SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS
SOCCA

# INTERCHANGE

Society of Critical Care Anesthesiologists Newsletter Volume 32 | Issue 4 | December 2021

## PRESIDENT'S MESSAGE

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*President, SOCCA*
University of Miami
Miami, FL

The period between Thanksgiving (some would even say Halloween) and New Year's Day feels like a sprint to the end, a mad rush of preordained traditions that fills us with a sense of the tried and true, the old leading to the new, the past looking towards the future. So, this is a good time for a look back at 2021, the second and (hopefully) final act of our very own modern Greek tragedy, a year where nearly 400,000 fellow citizens died as a consequence of a disease we didn't even know existed a little over 2 years ago.

The number of changes, and scientific advances, and pain, and fear, and hope, has been nothing like we have ever experienced before. And our ilk, those of us who care for patients in intensive care units and operating rooms, were asked to take on an outsize role, a performance of a lifetime, one that stretched the limits of our comfort zones and made us take stock of who we are, and where we stand as a specialty.

And just like we hear every January in a little-known TV broadcast, let me begin by saying that the state of our Society is strong. Over the last year, our membership has grown to be the biggest recorded, both in active and educational members, and now SOCCA is the umbrella that covers over 1,000 intensivists in practice or training. Our recruitment efforts, under the direction of Suzanne Bennett, now begin early with complimentary membership even during the first year after fellowship, and we expect to retain most of our educational members with a strong value proposition.

Our educational mission, traditionally one of SOCCA's strongest pillars, had to be completely reimagined at the beginning of 2020 and progressively evolve and adapt over the next 2 years. Once extremely fearful of not having an in-person annual meeting, now we feel we have diversified and bolstered our offerings substantially, creating excellent and consistently well attended webinars, a Board review course that continues to grow, and significantly expanded our pool of speakers and experts. Most of these new outstanding speakers are early to mid-career, showcasing the vibrancy and enthusiasm of our younger members. Kudos to Ashish Khanna, chair of the Educational Committee, for connecting all this energy.

Not long ago, the words "research" and "SOCCA" weren't used together frequently. A few years ago, the Society's leadership decided to put together a committee that

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**SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS ANNUAL MEETING 2022**

**PRELIMINARY PROGRAM NOW AVAILABLE!**

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## PRESIDENT'S MESSAGE *continued from the cover*

could harness the research drive of our members by finding common interests and threads. Now, under the leadership of Matthew Warner and Shahzad Shaefi, we are starting to see the results of those efforts. We should soon be publishing a very interesting survey about the demographics and patterns of practice of anesthesiologists-intensivists, as well as multiple collaborations in books and clinics.

The Society's growing in many directions, adapting to the needs of our membership: soon we will have a women's group, a clinical practice group and a service chief's advisory council, in addition to the physicians in private practice and the young intensivist group, which were established and have matured over the last year. Please consider joining a committee; our very different aptitudes, points of view and strengths is what makes us unique. The future of our Society is looked carefully after by our immediate past president, Dan Brown, serving as head of the nominations committee. In addition to applications for the Board of Directors, we want every member to feel not only welcome but an integral part of the organization.

And then there must be a voice. Anything and everything we do is disseminated through various channels, including this very newsletter, the SOCCA Drip, our email list, and our Twitter account. All this is coordinated by Brent Kidd, universal master of carrier pigeons and chair of our communications committee.

The International Anesthesia Research Society (IARS) provides SOCCA with a robust organizational backbone, and I would like to send very special thanks to Vivian Abalama, our society's Director, and Kristin Howard, responsible for our meetings and educational offerings. SOCCA is better because of the work they do.

So yes, 2021 was a convoluted, complicated, sometimes frustrating, sometimes promising, but certainly a thrilling year for SOCCA. To all our members, on behalf of the Board of Directors and myself, I would like to wish you the best during this Holiday season and raise a glass for the future of our specialty and SOCCA. Thanks for all you do and Happy 2022!

Looking forward to seeing you in Hawaii!

## COMMITTEE ON RESEARCH UPDATE

**Matthew Warner, MD**
*Chair, Research Committee*
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Despite another year of pandemic-related challenges in the clinical practice of intensive care medicine, the SOCCA Research Committee continues with enthusiasm as we move towards the end of 2021. Our three subcommittees (Data, Research Collaboration, Scientific Writing) have been extremely productive. The Subcommittee on Data continues to collect data on the current state of anesthesia-led critical care through a series of short surveys. The first wave of results is currently being prepared for publication, and several other surveys are in various stages of dissemination and data collection. The Subcommittee on Research Collaboration is busy reviewing research abstracts and assigning awards and invited presentations for the upcoming SOCCA 2022 annual meeting. Additionally, the committee has been working to establish a speaker-exchange program and other opportunities to improve research collaboration across institutions. Finally, the Subcommittee on Scientific Writing is very active in multiple endeavors, including most notably the curation of an entire forthcoming issue of the journal Anesthesia Clinics dedicated to key topics in anesthesiology-based critical care. We look forward to great things in the coming year and are looking forward to connecting with other SOCCA members (in-person or virtually) in 2022!

# SOCCA LAUNCHES NEW MENTORING PROGRAM

SOCCA's mission is to support the development of anesthesiologists who care for critically ill patients. Recognizing the key role of mentorship in development, SOCCA is thrilled to offer mentorship resources to its membership.

Members at all levels of experience can now connect with individuals who have elected to volunteer their time and expertise to help others learn and grow in their knowledge about clinical practice, administration, leadership, research, organizational volunteerism, and other domains. These bidirectional relationships are not only mutually beneficial but foster a robust spirit of community within the organization.

Members seeking to identify a SOCCA mentor may navigate directly to SOCCA's Mentor Directory (**member login required**) where mentors are organized by their primary area of interest. Upon reviewing the directory, mentees are encouraged to identify their preferred mentor via the brief Mentee Submission Form.

You may also navigate to the Mentor Directory from SOCCA's public Mentoring Program page.

Thank you for your interest in becoming a SOCCA Mentee—and thank you to the many SOCCA members who have graciously offered to serve as Mentors.

**Visit SOCCA's Mentor Directory today!**

## It's time to update your profile and renew your membership with SOCCA!

Visit **Renew my SOCCA Membership** and **Update my SOCCA Profile** to ensure another 365 days of:

- Timely member news and information via SOCCA Drip
- Free SOCCA Interchange newsletter
- Virtual education & onDemand learning
- Discounted pricing for the SOCCA Annual Meeting
- Discounted membership in the IARS
- Free ICU Residents' Guide
- Free access to SOCCA Doc Matter Community

Visit **My SOCCA Benefits** to review all SOCCA's member benefits

# Training the Intensivists of Tomorrow

As educators, we strive for a mindset of innovation in both how and what we teach in Critical Care Medicine. The intensivists of tomorrow are expected to be clinically excellent, adept in responding to changes in the healthcare environment and also competent in the administrative arena. One of the evolving approaches to meet these demands in Critical Care training is through integrated residency and fellowship programs, which propose several advantages that we will review below.

### What is the 5-year innovative track?

Select programs across the country are offering an integrated Anesthesiology and Critical Care Medicine track. Programs typically span 60 months, with Critical Care training integrated in the last 18 - 24 months. Most training sites offer multidisciplinary rotation exposure and an opportunity to learn from diverse faculty. Upon completion of the program, trainees are eligible for both Anesthesiology and Critical Care Medicine certification as offered by the American Board of Anesthesiology.

### Our Experience at University Hospitals Cleveland Medical Center (UH CMC)

The UH CMC program was founded in 2014. In addition to the aforementioned innovations, our program offers a particular focus on management and leadership in the perioperative setting, as well as exposure to administration.

Curriculum highlights include rotations that focus on operating room workflow management, scheduling, resource utilization and process improvement. Additionally there is an experiential learning focus on risk management and negotiation; all trainees attend administrative meetings with the department's Vice Chair of Operations. Notably, there is ample opportunity to apply this knowledge hands on in system wide quality improvement initiatives.

As a high reliability medicine organization, UH CMC offers trainees the opportunity to participate in initiatives that are designed to achieve the Institute for Healthcare Improvement's triple aim1. The triple aim is to improve population health and the patient experience while reducing per capita cost, and HRM projects are designed to achieve one or all of these aims on an institutional scale. Last, the capstone course of the training program occurs within the Weatherhead School of Management at the Case Western Reserve University (CWRU). The curriculum is designed to give trainees an overview of the practical leadership tools that are needed to enact meaningful change within an organization. Students are required to register for classes from within a curated list, and subjects vary from accounting and finance to emotional intelligence and change management. The course spans 12 - 18 months, depending on the trainee's rotation schedule and culminates in a leadership certificate.

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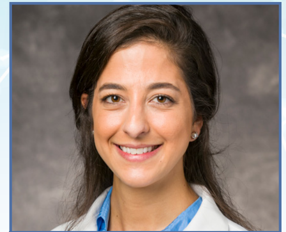

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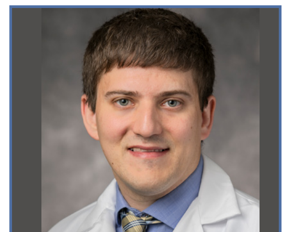

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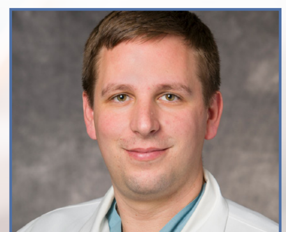

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Throughout this integrated learning experience, trainees are encouraged to present in all national Anesthesiology and Critical Care Medicine professional societies, particularly on projects that highlight the value of their educational track. The department sponsors all travel to these conferences, as scholarly activity and involvement in professional societies are a core value of the culture set forth by our department leadership.

### How is the combined track advantageous?

There is a practical benefit that is immediately apparent. For example, applicants who know that they will pursue Critical Care training can plan to settle in one location for 5 years. This eliminates the stress of repeated interviewing and allows trainees to focus solely on their education. Staying in the same hospital system may lend to a better ability to learn systems-based practice and to practice innovating systems solutions while in fellowship. If the trainee moves to a new system, there would be an inevitable time investment to learn the environment before it would be possible to make significant contributions on a systems-based level. Another advantage is that trainees would not spend a full year away from the operating rooms while they complete Critical Care rotations. Rather, the last portion of their training would involve rotating between both learning sites. For example, the operating room rotations such as TEE and Perfusion are complimentary to the traditional Critical Care medicine rotations. Finally, because many physicians who begin a critical care practice after training are involved in managerial duties fairly early in their career, the education and training focus on administrative and leadership skills gives the newly graduated critical care physician a valuable experience in these areas.

### What do our graduates have to say?

Current Fellow Erica Zanath: *"I ranked this program first during the residency match because I knew I wanted to pursue a career involving Critical Care practice and believed I would receive excellent training… The training I have received has been everything I expected and more. In addition to the typical Critical Care rotations, this program incorporates OR management rotations and courses through the Weatherhead School of Management which satisfy requirements for a certificate in perioperative leadership."*

Future (but matched!) Fellow Maddison Tenbarge: *"During medical school, I learned I not only wanted to become an anesthesiologist but also a Critical Care intensivist and it was important to me to find a program with a strong, anesthesia-led critical care department. With the combined anesthesia and Critical Care medicine program at Case Western University Hospitals, I appreciated the early integration into the fellowship program beginning in the middle of CA3...Additionally, the benefits of completing all facets of my residency and fellowship training at a single academic institution are substantial. By completing my entire training within the same system, I will be able to optimize my fellowship experience: my familiarity with the institution/EMR will allow me to spend more time learning the medicine I need to further patient care rather than the logistics of navigating a new hospital system and having already built relationships with the faculty within the Critical Care specialty as well as my peers within the combined program will provide me with increased opportunities for research and mentorship."*

### Future direction

Experimenting with this learning strategy to create physicians who have a developed language for collaborating with hospital administration could be of great value to the future of the field of Anesthesiology. Other ideas could involve integrating a full MBA or MHA program into the 5-year track, which would provide a more formal background for future careers in upper administration. Finally, a formal longitudinal rotation to teach trainees high reliability medicine in an experiential fashion could also offer insight to trainees into what jobs "in the real world" are like. Physicians not only need to provide excellent bedside care, but we also need to assume responsibility for initiatives that improve our system as well. This could be one way to introduce this concept into the way we provide training.

Critical Care Medicine will continue to evolve as technology evolves, and it will also evolve in response to environmental stimuli like the pandemic. No matter what the future brings, we are excited to work with the bright minds and caring hearts that are attracted to our field. We look forward to thinking about new ways to engage, inspire and motivate the intensivists of tomorrow so that they can lead a professional life filled with meaning.

#### REFERENCES

1. Triple aim for populations: IHI. Institute for Healthcare Improvement. (n.d.). Retrieved December 1, 2021, from http://www.ihi.org/Topics/TripleAim/Pages/default.aspx.

FEATURED ARTICLE

# Goals of Care Conversation in the Intensive Care Unit During the COVID-19 Pandemic

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With the holiday season upon us, in the US and globally, ICUs (Intensive Care Units) are still struggling with the deadly COVID-19 pandemic. For the first time in our history, hospital systems are forced to scramble to allocate scarce resources such as nursing, respiratory therapists, ICU beds, oxygenation, and drug treatments that lack adequate amount of literature support. According to provisional data, in 2020, there were notable changes in the number and ranking of deaths compared with 2019. COVID-19 was the third leading cause of death in 2020, with an estimated 345 323 deaths, and was responsible for the substantial increase in total deaths from 2019 to 2020 [Table 1].

**Table 1: Number of Deaths for Leading Causes of Death, US, 2015-2020**

| | No. of deaths by year | | | | | |
|---|---|---|---|---|---|---|
| Cause of death | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
| Total deaths | 2 712 630 | 2 744 248 | 2 813 503 | 2 839 205 | 2 854 838 | 3 358 814 |
| Heart disease | 633 842 | 635 260 | 647 457 | 655 381 | 659 041 | 690 882 |
| Cancer | 595 930 | 598 038 | 599 108 | 599 274 | 599 601 | 598 932 |
| COVID-19[b] | | | | | | 345 323 |
| Unintentional injuries | 146 571 | 161 374 | 169 936 | 167 127 | 173 040 | 192 176 |
| Stroke | 140 323 | 142 142 | 146 383 | 147 810 | 150 005 | 159 050 |
| Chronic lower respiratory diseases | 155 041 | 154 596 | 160 201 | 159 486 | 156 979 | 151 637 |
| Alzheimer disease | 110 561 | 116 103 | 121 404 | 122 019 | 121 499 | 133 382 |
| Diabetes | 79 535 | 80 058 | 83 564 | 84 946 | 87 647 | 101 106 |
| Influenza and pneumonia | 57 062 | 51 537 | 55 672 | 59 120 | 49 783 | 53 495 |
| Kidney disease | 49 959 | 50 046 | 50 633 | 51 386 | 51 565 | 52 260 |
| Suicide | 44 193 | 44 965 | 47 173 | 48 344 | 47 511 | 44 834 |

[a] Leading causes are classified according to underlying cause and presented according to the number of deaths among US residents. For more information, see the article by Heron.[4] Source: National Center for Health Statistics. National Vital Statistics System: mortality statistics (http://www.cdc.gov/nchs/deaths.htm). Data for 2015-2019 are final; data for 2020 are provisional.

[b] Deaths with confirmed or presumed COVID-19, coded to *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* code U07.1 as the underlying cause of death.

There is also chaos amongst the public. During the past few months, we have experienced the divide amongst those who believe in the vaccine and those who do not. Since we live in the virtual internet era, medical information is easily accessed by the public, however this also comes with false information that the public may not be able to discern. Patients are requesting medications such as Ivermectin that have not been supported scientifically. This resulted in family members of patients versus the hospitals and their doctors standing in front of the judicial systems and are finally forced to administer treatments that are not backed by science. We learn that even clinicians are divided into what are believed to be the best treatment. This had left the public with confusion, doubt, and questioning the legitimacy of treatment enforced by our governing bodies from the FDA (Food and Drug Administration) and CDC (Centers for Disease Control). For example, there have been different recommendations and endorsement between the FDA and CDC.

Combine this chaos with the already over-worked, exhausted ICU providers, and with families who are experiencing the unexpected dying of their family member from COVID-19 and are restricted in their visitation rights—some of whom are demanding treatments that you believe have not been backed by science and could potentially cause more harm than benefit. This created a state of animosity and lack of trust between family members and their ICU providers. The lack of trust becomes apparent, especially for the particularly important goals of care conversation that need to take place between providers and family members. At times, this leads to suffering of the patient.

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In the event we encounter a hostile interaction, we can refer to COVID Ready Communication Playbook | VitalTalk. This resource provides strategies on how to communicate and preference of what to say when emotions are high during an interaction with patients or their family members. The following is an example taken from VitalTalk on how to respond and the phrases we can use to diffuse these emotions:

| | |
|---|---|
| You people are incompetent! | I can see why you are not happy with things. **I am willing to do what is in my power to improve things for you**. What could I do that would help? |
| I want to talk to your boss. | I can see you are frustrated. **I will ask my boss to come by as soon as they can. Please realize that they are juggling many things right now.** |

Regarding goals of care discussions, palliative care can enhance both the quality of end of life, as well as extend longevity of end of life. Goals of care conversations are essential to ensure high quality care for our critically ill patients. However, not all hospitals have palliative team consultants available all hours of the day, 24/7. Amidst the above barriers, the lack of trust from patients and their families, and time constraints during the pandemic in an overloaded ICU, are requiring more than ever a system or framework that helps with goals of care conversations in a pandemic. As the COVID-19 crisis continues, ICU clinicians face an urgent need to conduct goals-of-care conversations. To ensure an effective goals of care conversation, when possible, clinicians should initiate goals-of-care conversations ideally, among all patients admitted to the ICU, and especially the very sick. However, many ICU clinicians lack not only in time required to hold these conversations, but also lack the experience and training, so that they face deep uncertainty in planning, conducting, and evaluating such interactions. [Petriceks]. According to provisional data, in 2020, there were notable changes in the number and ranking of deaths compared with 2019. COVID-19 was the third leading cause of death in 2020, with an estimated 345 323 deaths, and was responsible for the substantial increase in total deaths from 2019 to 2020.

To help guide clinicians with a comprehensive and effective goals of care conversation, using a checklist or framework will help to adhere to best practices and cover key points for an effective goals-of-care conversation[7]. There are several frameworks that can help guide the clinicians such as REMAP, SUPER, or "Just Ask" conversation guide.

In this article, we will describe The GOOD and REMAP Framework, and the Three Stage Protocol. No matter which framework or checklist to use, they all provide person-centered, high-quality care that leads to positive satisfaction and outcomes for your patients, their families, and your organization[7].

### The GOOD Framework

The GOOD framework was developed at the Stanford University School of Medicine and helps clarify uncertainties in working with older patients or those with serious illness particularly, though not exclusively, during the current pandemic. The framework, which stands for *Goal, Option, Opinion, and Documentation*, provides clinicians and their elderly patients in serious illness with steps and the resources to help with a successful goals of care conversation; it helps clinicians with the components to plan, conduct, and evaluate goals of care conversations. GOOD was developed for both palliative care clinicians and those nonpalliative care providers for use during the pandemic and ongoing [Petriceks].

The two primary purposes of the GOOD Framework (illustration 1) are:

1. Concise mnemonic that is useful at any time beyond the pandemic
2. Prepare the clinicians with resources and provide guidance of goals of care conversation to nonpalliative care clinicians, including resources in communicative strategies and empathic language. See Table 2 for empathetic responses.

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### Illustration 1: Good Framework

| | Clinician task | Potential uncertainties | Potential resources |
|---|---|---|---|
| Goals | Determine the goals and values of the patient | Patient may not know their own goals, or may have goals which contradict one another | – Patient Priorities Care<br>– Stanford Letter Project |
| Options | Determine and describe options available to patient — including details and probabilities — given their goals | Clinicians may be uncertain about clinical options; patient may have uncertainties or misconceptions but not know how to clarify | – VHA LSTDI[b]<br>– Video Decision Tools<br>– CAPC[c] |
| Opinions | Elicit patient preferences regarding options available; communicate clinician perspective on most conducive option; arrive at shared decision | Clinicians may struggle to provide clinical recommendation due to prognostic uncertainty | – Clinical Frailty Scale<br>– ePrognosis<br>– CAPC[c] |
| Documentation | Document outcome of decision-making process; highlight reasoning behind any decisions; make note of all participants | Clinicians often write brief notes (e.g., "DNR"), which may not reflect the nuance and situational dependency of patient values | – POLST[d]<br>– Prepare for Your Care<br>– VHA LSTDI[b] |

[a]Adapted from the Stanford University School of Medicine End-of-Life Curriculum for Medical Teachers.
[b]Veterans Health Affairs Life-Sustaining Treatments Decisions Initiative.
[c]Center to Advance Palliative Care.
[d]Portable Orders for Life-Sustaining Treatment.

### Table 2. Empathetic Responses

| EMPATHIC RESPONSES | | | | | |
|---|---|---|---|---|---|
| **Naming** | **Understanding** | **Respecting** | **Supporting** | **Exploring** | **"I Wish"** |
| This must be…<br>• Frustrating<br>• Overwhelming<br>• Scary<br>• Difficult<br>• Challenging<br>• Hard | What you just said really helps me understand the situation better. | I really admire your<br>• Faith<br>• Strength<br>• Commitment to your family<br>• Thoughtfulness<br>• Love for your family | We will do our very best to make sure you have what you need. | Could you say more about what you mean when you say…<br>• I don't want to give up<br>• I'm hoping for a miracle | I wish we had a treatment that would cure you (make your illness go away). |
| I'm wondering if you are feeling …<br>• Sad<br>• Scared<br>• Frustrated<br>• Overwhelmed<br>• Anxious<br>• Angry | This really helps me better understand what you are thinking. | You (or your dad, mom, child, spouse) are/is such a strong person and have/has been through so much. | Our team is here to help you with this. | Help me understand more about… | I wish I had better news. |
| It sounds like you may be feeling … | I can see how dealing with this might be …<br>• hard on you<br>• frustrating<br>• challenging<br>• scary | I can really see how (strong, dedicated, loving, caring, etc.) you are. | We will work hard to get you the support that you need. | Tell me more… | I wish you weren't having to go through this. |
| In this situation, some people might feel … | I can see how important this is to you. | You are such a (strong, caring, dedicated) person. | We are committed to help you in any way we can. | Tell me more about what [a miracle, fighting, not giving up, etc.] might look like for you. | I wish that for you too.<br><br>[In response to what a patient or family members wishes, such as a miracle] |
| I can't even imagine how (NAME EMOTION) this must be. | Dealing with this illness has been such a big part of your life and taken so much energy. | I'm really impressed by all that you've done to manage your illness (help your loved one deal with their illness). | We will go be here for you. | Can you say more about that? | I wish we weren't in this spot right now. |

Goals of Care Conversations training materials were developed and made available for public use through U.S. Department of Veterans Affairs contracts with VitalTalk [Orders VA777-14-P-0400 and VA777-16-C-0015]. Updated June 2018.

Graphic from Skillset Review - COVID-19 Curriculum (covidstudentresponse.org)

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### REMAP Framework

REMAP *(Reframe, Expect, Map, Align, Plan)* was published by the *Journal of Oncology Practice in 2017*. It provides a stepwise approach for complex goals of care conversations. It was originally developed to help oncologists who believed they had lack of training having goals of care conversations and that these conversations were occurring "too late" in cancer patients who were already diagnosed with advanced disease. This framework had been optimized for those late goals of care conversation where a clinical decision is needed urgently. It has been a commonly used framework that guides the clinicians to cover key components of the conversation[8]. With REMAP, the clinician can determine a patient's primary values, goals, and fears, which will then help the clinician to develop a plan that honors those values, goals, and fears [table 3]. The processes underlying REMAP encourage oncologists and other clinicians to seek to understand and remain flexible, adapting their recommendations to what they hear from the patient, with ongoing revision based on the shared decision-making process. This will lead to patient-centered decisions that promote better end-of-life care[8].

**Table 3: REMAP Framework**

| REMAP | ADDRESSING GOALS OF CARE |
|---|---|
| **REFRAME** why the status quo isn't working | *(You may need to discuss serious news such as a scan first.)* *"Given this news, it seems like a good time to talk about what to do now. We're in a different place."* |
| **EXPECT** emotion - respond with empathy | *"It's hard to deal with all this."* *"I can see you are really concerned about [x]."* *"Tell me more about that—what are you worried about?"* *"Is it ok for us to talk about what this means?"* |
| **MAP** out what's important | *"Given this situation, what's most important for you?"* *"When you think about the future, are there things you want to do?"* *"As you look toward the future, what concerns you?"* |
| **ALIGN** with the patient's values | *"As I listen to you, it sounds the most important things are [x-y-z]."* |
| **PLAN** to match values | *"Here's what I can do now that will help you do those important things."* *"What do you think about it?"* |

Goals of Care Conversations training was developed by VA National Center for Ethics in Health Care through contracts with VitalTalk. Updated 01/2018. www.ethics.va.gov/goalsofcaretraining/practitioner.asp

Graphic from Skillset Review - COVID-19 Curriculum (covidstudentresponse.org)

### The Three-Staged Protocol

This protocol was developed to guide an ED-based COVID-19 palliative care response team, focused on providing high quality GOC conversations in time-critical situations[10]. Stage 1 is for sharing knowledge and prognosis. This stage can be somewhat challenging as COVID-19 medical management and treatments are rapidly evolving. The author recommends emphasizing functional status outcomes rather than focusing only on mortality or survival data. The clinicians should expect a strong emotional reaction from this news which needs time and support prior to initiating stage 2. In stage 2, the conversation involves discussion about goals of care. This can be obtained from determining the patient's most important values and what makes them enjoy life. Finally, stage 3, the clinician emphasizes treatment options and makes recommendations that are in line with the patient's most important goals and values.

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## Summary and Future Goals

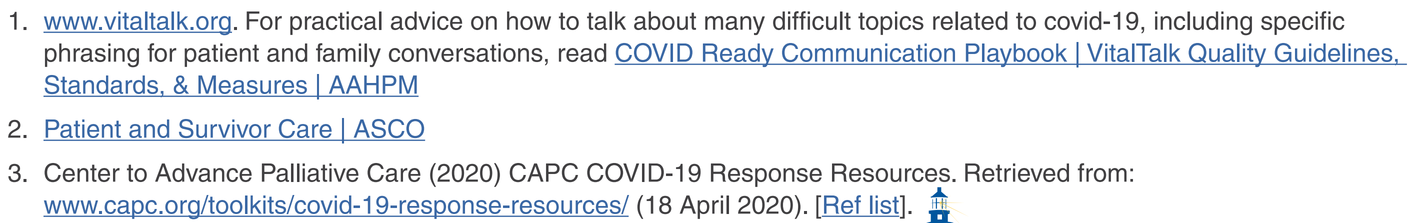
COVID-19 pandemic can lead to rapid progression to respiratory failure necessitating mechanical ventilation. Currently, the mortality for those on mechanical ventilation is high, especially for the elderly and those with comorbidities such as diabetes mellitus and hypertension. In those who survived, the threat is of being on prolonged mechanical ventilation and inevitably bed-bound and cachectic for an undetermined time period. This had caused the intensivists and clinicians from all specialties other than palliative care to learn and provide goals of care conversation in an urgent manner, regardless of their previous training and experience in holding these conversations. Ideally, goals of care conversation should start early on all patients admitted to the ICU, and not only undertaken for those close to end of life. These conversations require more than one sitting and should be considered a process. Expect that the first conversation will not usually reveal a change in any medical plan management or goals of care. With news of poor prognosis, patients and their families need to be provided with sufficient time to process and grief, it is not a time to discuss goals of care at the same time. Future studies are needed in the development of goals of care conversation specifically for nonpalliative care ICU providers during a pandemic. In the meantime, the ICU clinicians can use and follow guidance from the GOOD and REMAP frameworks or the Three-Staged protocol as they help with a comprehensive approach in determining the patient's most important values about their medical care and ultimately their satisfaction. It would be beneficial to have palliative care and goals of care conversation integrated into training programs or as requirement continuing medical education for those providers in intensive care.

**Illustration 2**

**Palliative Care & Hospice Care: What's the Difference?**

| Palliative Care: | Hospice Care: |
|---|---|
| • Can begin at the discretion of the physician at any time, at any stage of illness, serious to end-stage. | • Begins when two physicians certify that the patient has less than six months to live if the disease follows its usual course. |
| • Is supportive care with or without curative intent. This care may relieve only symptoms or it may have a curative effect on the disease itself. | • Is comfort care without curative intent; patient is no longer responding to curative treatment or has elected not to further pursue such treatments. |
| • Is paid for by insurance and/or self-pay, from office visits to prescription charges. Check with your health plan for coverage. | • Is completely covered by Medicare, Medicaid, and most private insurance, since it follows a terminal diagnosis. |
| • Usually takes place in a hospital or medical facility. | • Usually takes place in a home or home-like environment. |

Image taken from thedeathdeck.com



Where to obtain further resources and information:

1. www.vitaltalk.org. For practical advice on how to talk about many difficult topics related to covid-19, including specific phrasing for patient and family conversations, read COVID Ready Communication Playbook | VitalTalk Quality Guidelines, Standards, & Measures | AAHPM
2. Patient and Survivor Care | ASCO
3. Center to Advance Palliative Care (2020) CAPC COVID-19 Response Resources. Retrieved from: www.capc.org/toolkits/covid-19-response-resources/ (18 April 2020). [Ref list].

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5. Center to Advance Palliative Care (2020) CAPC COVID-19 Response Resources. Retrieved from: www.capc.org/toolkits/covid-19-response-resources/ (18 April 2020). [Ref list]
6. Skillset Review — COVID-19 Curriculum (covidstudentresponse.org)
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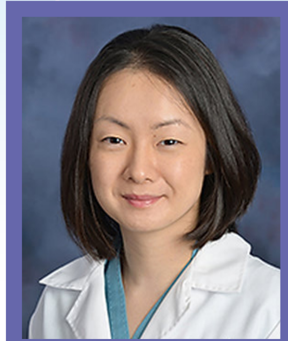
9. Goals of care and covid-19: A GOOD framework for dealing with uncertaintyAldis H. Petriceks, B.A. www.ncbi.nlm.nih.gov/pmc/articles/PMC7322160/
10. Time-Critical Goals of Care in the Emergency Department during COVID-19: A Three-Stage Protocol Shunichi Nakagawa,MD. www.ncbi.nlm.nih.gov/pmc/articles/PMC7323252/pdf/JGS-9999-na.pdf

MEMBER SPOTLIGHT

# A Brief Conversation with...Pinxia Chen



**Pinxia Chen, MD**
Saint Luke's University Health System
Bethlehem, PA

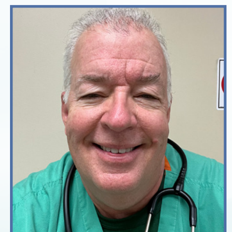
Dr. Pinxia Chen currently practices at Saint Luke's University Health System in Bethlehem, Pennsylvania and has been with her group for five years. Dr. Chen is originally from the South Jersey/Philadelphia area and started her career with an anesthesiology residency at Penn State Medical Center in Hershey and a fellowship in critical care at the Cleveland Clinic. Dr. Chen stated that she then looked for academic jobs with a strong anesthesiology presence in the ICU. However, the academic jobs available in her preferred geographic location left something to be desired and her current position in private practice did allow for strong clinical involvement by anesthesiologists in the critical care setting. When Dr. Chen started there were only two people in the group with formal critical care training. That number has grown considerably since that time.

According to Dr. Chen there are tradeoffs to working as an anesthesiology trained intensivist in private practice. The advantages include a better work life balance which allows for greater involvement with SOCCA and the Anesthesiology section of SCCM. Dr. Chen splits her time roughly 50% in the operating room and 50% in the ICU. Potential drawbacks with this arrangement included the challenges of being a new attending at a community hospital where not all the sub-specialists are represented. Therefore, critical care became the main resource for physicians in the Emergency Department and hospitalist staff.

Despite this, Dr. Chen said that members of her group were very supportive of her efforts. Since Dr. Chen practices in a community hospital setting, her ICU is made up of both medical and surgical patients with medical patients predominating. Dr. Chen leads clinical rounds with internal medicine residents but lectures to both medical and surgical residents on topics germane to critical care. Members of her group are encouraged but not required to participate in clinical research.

As far as the business aspect of her practice goes, Dr. Chen's group functions as independent contractors at the hospital but are either employees or stakeholders within the group. Most anesthesiology practices were impacted by COVID-19 and Dr. Chen's was no exception. After the pandemic began, Dr. Chen became a full-time intensivist for several months. Her group was proactive and cut down the duration of clinical shifts in the ICU from 24 to 12 hours. Elective surgeries were canceled and some nurse anesthetists in her group became extra resources in the ICU. Operating room anesthesia machines were converted to ICU ventilators.

Dr. Chen states that she has no regrets about how her career turned out and that she feels very fortunate. The training in anesthesiology is very different from medicine or surgery and our specialty brings a unique perspective to the ICU. Finally, groups like SOCCA and the Anesthesiology section of SCCM are very important to Dr. Chen since they embrace individuals with a similar training and mentality and help our subspecialty maintain its identity.



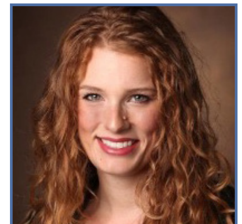
**Frank O'Connell, MD, FACP, FCCP**
Atlanticare
Pomona, NJ

**Don't forget to follow SOCCA on Twitter!**

FEATURED ARTICLE

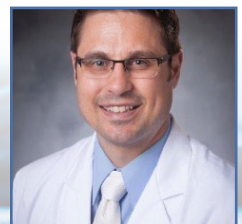
# Academic Medicine Extinction: a Fundamental but Poorly Discussed Matter

**Craig Jabaley, MD**
Associate Professor
Department of Anesthesiology
Division Chief of Critical Care Medicine
Emory University School of Medicine
Atlanta, GA



**Kimberly Rengel, MD**
Assistant Professor
Anesthesiology & Critical Care Medicine
Vanderbilt University Medical Center
Nashville, TN

**Santiago J. Miyara, MD, MSCE**
PhD Candidate in Molecular Medicine
Department of Critical Care Physiology
Elmezzi & Hearst Foundation Scholar
Feinstein Institutes for Medical Research
Manhasset, NY



**Jamie Privratsky, MD, PhD**
Assistant Professor
Department of Anesthesiology
Duke University School of Medicine
Durham. NC

It is not a new problem, but it is worsening. Physician-scientists are disappearing.

*In a word, I consider hospitals only as the entrance to scientific medicine; they are the first field of observation which a physician enters; but the true sanctuary of medical science is a laboratory; only there can he seek explanations of life in the normal and pathological states by means of experimental analysis.* — Claude Bernard, 1865

Peter Safar, the creator of the first intensive care unit (ICU) in the United States, father of cardiopulmonary resuscitation, pioneer of the modern ambulance design, and three-time nominee for the Nobel Prize, repeatedly delivered a very simple message: physician-scientists are in danger of extinction.[1]

In the last 30 years, the problem has only worsened: the 2014 report by the NIH Physician-Scientist Workforce Working Group showed that physician-scientists are consistently decreasing as a percentage of the medical workforce, fewer physicians apply for federal funding each year, and many are near retirement.[2] Further, the paucity of physician-scientists in anesthesiology is particularly prevalent when compared to other specialties.[3] What would a future look like with no physician-scientists? What would be the consequences of losing the physician-scientist workforce? Let's review their role: physicians involved in science and academic medicine are essential protagonists in making discoveries and translating them into clinical practice. They can unify and interpret worlds with different languages and dynamics: clinical medicine, clinical research, and science. Physician-scientists are uniquely qualified to apply clinical expertise and training to formulate clinically relevant hypotheses, testing them at the pre-clinical and clinical level.[4,5] In essence, physician-scientists can bridge the challenging gap between basic science knowledge, clinical research, and medical treatments, a role which cannot be easily fulfilled either by full-time clinicians or PhD scientists.[5,6]

Data show that physician-scientists trained through MD-PhD/Medical Scientist Training Program programs are (1) more likely to apply for NIH training awards than their MD-only counterparts, (2) more likely to go from a training award to an independent research award, and (3) more likely to receive NIH grants and re-apply after failed R01 applications. However, despite the important contributions of physician scientists, MD-PhD graduates represent only 3% of all medical graduates each year.7 For non-MD-PhD graduates, additional considerations including lack of access to formal mentorship and training, burdensome financial commitments, and inadequate institutional support of time and resources limit physicians from pursuing research after starting clinical practice.

The reasons behind the physician-scientist crisis are complex, however, historical records underscore the policy of grant restrictions for research training in the 1960's as a significant trigger: the Nixon Administration deemed research training as "personal equity that ought to be financed by the recipient."[5,8] Furthermore, in 1974, the National Research Act imposed serious restrictions, such as a payback provision for those who did not continue in research after training, which ultimately

*continued on page 13*

 continued from page 12

discouraged the physician-scientist pathway even among talented and motivated students and trainees. In summary, the limited number of MD-PhD graduates, the uncertainty of federal and institutional support, the extended curriculum from sub-specialization, and the burden of medical school loans coupled with the allure of more lucrative practice options have all impeded the growth of research among physicians.[5,9]

How could this concerning trend be reversed? We don't have a definitive answer, but we know for a fact that tomorrow's medical care depends on today's medical research. Accordingly, early recruitment and retention of physician-scientist trainees, formal research pathways during training, and departmental and institutional support for those pursuing research will all be critical pillars in reversing the current trend. The responsibilities and burdens of a combined clinician and scientist career can be overwhelming, often causing promising physician-scientists to abandon academic medicine at a very early stage in their careers and gravitate exclusively towards clinical care.

It is imperative that we support and cultivate the talents of scientific inquiry and pursuit of knowledge among physician-scientists to bring change, innovation, and the hope of translational research.

When should we start? As Peter Safar said, ***"If it's worth doing, it's got to be done right now."***

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9. National Research Service Award Authority. Public Law 93-348.


# 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

# WOMEN'S SECTION

**QUALITY + COMPASSION + BENEVOLENCE**

*Dear SOCCA Colleagues:*

*Dr. Shahla Siddiqui has spearheaded the creation of the Women in Critical Care group within SOCCA. She has put a tremendous amount of work into this project, and I am sharing this letter on her behalf to disseminate information about this group and increase its membership. Please consider sharing this with the faculty members in your department. Thank you.*

Miguel Cobas, MD, FCCM, President, SOCCA, University of Miami, Miami, FL

**Shahla Siddiqui, MD**
Beth Israel Deaconess Medical Center
Boston, MA

Dear All, I hope you are all well. The past two years have been challenging for the critical care community, yet it has brought us to the forefront of providing excellent and evidence-driven care for the sickest of all patients. Teamwork and resilience have been the mainstay of our efforts. However, at the same time, the pandemic and its fallout have shown our community's crevices with high rates of burnout. Women intensivists have been facing the brunt of many of these issues.

We at SOCCA would like to invite you to join our initiative to form a women's group within the ACCM community. (Both SOCCCA members and non-members are welcome, although within one year of joining we will expect non-members to make a membership commitment to SOCCA.)

Similar to groups such as Women in Cardiothoracic Anesthesiology (WICTA) and Women in Anesthesiology (WIA), this group is aimed at delivering academic advancement, networking, and a social community to anesthesia trained women in critical care, as well as others who wish to advance women in academics.

Initially, we aim to meet quarterly, maintain a presence on the SOCCA website and within the Interchange newsletter, formulate a list of potential speakers and panelists, and reach out to editors for special issue authorships.

### SOCCA Women's Section Survey

As a first step, we ask that you express your interest in our group by participating in its development via a brief survey.

### SOCCA Women's Section Zoom Meeting

Please join us **Wednesday, February 23, 2022** at 4:00 PM ET (US and CN)

Please register in advance for this meeting: *(After registering, you will receive a confirmation email containing information about joining the meeting.)*

### SOCCA Women's Section Meet Up

We are holding an in-person Meet Up at SOCCA's 2022 Annual meeting on **Thursday March 17th** from 6 to 7:00 PM HST. Please look for the announcement on the meeting registration form as a SOCCA Women's section meetup and register.

We are looking forward to working with everyone on this important initiative. All of your ideas are welcome!

We will be in touch with you shortly. If you have any questions, please contact us via email at vabalama@iars.org or ssiddiq4@bidmc.harvard.edu.

Thank you,
Shahla Siddiqui, MD, MSc, FCCM

## THURSDAY, MARCH 17, 2022

### SOCCA Women's Section Meetup

6:00 pm – 7:00 pm

### SOCCA Early Career Group Networking Event

6:00 pm – 7:00 pm HST

## FRIDAY, MARCH 18, 2022

### Introductions from the BOD Chair & Education Committee Chair

7:00 am – 7:05 am HST

*Miguel Cobas, MD, Jackson Health System, Miami, FL,*
*Kunal Karamchandani, MD, FCCP, Penn State Health Milton S. Hershey Medical Center, Hershey, PA and*
*Allison Dalton, MD, The University of Chicago Medicine, Chicago, IL*

### Education Session I: What Constitutes a Fair Day's Work? The Future of Critical Care Employment

7:00 am – 8:00 am HST
Moderator: *Michael Nurok, MBChB, PhD, FCCM, Cedars-Sinai Medical Center, Los Angeles, CA*

| | |
|---|---|
| 7:00 am – 7:15 am | Are RVUs Meaningful for Critical Care Anesthesiologists?<br>*Michael Nurok, MBChB, PhD, FCCM*<br>*Cedars-Sinai Medical Center, Los Angeles, CA* |
| 7:15 am – 7:30 am | Should the Nature of Work Be Considered in Effort (For e.g. Should Work in an ECMO Unit Count More Than Work in A Community ICU)?<br>*Mark Nunnally, MD, FCCM*<br>*New York University Langone Medical Center, New York City, NY* |
| 7:30 am – 7:45 am | What is the Future of Reimbursement for Surgical Critical Care Services?<br>*Meghan Lane-Fall, MD, MSHP, FCCM*<br>*University of Pennsylvania, Philadelphia, PA* |
| 7:45 am – 8:00 am | Q&A |

### Oral Scientific Abstract Session

8:00 am – 9:00 am HST

## FRIDAY, MARCH 18, 2022

### Break – Poster session I
9:00 am – 10:00 am HST

### Education Session II: Challenges to Improving Post-ICU Survivorship
10:00 am – 11:00 am HST

Moderator: *Christina Boncyk, MD, Vanderbilt University Medical Center, Nashville, TN*

| | |
|---|---|
| 10:00 am – 10:15 am | COVID 19 Critical Illness and Its Long-Term Effects<br>*Robert White, MD*<br>*Weill Cornell Medicine, New York, NY* |
| 10:15 am – 10:30 am | Post-ICU Cognitive Dysfunction: An Ounce of Prevention Is Worth a Pound of Cure<br>*Michael Devinney, MD, PhD*<br>*Duke University Medical Center, Durham, NC* |
| 10:30 am – 10:45 am | Muscle Health at the Core of Critical Illness Recovery<br>*Kimberly Rengel, MD*<br>*Vanderbilt University Medical Center, Nashville, TN* |
| 10:45 am – 11:00 am | Q&A |

### Break
11:00 am – 11:15 am HST

### Lifetime Achievement Award, Burchardi Award
11:15 am – 12:15 pm HST

| | |
|---|---|
| 11:15 am – 11:20 am | Lifetime Achievement Award Introduction |
| 11:20 am – 11:40 am | Lifetime Achievement Award Presentation |
| 11:40 am – 11:45 am | Q&A |
| 11:45 am – 11:50 am | Burchardi Award Introduction |
| 11:50 am – 12:10 pm | Burchardi Award Presentation |

### SOCCA Business Meeting
12:15 pm – 1:15 pm HST

## FRIDAY, MARCH 18, 2022

### Break
1:15 pm – 1:30 pm HST

### Education Session III: Steroids in ARDS – Where We Are, Where We Were and Where We Will Be
1:30 pm – 2:30 pm HST
Moderator: *Joseph Meltzer, MD, University of California, Los Angeles, Los Angeles, CA*

| | |
|---|---|
| 1:30 pm – 1:35 pm | Intro and Audience Poll<br>*Joseph Meltzer, MD*<br>*University of California, Los Angeles, Los Angeles, CA* |
| 1:35 pm – 1:50 pm | Pro - Steroids in ARDS<br>*Shaz Shaefi, MD, MPH*<br>*Beth Israel Deaconess Medical Center, Boston, MA* |
| 1:50 pm – 2:05 pm | Con – Steroids in ARDS<br>*Vadim Gudzenko, MD*<br>*David Geffen School of Medicine at UCLA, Los Angeles, CA* |
| 2:05 pm – 2:15 pm | Discussion/Q&A |
| 2:15 pm – 2:20 pm | Summation<br>*Shaz Shaefi, MD, MPH*<br>*Beth Israel Deaconess Medical Center, Boston, MA* |
| 2:20 pm – 2:25 pm | Summation<br>*Vadim Gudzenko, MD*<br>*David Geffen School of Medicine at UCLA, Los Angeles, CA* |
| 2:25 pm – 2:30 pm | Audience poll<br>*Joseph Meltzer, MD*<br>*University of California, Los Angeles, Los Angeles, CA* |

### Break
2:30 pm – 2:45 pm HST

### ASA Update
2:45 pm – 3:00 pm HST

## FRIDAY, MARCH 18, 2022

### Break – Poster Session II

3:00 – 4:00 pm HST

### Education Session IV – Snap Talks? Hot Topics in Critical Care

4:00 pm – 5:00 pm HST

Moderator: *Sarah Rae Easter*

| | |
|---|---|
| 4:00 pm -4:10 pm. | The Tube Went In, But Why Did My Patient Collapse?<br>Kunal Karamchandani, MD<br>UT Southwestern Medical Center, Dallas, TX |
| 4:10 pm- 4:20 pm | Identification and Care of Critically Ill and Injured Patients Who May Become Organ Donors<br>George Williams, MD, FASA, FCCM, FCCP<br>McGovern School of Medicine at the University of Texas Health Science Center, Houston, TX |
| 4:20 pm – 4:30 pm | Optimizing Outcomes for Critically-Ill Obstetric Patients<br>Bushra Taha, MD<br>Brigham and Women's Hospital, Boston, MA |
| 4:30 pm – 4:40 pm | Collaborative Management of Cardiac Arrest<br>Aalok Kacha, MD, PhD<br>The University of Chicago Medicine, Chicago, IL |
| 4:40 pm – 4:50 pm | Keep them together! SICU is the ideal place for both PRE and POST-transplant patients<br>Michael Y. Lin, MD<br>University of California Los Angeles, Los Angeles, CA |
| 4:50 pm – 5:00 pm | Moderated Discussion and Q&A |

### Young Investigator Award Presentations

5:00 pm – 5:30 pm HST

| | |
|---|---|
| 5:00 pm – 5:07 pm | Young Investigator Presentation #1 – Winner |
| 5:07 pm – 5:10 pm | Q&A |
| 5:10 pm – 5:17 pm | Young Investigator Presentation #2 - 1st Runner Up |
| 5:17 pm – 5:20 pm | Q&A |

## FRIDAY, MARCH 18, 2022

5:20 pm – 5:27 pm Young Investigator Presentation #3 – 2nd Runner Up

5:27 pm – 5:30 pm Q&A

**Aligned Session with IARS, AUA and SOCCA: A&A Sponsored Journal Symposium**
6:00 pm – 7:00 pm HST

## SATURDAY, MARCH 19, 2022

**IARS, AUA and SOCCA Aligned Meeting Day and Critical Care Update**
7:00 am – 2:00 pm HST

## SOCCA MEET-UP AT ANES 2021

SOCCA hosted a Critical Care Anesthesia Meet-Up at ASA's ANES 2021 in San Diego, California in October.

SOCCA's Board of Directors was on hand to meet SOCCA members and nonmembers alike.

the ANESTHESIOLOGY annual meeting
American Society of Anesthesiologists®

# Discounted Membership Available with IARS

As a Society of Critical Care Anesthesiologists member, you are eligible to receive a discount on an IARS membership.

IARS membership benefits include a subscription to Anesthesia & Analgesia, SOCCA's official journal, A&A Practice e-journal, free journal CME, access to a member community and discounted registration to the IARS Annual Meeting. Click here to view a list of membership options. Enter the discount code during checkout to receive preferred affiliate society dues pricing at the membership level of your choice.

**IARS Full Membership = $195/year**
Includes full IARS member benefits including print and online journal access

**IARS Limited Plus Membership = $135/year**
Includes print and online journal access only

**IARS Limited Membership = $75/year**
Includes online journal access only

SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS
SOCCA

# SURVEY

SOCCA Colleagues:

We are conducting a survey of practicing anesthesiology critical care physicians. This survey was created to gain insight into our specialty's practice logistics, level of personal fulfilment, and job satisfaction within critical care during the pandemic related to a better perception of respect and dignity.

Please look for the survey link in your email.

Please note that the survey is anonymous and should take you no more than five minutes to complete. The survey will remain open until January 15, 2022.

We greatly appreciate your time and consideration in completing this survey.

Thank you,

Shahla Siddiqui, MD Erika Monteith, BS Avery Tung, MD Shahzad Shaefi, MD Robert Sladen, MD

## JOB BOARD

Read members-only job posts—including roles with:

- Oregon Health & Science University, Department of Anesthesiology and Perioperative Medicine
- The University of Vermont / University of Vermont Medical Center, in affiliation with the University of Vermont Medical Group
- Ochsner Health System
- Keck School of Medicine of USC
- University of Washington

—at 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.

# SOCCA AWARDS

## THE BURCHARDI AWARD

Nominations for the Burchardi Award will be accepted through December 31, 2021.

### About the Burchardi Award

The Burchardi Award is jointly sponsored by the Society of Critical Care Anesthesiologists (SOCCA) and the Society of Critical Care Medicine's (SCCM) Anesthesiology Section. It was named after its first recipient Dr. Hilmar Burchardi, a pioneer in the field, a revered teacher and founding member of the European Society of Intensive Care Medicine, which he presided over from 1998 to 2000. The award was first established in 2002 at the SCCM Critical Care Annual Congress and will be presented every two years, alternately during the SOCCA or SCCM event.

### Criteria for Nomination

- Nominees must be an anesthesia-based intensivist, who has been practicing for at least 12 years and who has held a leadership position in at least one of the established national or international critical care societies/organizations.
- He/she should have made considerable contributions to the specialty, not necessarily in terms of research, but especially in terms of ability to motivate and touch people.
- His/her greatness and leadership should be defined equally by competence, humility, humanity, and a sense of humor; in short, this is a "Good Guy/Good Gal" award.
- Nominees should be members of at least one, preferably both sponsoring organizations and should have at least two letters of support from members of the societies.

### Process

To nominate a SOCCA Member, please email a letter of recommendation to SOCCA Staff, Vivian Abalama, IOM, CAE at vabalama@iars.org by December 31, 2021.

Learn more and view past recipients.

## LIFETIME ACHIEVEMENT AWARD

Nominations for the Lifetime Achievement Award will be accepted through December 31, 2021.

### About the Lifetime Achievement Award

The Society of Critical Care Anesthesiologists (SOCCA) Lifetime Achievement Award is the highest and most prestigious award given to a member of the organization recognized by the broader critical care community as a significant leader in the critical care anesthesiology profession.

Selection for this honor recognizes an individual's outstanding and sustained contributions to the critical care profession and SOCCA, as well as exemplary professional practice and leadership.

The nominee must have served SOCCA and the profession of critical care anesthesiology in a significant leadership capacity, demonstrating the qualities of leadership and service to the critical care anesthesiology profession by his/her professional and personal example.

### Eligibility Criteria

- Must be a member of SOCCA or a retired member of SOCCA
- Current members of the SOCCA Board of Directors are not eligible

### Process

To nominate a SOCCA Member, please email a letter of recommendation to SOCCA Staff, Vivian Abalama, IOM, CAE at vabalama@iars.org by December 31, 2021.

Learn more and view past recipients.

# SOCCA onDemand

## Recorded Webinars Now Available OnDemand

**Have you missed any SOCCA eLearning Webinars? SOCCA members can now view recorded Webinars, onDemand! Visit SOCCA eLEarning for the full library of Webinars!**

## SEDATION IN THE ICU AND COGNITIVE FUNCTION

### MODERATOR

**JEANINE WIENER-KRONISH, MD**
Massachusetts General Hospital

### PANELISTS

**DUSAN HANIDZIAR, MD, PHD**, Massachusetts General Hospital
*Burst Suppression in the ICU*

**BRANDON WESTOVER, MD, PHD**, Massachusetts General Hospital
*Sleep and Delirium in the ICU*

**RAQUEL BARTZ, MD, MMCI**
Brigham & Women's Hospital
*Long Term Cognitive Abnormalities after ARDS*

## ECMO WEANING: STRATEGIES FOR SUCCESS

### MODERATOR

**JOSEPH MELTZER, MD**
UCLA Medical Center

### PANELISTS

**MICHAEL L. HALL, MD**
University of Washington
*Weaning of VA-ECMO in the Patient with Cardiopulmonary Failure*

**NATALIA IVASCU, MD**
Weill Cornell Medicine
*Weaning of ECMO in the Era of COVID-19*

**BREANDAN SULLIVAN, MD**
University of Colorado Hospital
*Weaning of VV-ECMO in the ARDS Patient*

## POINT-OF-CARE ULTRASOUND OSCEs: An Approach to Skills Assessment & Retention

### MODERATOR

**NIBRAS BUGHRARA, MD, FCCM, FASA**
Albany Medical College

### PANELISTS

**SARA NIKRAVAN, MD**
University of Washington
*Point of Care Ultrasound: The Journey*

**JENNIFER ELIA, MD**
University of California Irvine
*Education in Anesthesia & Point-of-Care Ultrasound*

**JAY SHEN, MD**
University of California Irvine
*Point-of-Care Ultrasound OSCEs: An Approach to Skills Assessment & Retention*

# SOCCA Board of Directors

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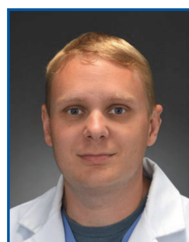

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If you would like to contribute a review for a Fellowship Program at your institution in a future issue of the SOCCA Interchange, please contact: Vivian Abalama, IOM, CAE at vabalama@iars.org.

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