewpoints.

The Women in Critical Care group is aiming to launch several initiatives in social media outreach, networking, motivational talks, podcasts for the busy woman intensivist to watch at a convenient time (aimed at work and life aspects), webinars (on wellness and other topics) and a white paper on suggestions and input from stakeholders on how societies and organizations can move forward with gender diversity.

We will need support and involvement from within and outside SOCCA to make these initiatives a success. 🏛️



Women in Medicine Month

Mentors and Mentees: A Powerful Connection

A 2018 viewpoint published in JAMA Internal Medicine highlighted four archetypes of “mentorship”: the traditional mentor, the coach, the sponsor and the connector.¹ The authors explain, “To put it simply, the mentor guides, the coach improves, the sponsor nominates, and the connector empowers, but always the mentee benefits.” As I read this article, I was struck by how rare it is for one person to be able to fulfill all these needs, and how I was lucky enough to have a mentor, Dr. Hannah Wunsch, who can and does embody all four roles.

The traditional mentor cultivates a mutually beneficial relationship that aims primarily to advance the career of the mentee. Throughout my career, Hannah has provided both “in the weeds” and “bird’s eye” level support. Whether it was helping me find what field of science I wanted to contribute to, which questions I wanted to ask, or what types of opportunities I should say yes to, she guided me to find a path and vision that was my own. Under her guidance, I successfully applied for the first FAER Mentored Training Research Grant in Health Services Research in 2013, which jumpstarted my research career; I then transitioned to a federally funded career development award, and eventually, to being an independent investigator.



**Hannah Wunsch,
MD, MSc**

Coaches teach their mentees particular skills, with a focus on improving performance. Hannah taught me how to analyze data, ask interesting questions, and write, frame and publish studies. She always has constructive criticism, and I have learned something from her about every single part of conducting research,



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from how to write a good figure legend to how to run a difference-in-differences analysis.

Sponsors use their influence to give their mentees visibility, while connectors connect mentees with others who may benefit their career. When I was an early career researcher, Hannah used her incredible network to facilitate my successful collaborations with senior, prominent researchers in the field of ICU palliative care. Since then, I have been able to develop my own international network of collaborators. Of course, this has helped my publication record, but more importantly, it has made research more engaging and enjoyable. Additionally, due to her sponsorship, I have had

the opportunity to write editorials in high-impact journals, give talks in national and international forums, and serve in various roles in professional societies and journals.

Early on, I knew that Hannah was a great mentor because no matter what the situation, I would leave her office feeling better and ready to take on more challenges. To succeed in academic medicine, you need someone who can guide you on the right path, and someone who will support and encourage you when the inevitable pitfalls occur. I feel incredibly fortunate to have benefitted from such amazing mentorship and can only hope to do the same for others as I move forward. 🏢

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1. Chopra V, Arora VM, Saint S. Will you be my mentor?—Four archetypes to help mentees succeed in academic medicine. JAMA Internal Medicine. 2017.

Watch Dr. Wunsch’s recent Fireside Chat with SOCCA’s Women in Critical Care

Women in Medicine Month

Belonging to an Organization: Professional Advancement & Personal Gains

Our realities changed during the pandemic and many people asked a very important question, possibly for the first time in their lives: what brings me joy and fulfillment? Is my choice of career a good fit for me? Outside of medicine, it is this feeling of being unfulfilled that has led to what is being dubbed 'The Great Resignation'. Amongst physicians, the lack of connectedness and satisfaction with one's specialty has led to high rates of burnout. Pre-pandemic literature on burnout suggested that engaged physicians tend to have less burnout. Engagement outside of clinical work can be driven by continued learning, faculty development and mentorship, having a social network and many more things. For me, engagement included interacting with my trainees, seeking ways to improve my clinical practice and finding mentorship from other physicians in my area of interest. This is where the role of belonging to a professional organization became very important.



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As a trainee, we are all encouraged to join our professional societies and I did the same. The importance of my membership did not become clear to me till I was a junior attending. Initially, professional meetings were a venue to showcase the research projects I participated in. However, I realized that professional organizations such as the Society of Critical Care Anesthesiologists (SOCCA) do more than just highlight my current projects.

One of the biggest personal gains I experienced from being a part of an organization was mentorship and faculty development. Subgroups and committees within the organization provided me the opportunity to network with those in my field of interest. As an example, I joined the Women in Cardiothoracic Anesthesia (WICTA) special interest group within the Society of Cardiovascular Anesthesia (SCA). I participated in their inaugural Professional Development Mentoring Program, where I was paired with an amazing anesthesiologist with experience in congenital heart disease, Dr. Johanna Schwarzenberger from UCLA. The group conducted webinars on presentation skills, storytelling and communication, statistics, and manuscript writing. All these skills are essential to the growth of a junior faculty member

in academic medicine. The culmination of this program was a presentation by the participating 'class' on their topic of interest using the various presentation skills taught during the seminar series. This was judged by senior faculty from all over the country and we all received meaningful feedback. The exercise helped me develop contacts, find a mentor, and improved my presentation and communication skills.

Being part of professional organizations such as SOCCA and SCA has been fulfilling in many other ways. I have learned to network within committees and at national meetings. As a newly minted program director for a medium sized critical care fellowship, this has allowed me to learn the ropes from my more experienced colleagues as well as be a part of the conversation about educating our future anesthesiologist intensivists. The continued learning and innovation at meetings keep me

updated with evolving practice patterns nationally and internationally. Lastly, it is always a joy to meet alumni and colleagues in an informal setting at national meetings.

Each of us finds meaning in their personal and professional lives in a variety of ways. I have experienced the many ways that being part of professional societies has prevented me from being burnt out by a heavy clinical load, even at the peak of the pandemic. The best balance of clinical work and professional engagement is personal and individualized. When the balance is right, it fuels one's passion and can help sustain their career through the highs and lows of clinical medicine. 🏛️



Women in Medicine Month

Burnout: No Easy Answers in a Post-Pandemic World

As I sit here writing a piece about work-life balance for women critical care physicians, I feel compelled to paint the picture of my current situation: in-house on call at 9pm on a Friday night, an AirPod in one ear teleconferencing my children to say goodnight, strapped into a portable breast pump, eating the fastest thing I could get from the hospital cafeteria (which is invariably fried), all while typing away at this piece in the physician work room. I am awash in irony. Is this the image of the prototypical woman intensivist? Not at all. Am I currently burned out? Actually, I don't think so. Have I been burned out at some point during my medical career thus far? Definitely. How do I refine my career plan to achieve work-life balance and sustainability for a satisfying and productive professional career? Unclear, check back later.



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reported they would be likely to take a pay cut for better work-life balance.

While these trends have made headlines in the setting of the pandemic, women intensivists have long felt the societal pressure to not only be a great physician/researcher/educator/leader, but also be outstanding in our roles outside of the hospital (as a parent, wife/partner, etc.).

What do we do about it? How do we balance this expectation when it is clear that burnout is running rampant among our ranks? Maybe more importantly, how do we become role models and agents of change for the future generations of medical students, residents, and fellows who are interested in our specialty but concerned about a sustainable professional career?

We are over two years into the COVID-19 pandemic and while we are largely out of quarantine and back out in the world, stress and burnout continue to play major roles in the intensive care unit, particularly for women intensivists. A look at the Medscape 2022 Physician Burnout & Depression and the Physician Lifestyle & Happiness Reports put into numbers what we all probably intuitively expected: With over 10,000 respondents to both surveys (38% women) across 29 specialties, burnout in 2021 continued to increase with 47% of respondents reporting burnout vs. 42% in 2020. Of these physicians experiencing burnout, the majority were women (56% vs. 41%). More concerning yet, critical care was the second highest specialty reporting burnout at 56%. So, for all of the women critical care physicians out there feeling tired and burned out – take solace that you are not alone.

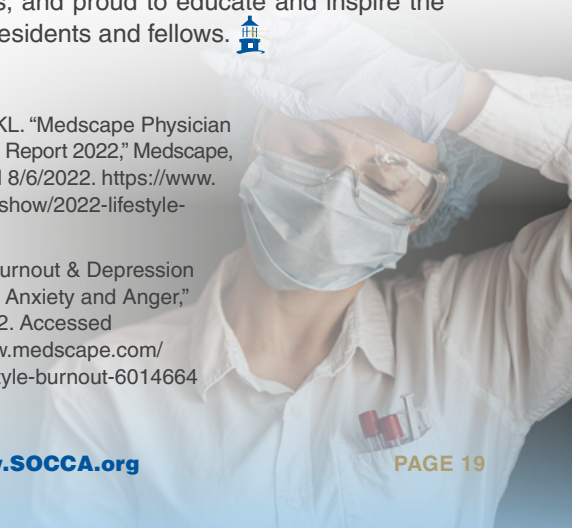
Women were over twice as likely to feel “very conflicted” as parents due to work demands during the last year, and indeed many women left the workforce entirely to assume childcare and homeschooling responsibilities. On top of that, “Mom guilt” (the feeling of not doing enough as a parent, or making incorrect parenting decisions) during time outside of our professional roles compounded this stress. Not only do we feel stressed as parents, but 68% of respondents also reported that burnout had affected their relationships with their spouse or partner. We feel this imbalance so much so that 60% of female respondents

The simple answers for our personal wellbeing (spend time with family & friends, participate in hobbies, eat healthy and get plenty of sleep and exercise) are all represented in the Medscape reports. But the truth is there isn't an easy answer to how we support women who are disproportionately experiencing higher rates of stress and burnout. As we define our “new normal” in the post-pandemic world, we have the opportunity to emphasize wellness, health, work-life balance and burnout prevention systemically, particularly for the support of women critical care physicians.

So, tomorrow I will spend time with my family, we will go hiking and enjoy the sunshine. I will be proud of my efforts in the hospital, honored at the opportunity to provide critical care for my patients, and proud to educate and inspire the next generation of residents and fellows. 🏠

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- 2 Kane L. “Physician Burnout & Depression Report 2022: Stress, Anxiety and Anger,” Medscape, 1/21/2022. Accessed 8/6/2022. <https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664>



SOCCA Critical Care Medicine 2022 Board Review Course

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SESSION OVERVIEW View and [download the full 2022 agenda](#) for all faculty and session sub-topics

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Session 2: Digestive/Nutrition, Renal, Hepatology

Course Director: Brian T. Wessman, MD, FACEP, FCCM, Division Chief Critical Care Medicine; Associate Professor, Anesthesiology & Emergency Medicine, Washington University in St. Louis, St. Louis, MO

Session 3: Hematology & Infectious Disease

Course Director: Talia K. Ben-Jacob, MD, MS, Division Head, Critical Care Anesthesiology, Cooper University Health Care, Camden, NJ

Session 4: Endocrine, Rheumatology, Dermatology, ICU Administration

Course Director: Anoop K. Chhina, MD, Associate Program Director, Henry Ford Health System, Detroit, MI

The objective of the SOCCA 2022 Critical Care Medicine Board Review is to further prepare fellows planning to take their critical care board examination through the American Board of Anesthesiology in the fall of 2022. The course covers frequently missed topics from prior exams and other high yield, frequently tested content. Exclusively taught by faculty that have recently taken the test themselves and can provide further insight on test preparation, trainees at any stage in their training are welcome, as well as junior faculty who want a refresher.

Medical students, residents, and fellows are eligible for complimentary SOCCA membership. If you are not currently a SOCCA member and would like access to the [2022 SOCCA Critical Care Medicine Board Review Course onDemand](#), please visit SOCCA's 2022 Board Review Course eLearning site or [click here](#) to learn more about the benefits of SOCCA membership.



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2022 SOCCA WEBINAR SERIES

The Society of Critical Care Anesthesiologists will continue its series of 60-minute webinars. This high-quality education series will feature informative content based on current research and is designed to help advance the field of critical care anesthesiology.

These webinars will be free for the public to attend but will require pre-registration. CME credits will be available for SOCCA members only.

November 17, 2022 | 6:00 pm ET | [Register here](#)

Peripartum Cardiomyopathy: Management in the Critical Care and Peri-operative setting

December 15, 2022 | 6:00 pm ET | [Register here](#)

Fearful Infections in the Postoperative Cardiothoracic Patient

Visit: [SOCCA 2022 Webinar Series page](#) for additional information.

CONTINUING MEDICAL EDUCATION ACTIVITY INFORMATION




ACCREDITATION STATEMENT This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the International Anesthesia Research Society and the Society of Critical Care Anesthesiologists.

The International Anesthesia Research Society is accredited by the ACCME to provide continuing medical education for physicians.

CREDIT DESIGNATION STATEMENTS The International Anesthesia Research Society designates this live activity for a maximum of 1 AMA PRA Category 1 Credit™ per session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

SUPPORT This program has not received any commercial support

Coming Soon: Full roster of [SOCCA 2023 Webinars](#).



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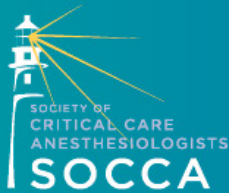
WHAT: Critical Care Anesthesia Meet-Up | Sponsored by SOCCA

**WHEN: Sunday, October 23
4:00-4:45pm**

**WHERE: Connection
Lounge 2**



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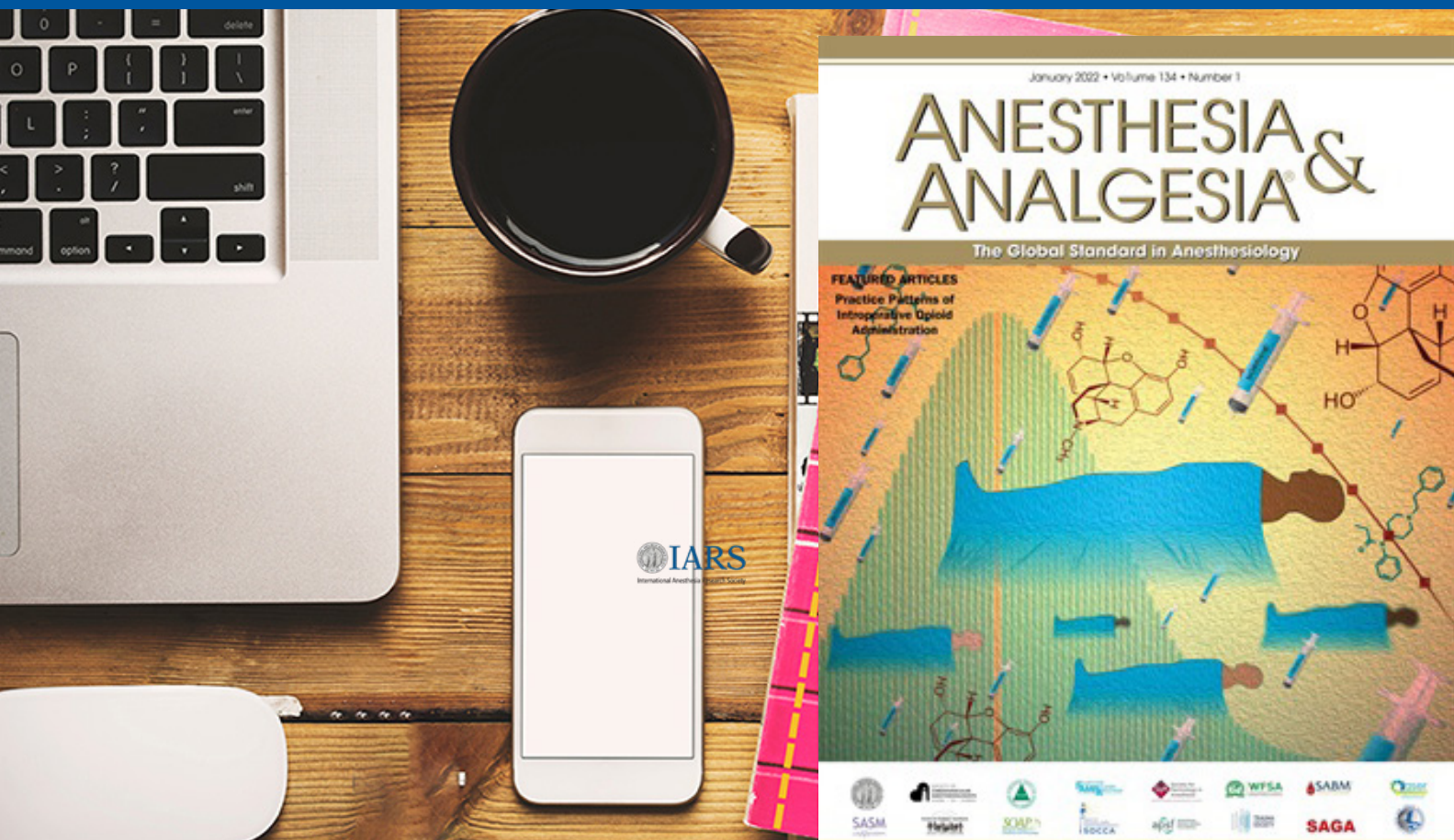
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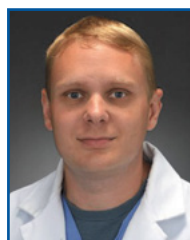
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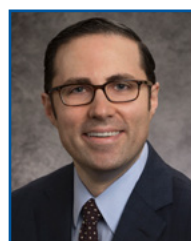
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