President’s Column

Aryeh Shander, MD, FCCM, FCCP

The Society of Critical Care Anesthesiologists (SOCCA) continues to be a leader and the largest subspecialty society dedicated to critical care anesthesiologists on all fronts — education, clinical practice, and research. As the new President of SOCCA, I will continue to champion initiatives at SOCCA that will expand the engagement and learning opportunities available to our members and critical care anesthesiologists. Over the past year, SOCCA has offered a range of programs and resources from the first aligned SOCCA Annual Meeting with the International Anesthesia Research Society (IARS) to the SOCCA ICU Residents’ Guide.

The SOCCA Annual Meeting occurred in Montreal, Canada — the first international meeting for SOCCA. This aligns with SOCCA’s mission of engaging critical care anesthesiologists from all over the world, and of note the immediate past Annual Meeting included critical care anesthesiologists from Canada as well as others speaking to a global audience. The SOCCA Annual Meeting took place a day before the International Anesthesia Research Society (IARS) Annual Meeting. As part of IARS providing the management infrastructure for SOCCA, both organizations have formed an alliance for future initiatives.

The SOCCA Annual Meeting program opened with an address by the IARS President of the Board of Trustees welcoming SOCCA to IARS, and in particular to this meeting venue. The SOCCA Annual Meeting included sessions focused on right ventricular function, including pulmonary hypertension, mechanical assist devices, celebrating science with updates on important publications, biomedical and health informatics in the intensive care unit, and finished with an interactive case management panel. The American Society of Anesthesiologists (ASA) President-Elect provided an update on ASA activities.

SOCCA members contributed their expertise with a critical care-themed first day of the IARS Annual Meeting. Presentations including educational content by SOCCA members that provided two workshops, one on critical care ultrasound and the other a perioperative ACLS simulation workshop. In addition, SOCCA sponsored a panel dealing with issues of management and ethics issues with a critically ill patient with advanced directives from the ICU to the OR. There was also a well

attended discussion about critical illness intraoperative decisions with a problem-based learning session.

The SOCCA ICU Residents’ Guide which contains 45 chapters, co-edited by Drs. Elizabeth Mahanna, David Shimabukuro, Christine Doyle and Linda Liu, was introduced at the Annual Meeting, which serves as a great resource for trainees rotating through critical care. The guide was made available as a member-only benefit in iBooks and PDF formats. Also available for resident and fellow members is additional imaging capability. The PDF version of the guide is available for purchase to non-members. Visit https://socca.megahosters.com/residents-guide.php for more information. SOCCA continues to offer reduced membership fees for resident and fellow trainees, and also offers membership to interested medical students.

The SOCCA Annual Meeting continues to offer its annual mentorship program for residents. SOCCA’s mentorship program pairs the residents with host faculty mentor mentors from other institutions. This accomplishes two objectives. First, the anesthesiology residents who attend the SOCCA Annual Meeting have separate educational content tailored to their educational level and development needs and second, assigns a mentor who can provide another institution’s perspective on critical care.

This year SOCCA sponsored the first match for critical care using San Francisco Match for fellowship. An anesthesia resident entering the match must have a minimum of 4 months of critical care training during the 48-month continuum of training. This anesthesiology critical care fellowship program entails a minimum of 12 months of training; nine months of training must include responsibility for the care for critically ill patients in the ICU. SOCCA’s committee structure supports fellowship training and provides a forum annually for a fellowship directors’ breakfast that takes place the morning after the SOCCA Annual Meeting.

SOCCA continues its momentum from the previous year’s offerings this year by aligning with the IARS again for its Annual Meeting, providing double the educational opportunities to critical care anesthesiologists. The SOCCA 28th Annual Meeting and Critical Care Update, taking place Friday, March 20, 2015 in Honolulu, Hawaii, promises an invigorating educational program. Over the next two years we will work together to provide critical care anesthesiologists with the latest advances in the subspecialty and anesthesiology and the resources they need to excel and succeed.
## CONTENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>President’s Column</td>
<td>1</td>
</tr>
<tr>
<td>The Right Time: Early or Late Initiation of Renal Replacement Therapy in Acute Kidney Injury (AKI)</td>
<td>3</td>
</tr>
<tr>
<td>Protocols Don’t Help Patients – Doctors Do!</td>
<td>5</td>
</tr>
<tr>
<td>Protocols Save Lives!</td>
<td>7</td>
</tr>
<tr>
<td>Prone Positioning in Severe Acute Respiratory Distress Syndrome</td>
<td>9</td>
</tr>
<tr>
<td>SOCCA Board of Directors 2014-2015</td>
<td>12</td>
</tr>
</tbody>
</table>

## MEMBERSHIP INFORMATION

### E-mail

E-mail inquiries to SOCCA at: SOCCA@iars.org

Meeting Information: SOCCameetings@iars.org

Membership Information: SOCCAmembership@iars.org

### Web Page

Visit the SOCCA website at: www.SOCCA.org

### SOCCA Dues

**Dues:**
- $160 for active members
- $110 for affiliate members
- $25 for educational members

Medical Student Membership, individuals in full-time training in an accredited school of medicine, is free.

Dues may be paid online at: www.SOCCA.org/membership.php

### Membership

Membership in SOCCA is open to all anesthesiologists and residents in approved anesthesiology programs.

Visit www.socca.org/membership.php for complete information on SOCCA membership.

## EDITORIAL NOTES

### Editorial Policy

The opinions presented are those of the authors only, not of SOCCA. Drug dosages, accuracy and completeness of content are not guaranteed by SOCCA.

### Editor

Jordan E. Brand, MD  
San Francisco VA Medical Center  
University of California  
San Francisco, California  
Jbrandmd@gmail.com

### Editorial Board

Francis X. Dillon, MD  
Eliot Fagley, MD  
Caron Hong, MD  
William T. O’Byrne III, MD  
Keven W. Hatton, MD  
James A. Osorio, MD  
Sadeq Quraishi, MD  
Michael Woo, MD

### A Note from the Editor to SOCCA Members:

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: jmccgrath@iars.org

---

**Call for Abstracts**

Deadline: October 24

28th Annual Meeting and Critical Care Update  
March 20, 2015 | Honolulu, Hawaii
Acute Kidney Injury (AKI) continues to be a significant complication among critically ill patients, with a prevalence nearing 40%, and with more than 5% of these patients having severe AKI requiring renal replacement therapy (RRT). 1-3 Although there are evidence-based recommendations for continuous renal replacement therapy (CRRT) dosing at an effluent volume of 20-25 ml/kg/h, 4 there is uncertainty regarding the timing of initiation of RRT and what parameters define “early” versus “late” initiation in the critically ill. Recently, several researchers have investigated early versus late initiation of RRT with conflicting results. There was significant variability among definitions of early and late initiation and a variety of inciting factors that would trigger initiation. This has resulted in controversy over whether timing is associated with morbidity and mortality.

In 2012, Wang et al. 5 performed a meta-analysis of 15 studies, including 3 RCTs and 12 non-RCTs, totaling 2955 patients. They demonstrated that early RRT could benefit patients with AKI but found heterogeneity among the studies secondary to RRT modality; this was clarified through subgrouping by CRRT and intermittent hemodialysis (IHD). 5 Both CRRT and IHD demonstrated mortality benefits when initiated early compared to late in AKI with RR of 0.69 (CI: 0.56-0.84) and RR of 0.26 (CI: 0.15-0.45), respectively. 5 Wang and colleagues relied upon the primary authors’ definitions of “early” and “late” based on serum biomarkers (including creatinine, urea, or potassium), RIFLE (Risk, Injury, Failure, Loss, End Stage) criteria, or urine output. Therefore, although this meta-analysis demonstrated overall benefit with early initiation of RRT, its applicability to specific cohorts is unclear and it has limited utility in determining an appropriate trigger for initiation.

Clark et al. 6 published a multicenter observational study in 2012 examining the timing of RRT initiation among Canadian intensivists from 11 different ICUs totaling 119 patients. RRT was initiated within a median of 2 days from hospital admission with an observed mortality of 42%. 6 Mortality compared favorably to Bagshaw et al’s 2009 study, 7 which demonstrated mortality of 52% when RRT was initiated at a median of 5 days after admission. Further comparison demonstrated that the patients in Clark et al. had higher SOFA scores (mean of 13.4) when compared to Bagshaw et al. (mean of 10.9). This analysis again suggested a mortality benefit with early RRT initiation.

In 2012, Wu et al. 3 used the RIFLE criteria to categorize early versus late initiation of RRT with Risk being early, and Injury/Failure being late for 73 postsurgical patients. Twenty patients qualified for early initiation and demonstrated a significantly lower mortality at both 30 and 90 days when compared to the late group (40% and 50% versus 77.4% and 84.9% respectively). The authors concluded that, when using the RIFLE criteria, late initiation of RRT is associated with a lower survival rate.

Oh et al. 8 used urine output at 6 hours prior to CRRT as a determinant of early versus late initiation of CRRT for their 2013 study. They demonstrated that patient survival in the nonoliguric group was higher when compared to the oliguric group. 8 They found no clinical differences when CRRT initiation was timed according to serum BUN (low BUN < 45.7 mg/dL, high BUN > 45.7 mg/dL) which was consistent with Bagshaw et al’s previous research. However, Liu et al demonstrated that late CRRT initiation using a BUN of 76 is associated with higher mortality. 9 This controversial data may be indicative of the need for better indications for timing of CRRT instead of relying on serum biomarkers alone.

The largest, and most recent, RCT by Jamale et al. 10 in 2013 demonstrated that early initiation of RRT before the onset of significant symptoms (including hypervolemia, hyperkalemia, and uremia) does not improve mortality in community acquired AKI. Similar to several earlier studies, the instigating factor to initiate early RRT was serum creatinine or serum urea levels (early levels: 7.4 and 71.7 mg/dL, and late levels: 10.4 and 100.9 mg/dL, respectively). Furthermore, the early RRT group’s return of renal function was delayed when compared to...
The Right Time: Early or Late Initiation of Renal Replacement Therapy in Acute Kidney Injury (AKI)

Continued from page 3

The authors concluded that the only indications for RRT in AKI were 1) hypervolemia unresponsive to diuretics, 2) hyperkalemia, and 3) refractory metabolic acidosis. This was consistent with Pannu et al.'s 2008 meta-analysis. However, Jamale et al. focused on community acquired AKI, and noted limitations extrapolating their findings to an ICU population.

Osterman et al. demonstrated the variability in defining early versus late RRT and specific indications for initiation among current studies, identifying the use of serum creatinine, serum urea, and urine output as the most common indicators for early versus late timing. They found little consistency among the original authors of the studies examined, and postulate that no single biochemical marker was adequate to define the optimal indication and time for RRT. They proposed the use of frequent clinical assessment including overall severity of illness, signs of volume overload, and clinical condition to decide the initiation of RRT and to individualize care and appropriate management. The authors also noted that the benefits of early RRT may include maintenance of metabolic and volume homeostasis, and prevention of further deterioration.

The inconsistent definitions of "early" and "late" timing in the literature, and the varying indications for RRT in ICU patients underline the need for more research. The available data does suggest that initiation based on serum biomarkers alone may not be efficacious. Individualized care, as proposed by many experts in this field, may be the factor that should trigger use of CRRT and may improve outcome. Early initiation of RRT may still benefit the appropriate patient population; however, the decision to initiate RRT should also incorporate clinical symptoms and be tailored to each patient.

References:
The practice of critical care medicine and training of residents and fellows appears to be increasingly based on the application of published guidelines to patient populations and patient conditions by physicians and non-physicians alike. The application of these guidelines to individual practice frequently results in the creation of protocols and checklists (a series of small stepwise tasks), whether published in manuscript form, or applied to an individual ICU or hospital system. Administrators at many different levels then monitor the use of these protocols and determine the effectiveness of clinical providers, clinical systems, and even clinical specialties on how well these guidelines are followed on a day-to-day basis.

While the use of these specifically created protocols and checklists may benefit a population of patients (and there are a plethora of published studies that show benefit), the application of these same protocols and checklists to any given patient may ultimately fail to administer best care for that patient. By design, published guidelines and protocols are based on the application of the best trials, taken together to form a single, cohesive plan out of a group of patients with a seemingly similar background, history, and/or pathological condition. These populations are frequently more homogeneous in research than they are in the real world, using additional resources (namely trained professionals) to monitor research and provide additional medical, surgical or nursing care that is, quite frankly, not available in any real world setting. While reducing confounding bias in research trials is a critical component of a well-designed trial, the overall application of these homogeneous study findings to a more heterogeneous population or to the individual patient is difficult—yet, we are frequently asked or mandated to apply these same protocols and checklists to all patients that loosely match the inclusion criteria for good or bad patient care outcomes.

The most recent, large publication regarding patient care in sepsis, the ProCESS trial, seems to support this notion. While reducing confounding bias in research trials is a critical component of a well-designed trial, the overall application of these homogeneous study findings to a more heterogeneous population or to the individual patient is difficult—yet, we are frequently asked or mandated to apply these same protocols and checklists to all patients that loosely match the inclusion criteria for good or bad patient care outcomes.

The real message of this and other similar studies appears to be that good ideals and good care for patient populations, based on the best available literature, should be reconsidered and applied only at the individual patient level. It takes an experienced and well-trained clinician to apply the principles developed in clinical trials and formulated in guidelines to the individual patient and the individual medical problems and considerations within each hospital or ICU setting. The expectation that any large, or highly structured patient care protocol will fit all patients (or even any patient) should be reconsidered and a greater, more intense consideration for the application of larger concepts applied specifically to the individual patient should be emphasized whenever possible.

References:
Call for Abstracts!

Submission Deadline: Friday, October 24

SOCCA
28th Annual Meeting and Critical Care Update

Friday, March 20, 2015

Hilton Hawaiian Village Resort
Honolulu, Hawaii

Register Early and Save!

Hold your spot today for the SOCCA 28th Annual Meeting and Critical Care Update

For program updates, visit www.socca.org
Large physician practice variability exists in modern medicine and can affect the quality of healthcare delivered worldwide. Studies show that only 55% of patients receive recommended preventive care and care for chronic medical conditions, including CHF, asthma, and hypertension. A review of the complexities of medical decision-making notes, “many non-rational cognitive factors influence medical decisions and may lead to error,” including overconfidence (the majority of physicians believe they are better than average), emotional influences, and preferences for certainty. The ICU is not immune to practice variability and quality. Approximately 45% of critical care-related medical errors are preventable. Our patients deserve high quality medical care based on rigorous scientific method. We need tools to help us deliver high quality care.

Checklists and protocols are cognitive aids that assist task completion by providing the framework needed to complete the desired task. They are tools intended to assist healthcare providers to improve the quality of care and reduce practice variability. Checklists and protocols, when coupled with proven therapies, timeliness of care, and the right patient population, have been shown to decrease the rate of catheter-related bloodstream infections, and ventilator-associated pneumonia, and improve surgical outcomes. However, it is not clear that implementation of checklists/protocols universally results in improved patient outcomes. The recently published ProCESS trial and the Ontario, Canada Surgical Safety Checklist study did not show improvement in outcomes from protocolization.

The question is, why do some checklists/protocols improve care where others do not? The fundamental goal of these tools is to improve communication, change culture, and promote accountability. The culture of care regarding sepsis resuscitation has fundamentally shifted a decade after the Rivers trial to earlier, more appropriate care. The ProCESS trial was negative because the paradigm of care has already shifted. The Canadian Surgical Safety Checklist study demonstrated that checklists can only be effective when used and used appropriately.

We should provide safer, higher quality care to our patients if checklists/protocols are used as tools to improve healthcare provider communication, change our culture to a patient safety-oriented approach, and promote accountability. Protocols and checklists have clearly changed the culture of medicine so that multidisciplinary providers can work in teams and produce positive outcomes for patients. The time is now to continue to use these vehicles to strengthen the culture of patient safety in critical care medicine.

Protocols Save Lives!

Jeffrey Katz, MD
Clinical Assistant Professor,
Department of Anesthesia and Critical Care
University of Chicago
Pritzker School of Medicine
Evanston, Illinois

“Protocols and checklists have clearly changed the culture of medicine so that multidisciplinary providers can work in teams and produce positive outcomes for patients.”

References:
Stop by and visit SOCCA at the ASA Meeting in New Orleans!

Take some time out of your ASA schedule – and attend a special reception for SOCCA members on October 10. Visit the SOCCA exhibit booth, October 11-13.

**SOCCA Member Reception**

**Friday, October 10 • 5:30 – 6:30 pm**

Network and unwind with your SOCCA colleagues at the Member Reception at the Embassy Suites Convention Center. Get a preview of some of the Hawaiian flavor you can expect at the SOCCA 28th Annual Meeting in Honolulu, Hawaii!

**Member Reception Location**

Embassy Suites Convention Center
315 Julia Street
New Orleans, Louisiana

This reception will take place in the Fontainebleau Room on the 6th floor of the hotel.

**SOCCA Exhibit Booth**

**Saturday, October 11 – Monday, October 13**

Be sure to stop by the SOCCA Exhibit Booth and drop off your business card for a chance to win one of three complimentary registrations to the SOCCA 28th Annual Meeting and Critical Care Update, Friday, March 20, 2015 in Honolulu, Hawaii.

**Exhibit Booth Location and Hours**

Ernest N. Morial Convention Center
Subspecialty Society Pavilion
Hall B-2, Booth #111

- **Saturday, October 11, 2014**
  - 11:00 am – 6:30 pm
- **Exhibit Reception**
  - 5:00 pm – 6:30 pm
- **Sunday, October 12, 2014**
  - 9:00 am – 4:00 pm
- **Monday, October 13, 2014**
  - 9:00 am – 3:00 pm
Acute respiratory distress syndrome (ARDS) is a severe widespread inflammation affecting bilateral lung parenchyma leading to impairment in gas exchange. This distinct form of acute respiratory failure was first recognized in the 1960s. Military physicians called it “shock lung,” while civilian physicians used the term “adult respiratory distress syndrome” (ARDS). The first description of this syndrome by Ashbaugh included a observation of bilateral lung infiltrates on chest radiography, decreased lung compliance (“stiff lungs”), and a measured low pulmonary capillary wedge pressure (PCWP). ARDS is estimated to have an incidence of 190,600 cases annually with a mortality that is significantly higher in elderly patients; >60% in those older than 85.

Since the original description of ARDS, the American-European consensus taskforce (AECC) refined the definition of ARDS over the last four decades. Most recently, the Berlin Classification of 2012 stratifies ARDS based on PaO2:FIO2 ratio with mild (PaO2:FIO2 201-300 mmHg), moderate (PaO2:FIO2 101-200 mmHg) and severe (PaO2:FIO2 <100 mmHg), in addition to bilateral infiltrates on CXR, acute onset, and lack of evidence of CHF or volume overload. Using the Berlin definition, stages of mild, moderate and severe ARDS were associated with increased mortality and increased median of duration of mechanical ventilation in survivors. The updated Berlin classification of ARDS addresses some of the limitations of the AECC definition, such as clarification of exclusion of hydrostatic pulmonary edema and providing improved predictive validity.2

The current management of ARDS includes treatment of the underlying condition, implementation of lung protective strategies, and providing optimal supportive care.3-4 Therapeutic prone position is one modality of protective ventilation that has received significant attention. Improvement of oxygenation with prone positioning is reliable and likely multifactorial. Improved configuration between the lung and thorax results in a more homogeneous pleural pressure gradient in the ventro-dorsal and cephalo-caudal planes. In the prone position, the upper chest and pelvis are supported with the abdomen being suspended, contributing to improved bronchial drainage and improved effect of aerosolized medications. The prone position also provides more homogenous perfusion with an improvement in V/Q matching. Several studies have reported improvement in oxygenation with prone position without any mortality benefit. Meta-analyses, however, have suggested potential improvement in survival in those with severe ARDS placed in prone position.5-6

In this article, Guérin et al. conducted a multicenter randomized, prospective study to evaluate the efficacy of early prone positioning in reducing 28-day mortality among patients with severe ARDS. The authors included patients who had severe ARDS (PaO2:FIO2 ratio of <150 with FiO2 >60%, PEEP ≥5 cm H2O, Vt= 6cc/kg ideal body weight) who were endotracheally intubated and mechanically ventilated for less than 36 hours prior to prone positioning. Mechanical ventilation was based on ARDSnet protocol. A total of 466 patients from European ICUs were randomized. 237 patients randomized into the prone group versus 229 patients in the supine group. Those randomized to prone positioning underwent prone-positioning sessions for approximately 16 hours per day for up to 28 days. The primary outcome was mortality at 28 days. Secondary outcomes were mortality at 90 days, rate of successful extubation, length of stay in the ICU, complications, the use of non-invasive ventilation, tracheostomy rate, and number of days free from organ dysfunction.

The two groups were well-matched in terms of coexisting conditions, respiratory mechanics, and ventilator settings at inclusion, although the supine group had slightly higher SOFA scores and vasopressor use, while the
prone group had a higher rate of neuromuscular blocker administration. The authors reported greater improvement in ventilation in the prone group within the first week of treatment including increased PaO2:FiO2 ratio, lower PEEP, lower FiO2, and lower plateau pressure. The prone group had a lower rate of using adjunct/rescue therapies during this study compared to the supine group (ECMO 2.6% vs. 0.8% p=0.14, iNO 15.7% vs. 9.7% p=0.05, and almitrine bismesylate 6.6% vs. 2.5% p=0.04). In terms of primary outcome, mortality was significantly lower in the prone group than in the supine group (16% vs. 32.8% p<0.001) at 28 days. This significant difference in mortality was also present at 90 days follow up (23.6% in the prone group versus 41% in supine group; p<0.001). The prone group had a shorter duration of mechanical ventilation at 28 days (10 vs. 14 days; p<0.001) and 90 days follow up (43 days vs. 57 days; p< 0.001). In terms of length of stay in the ICU, incidence of pneumothorax, rate of use of non-invasive ventilation after extubation, and tracheostomy rate, the authors did not appreciate a significant difference in the two groups in this study. Importantly, while there were roughly twice as many cardiac arrests in the supine group as the prone group (31 vs. 16), rates of complications were otherwise similar between the two groups.

This study is not without limitations. The centers that participated in this study were experienced in the process of turning positions onto the prone position as demonstrated by the lack of adverse events. Therefore, the applicability of this data to centers with less experience is questionable. Fluid balance and catecholamine dosing were not assessed. There was also a possibility of inclusion bias as the data from patients excluded from this study was not included. In addition, imbalances in vaso-pressor use, neuromuscular blocker and sedation use between the prone and supine group may have influenced the results.

Overall, this study conducted by Guérin et al. demonstrated the effectiveness of prone positioning in this population of patients with severe ARDS who were treated aggressively and immediately following diagnosis.

References:
3. The ARDS Network; Ventilation with lower tidal volumes as compared with traditional tidal volumes for acute lung injury and the acute respiratory distress syndrome. NEJM 2000; 342:1301-8.
MOVE MOUNTAINS

Practice at a whole new level. The Self-Assessment Module Critical Care (SAM-CC) evaluates your established skill-set in the area of critical care medicine and identifies areas where you can increase your knowledge. SAM-CC is an online CME activity that comes in a question and answer format with detailed discussions to help you navigate challenging terrains.

How far will your education take you?

Learn more
education.asahq.org/samcc
SOCCA Board of Directors 2014-2015

**Officers**

**President**
Aryeh Shander
MD, FCCM, FCCP
Englewood Hospital
Englewood, New Jersey

**President-Elect**
Avery Tung
MD
University of Chicago
Chicago, Illinois

**Treasurer**
Daniel R. Brown
MD, PhD, FCCM
Mayo Clinic
Rochester, Minnesota

**Secretary**
Miguel A. Cobas
MD, FCCM
University of Miami
Jackson Memorial Hospital
Miami, Florida

**Immediate Past President**
Brenda G. Fahy
MD, MCCM
University of Florida
Gainesville, Florida

**Directors**

Laureen L. Hill
MD, MBA
Emory University Hospital
Atlanta, Georgia

Benjamin A. Kohl
MD, FCCM
University of Pennsylvania
Perelman School of Medicine
Philadelphia, Pennsylvania

Linda Liu
MD
University of California
San Francisco, California

Mark E. Nunnally
MD, FCCM
University of Chicago
Chicago, Illinois

Michael H. Wall
MD, FCCM
University of Minnesota
Minneapolis, Minnesota

Liza M. Weavind
MBBCh, FCCM
Vanderbilt University Medical Center
Nashville, Tennessee

**Delegates**

ASA Delegate (Ex-Officio)
Daniel R. Brown
MD, PhD, FCCM
Mayo Clinic
Rochester, Minnesota

ASA Alternate Delegate (Ex-Officio)
Stephen D. Surgenor
MD
Dartmouth Hitchcock Medical Center
Lebanon, New Hampshire

**International Representative**

Patricia M. Murphy
MD
Toronto General Hospital
Toronto, ON, Canada
Take Your SOCCA Membership to the Next Level! 
Serve on a Committee

SOCCA is now inviting members to join and serve on SOCCA committees. Represent the membership in an area of your interest and take an even more involved membership role.

The following committees are currently accepting new members:

- Nominating Committee
- Committee on Communications
- Committee on Membership
- Committee on Education
- Committee on Bylaws
- Committee on Research

Join a Committee Today!

If you are interested in joining one of these committees, submit your name, email, committee(s) of interest along with a short CV to soccameetings@iars.org by October 31, 2014.