

Oration, College of Intensive Care Medicine Ceremony, Sydney 5 June 2010

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Salutation

President, Vice President, Board members, distinguished guests, Fellows, ladies & gentlemen. Thank you for this honour. It's a great pleasure to be here tonight

My topic tonight is *"It's Intensive Care, Stupid!"* Bill Clinton's team used the catch cry "It's the economy, stupid" during his successful 1992 presidential campaign against George Bush Snr, who was considered unbeatable. The catch cry spotlights the notion that Clinton was a better choice because he was focussing on the economy which had gone into recession and Bush was not. This is a formulaic focus on a central issue or goal, using the proven advertising formula KISS (Keep It Simple Stupid). This new College has taken over the baton in the campaign to project the value of Intensive Care to doctors, hospital administrators, policy makers, patients and relatives. "It's Intensive Care, Stupid" is an appropriate reminder of the campaign. Tonight, I'm going to reflect on that campaign.

Who are we?

How did we get here?

Where are we going?

What is Intensive Care?

It is the care of seriously ill patients by specially trained doctors and nurses in a hospital ward, the ICU, equipped with monitoring and life support equipment.

How did it come to being?

The most common view is that Intensive Care began in Scandinavia during the 1950's polio epidemic. Victims were concentrated in one ward and ventilated by 'iron lung' ventilators, which saved many lives. This special care of unstable patients in one area gave rise to Postoperative Recovery Rooms and ICUs. However, we can pre-date special care to WW2, even Florence Nightingale. Indeed, the actuality of Intensive Care had been prophesied 2,000 years ago, around 50 AD in the New Testament. *Revelation*, Chapter 6, verses 1-8, describes the *Four Horsemen of the Apocalypse* and presaged the trials & tribulations of an Intensivist.

*"...and there before me was a **white** horse! Its rider held a bow, and he was given a crown, and he rode out as a conqueror bent on conquest."* The white horse warned of pestilence that can be inflicted by the empire builder, called Professor of Medicine.

*"...Then another horse came out, a fiery **red** one. Its rider was given power to take peace from the earth and to make men slay each other"*. The red horse spoke of war inflicted by Men with Knives.

*"...and there before me was a **black** horse! Its rider was holding a pair of scales in his hand."* The black horse warned of widespread famine inflicted by hospital budget cuts.

*"...and there before me was a **pale** horse! Its rider was named Death, and Hades was following close behind him."* The pale horse of death reminded Intensivists of death and dying - those of whom we cannot save.

Development of Intensive Care in Australia & NZ

Much of this relates largely to a few committed individuals, who from the late 1960s, began running ICUs as solo practitioners and then attracted others to join them.

They were pioneers, truly a Band of Brothers but were more aptly a Band of Few. They were on-call 24/7. They started teaching. They invented gadgets. They used new techniques, self-taught of course. They made crude ventilator circuits. They argued with each other and with everyone else. They were dogmatic, opinionated, pig headed, and obtuse, but they were also strong-willed, and they defended their turf, and they fought for recognition. They mentored their disciples and the Band of Few became a Tribe of Intensivists which, like Avatar, grew from strength to strength.

The Band of Few and the Tribe climbed mountains. They gained the trust and respect of traditional specialists. They implemented a closed ICU model. They engaged in quality research, and they established a training program. Milestones included the first Intensive Care exam in the world conducted by the Faculty of Anaesthetists in 1979, recognition by NSQAC (now defunct) as a subspecialty of medicine and anaesthesia in 1980, a Joint Faculty single training pathway in 2002 and recognition by AMC as a specialty in its own right. While there were turf wars claiming parent-hood of Intensive Care, which qualification was never an issue with Tribal members.

How did the Band of Few and subsequent Tribal leaders succeed? What did they do right? In my view, they exercised Leadership. The US Army promotes 11 Principles of Leadership. I know, I know, an army with a supreme commander George W Bush is not the best leadership example, but these principles are widely adopted, and they are reflected by Tribal leaders and in the ICU today, and they show why we developed Intensive Care so successfully in Australia and NZ. Some principles are:

1. **Know yourself and seek self-improvement** – the great meetings of ANZICS, Jean-Louis Vincent's in Brussels, and the US SCCM attest to this. We have always been at the cutting edge.
2. **Be technically proficient** – In Intensive Care, this is a no brainer.
3. **Seek and take responsibility** - We have got on to hospital, State, National, and International committees & meetings. We searched for ways to guide Intensive Care forward. We did not wait for Godot or God. We seized the day.
4. **Make sound and timely decisions** – Quick problem-solving and decision-making are the hallmarks of the Intensivist at the bedside.
5. **Set the example** – Are we good role models? The answer is the increasing numbers of the Tribe, those willing to commit to a career in Intensive Care, as seen by the large number of New Fellows graduating tonight.
6. **Know your people and look out for their well-being** – Intensive Care demands teamwork and collegiality of spirit. Only fools ignore their team.
7. **Ensure that tasks are understood, supervised, and accomplished**
8. **Train as a team**
Handovers, De-briefings, communications, supervision of trainees, and teaching are bread and butter ICU operations.

Also, I believe in promoting team elitism. The Roman philosopher Lucius Annaeus Seneca (Seneca the Younger) said *“No one is better born than another.... unless they are born with better abilities.”* Indeed. If you want your team to be the best, make them believe that they are the best. Elitism promotes this focus.

I pay tribute to the Band of Few and their protégés and successors, many of whom are now “big names” here tonight, and to their teams. Isaac Newton said *“If I have seen farther than others, it is because I was standing on the shoulder of giants.”*

I pay tribute to our medical professional bodies, ANZICS, ANZCA (with the past Faculty of Anaesthetists), RACP and RACS for their support for Intensive Care. Leona Wilson and her ANZCA Council gave gracious support to let go their Faculty offspring.

ANZICS was the initial principal advocate for Intensive Care, and was started largely by the efforts of the late Matt Spence, Bob Wright, and Geoff Clarke in 1975.

The first ANZICS combined scientific meeting was held in Adelaide on 14 May 1976 with Critical Care Nurses and the newly formed Section of Intensive Care of the Faculty of Anaesthetists. It was the forerunner of the famous ANZICS annual combined scientific meetings, where convenors tried their utmost to outdo each other and Malcolm Fisher and Bob Wright entertained everyone. I remember that first meeting well. I had got married in Canberra only a few days before, and I took my bride Lala to Adelaide on a tax-deductible honeymoon. Fortunately my marriage survived and flourished with ANZICS.

What of the Present?

Today, we have a specialty and we have a College. I pay tribute to the present Intensive Care leaders: Presidents Geoff Clarke & Alan Duncan of the Faculty, Felicity Hawker, Neil Matthews, Jack Havill, Richard Lee & Vernon Van Heerden of the Joint Faculty, and John Myburgh our new President. I pay tribute to their respective Board Members. They all achieved a lot, ending in the founding of a new College. Vernon Van Heerden displayed great skills to sign off on the new College and became its Inaugural President.

What of the Future?

In my view this can be summed up in two words – “all good”. But there will be challenges.

There will be Challenges posed by Health Systems –

All medical Colleges are part of eight health systems of NZ & Australian Federal & State Governments. It can be frustrating at times having to deal with eight species of officialdom, rather like negotiating with Snow White and the seven dwarfs. If we include the Australian Territories, there are now 10 systems. Despite the current Rudd- Roxon plan, they are not going to go away. The challenge then is how to negotiate with all of them for improvements in our health systems and in Intensive Care in particular.

Carol VanDuesen Lukas, a US health academic researched 12 US Healthcare Systems and identified 5 elements for Transformational Change in healthcare (in English, it’s “improvement” in healthcare).

- *Strong impetus for change,*
- *Leadership commitment to quality*
- *Seamless integration of all components of the system*
- *Engagement of all parties*
- *Consistency of actions with goals*

This College has much talent in these elements and must step forward to use them.

There will be Challenges of the Specialty

1. Resources Challenge

A big challenge to the Specialty of Intensive Care will be that of resources – the Black Horse of Apocalypse. ICUs consume a high proportion of health care resources, concentrated to so few, and with the highest individual share going to those least likely to survive. We are taught the 6 principles of medical ethics;

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| 1. <i>Autonomy</i> | 4. <i>Fidelity</i> |
| 2. <i>Beneficence</i> | 5. <i>Justice</i> |
| 3. <i>Nonmaleficence</i> | 6. <i>Utility</i> |

- *Justice* is the principle of fairness, equity, and the entitlement and right of every patient to be treated properly.
- *Utility* is the principle of doing most good for most patients – getting the “best outcome & best value” from the use of available resources.

Justice and Utility seemingly contradict each other – Entitlement for the Individual vs Best Value for All. We have always faced this dilemma, but the challenge will become more acute and more difficult.

2. Manpower Challenge

Predicting needs of two countries is a huge challenge. How do we address the distribution of Intensivists in cities & non metro regions? Bedevilling factors are baby boomers retiring, immigration, lifestyles, and increasingly traditional roles taken by non-doctors.

3. Training Challenges

Intensive Care bases patient selection on acuity, which defies traditional specialties' concepts of patient ownership. Intensive Care crosses specialty boundaries, and Intensivists must have good knowledge of some parts of these specialties. Also, there is much co-ordinating, quick decision-making and application of procedural skills. What then are the best training programs? And what qualities apart from leadership, do we want to foster in a budding Intensivist?

The AMC adopted the Canadian CanMED Attributes of a Specialist:

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| • Medical Expert | • Scholar |
| • Communicator | • Professional |
| • Collaborator | • Manager |
| • Health Advocate | |

These attributes are also identified in multiple studies in multiple countries that showed better outcomes if ICU patients were cared by Intensivists than by other primary specialty doctors. A recent pan European study of the views of patients and relatives on what makes a good intensivist also identified these attributes but emphasized communications skills. These qualities have been incorporated into the international competency-based ICM training program, CoBaTrICE.

Clearly, knowledge, technical skills, and communication are standout qualities to teach, but I would like to see imbued *commitment* and *compassion*. Commitment is the fuel to complete the journey. Compassion is the basis of morality and the basis of medicine. This is all food for thought for our leaders tonight.

4. Challenge of Change

The most important challenge is change, or how to manage change.

Some great unknown said *“Change is inevitable - except in vending machines”*

As doctors and educators, we have seen a lot of change in the past 20 years. The paradigm of education has changed. The traditional concept that academic achievement guarantees work, in other words, “Want a good job? Get a Uni degree, any degree” has now been replaced by more vocational qualifications and competence-based learning, with focus on understanding concepts such as Problem Based Learning. Our training program must also continue to adapt accordingly.

We must keep up with changes in Medical Advances, Technology and New Drugs. They are the tools of our profession, our *raison d’être*.

Community Expectations have changed. Doctors are no longer automatic heroes. We are now bound to a Duty of Care. Our patients will expect Safety & Quality in that Standard of Care. Affordability and Accountability are now benchmarked. There will be more robust Patient Charters and Consumer Councils.

There will be ongoing change in Medical Liability issues. Informed consent and determinations of liability will be more rigorous. The **Bolam Principle** that may spare a negligence claim, if treatment is in accordance with an opinion of peers, is no longer on solid ground and will become shakier.

Just like the ACCC’s trade practices act, there will be more changes in Legislation & Governance on healthcare. National registration is now being implemented in Australia as I speak. Continuing Professional Development is now mandatory and will be an inextricably linked to re-registration.

How should our leaders manage change?

The late American writer Lewis Grizzard said: *“Life is like a dogsled race – if you ain’t the lead dog, the scenery never changes.”*

Do not fear change. Do not ignore change. Do not fight change. Embrace change. But participate as leaders & professionals. Do not follow blindly or your scenery will not change. And always keep sight of your core principles. Mahatma Gandhi *“We must become the change we want to see”*

New Generation

What about our future Intensivists? Nancy Borkowski, the author of the book *Organizational Behaviour, Theory, & Design in Health Care* researched Gen Y doctors (those born from mid 1970s to early 2000s). She found that her subjects showed these attributes:

- *High Expectations of self* - they work hard and have high standards
- *High Expectations of Employers* – they expect the oldies to perform too
- *Ongoing learning* – CPD is ingrained
- *Immediate responsibility* – they face challenges
- *Goal-orientated* – they are achievers.

Thus we can be assured that the future of Intensive Care is in safe hands. To our New Fellows, I am in awe of your potential and I wish you every success.

But I also leave you with some wise words. Man does not live on career alone. Willy Loman, in Arthur Miller's "Death of a Salesman" said "*After all the highways, and the trains, and the appointments, and the years, you end up worth more dead than alive*". Live a balanced life. And give something back to the system that rewards you, such as by teaching and doing work for the College.

Before I close, I want to thank my family; my children and Lala, my lovely wife who is my greatest supporter. I could not have made my career & life journey without her. She has patiently tolerated my absences and bad attributes although she has never forgiven me for taking her on a tax-deductible honeymoon.

In closing, I thank the President, the Board, the College and you all for tonight. There is no longer, any need, for any of you, to shout, "It's Intensive Care, Stupid!"