Excerpts from Dr. Murray Pollack’s acceptance speech for the
Distinguished Career Award – given at the AAP National Conference
and Exhibition, October 2001, San Francisco, CA

I want to thank the Critical Care Section and the American Academy of Pediatrics for
this award. Honestly, it is very nice — actually, much more than very nice. This is a most
meaningful academic achievement and I truly appreciate it.

One of the very nice things about an award such as this is that it allows me to say
thank you in a very public way. Families don’t get thanked enough and certainly they rarely
get acknowledged publicly. I want especially to thank my wife Mona. There are a lot of nights
and weekends spent on these projects and my family has put up with this as generously as
any. Time extends innocently from a night to a week to a month to a year, and so on. Obvi-
ously, my family has taken the brunt of this, and it is very nice to be able to publicly say thank
you - Mona.

This is also a time to thank and remember Urs Ruttimann, my research colleague for almost 20 years. Urs died several
years ago. Most of you never met Urs. He was a biomedical engineer with an expertise in dynamic modeling, especially image
modeling. And, he was a very good mathematician, so when he didn’t understand the statistics, he would learn it very fast.
We were some of the first medical investigators to do relatively sophisticated regression analysis. Because he was an
engineer and not a statistician, he was very attuned to the dynamic state of nature, and how analyses needed to truly model
nature. Early on, we were able to use sophisticated analyses because he had an account at NIH, which had an excellent
software package. For reasons too contorted to explain now, we needed to enter data into the NIH software via the hospitals
first PC, an apple 2C and a 9K-baud modem. Back then, a 300 patient study was huge, and I can only begin to remember why -
300 data points/patient and 2-5 seconds per keystroke... But I did learn from this that there is no substitute for knowing your
data. Although my mind did not work as fast as a computer, it did keep up with a 9K modem. Since then, I have always tried to
do a substantial part of all the research assistant tasks, because that is crucial to understanding the strengths and limitations
of the data. We all benefited from Urs, and we all have been a little cheated by his early death.

I remember well a Society of Critical Care Medicine meeting in the early 80’s when I presented some very early work
with severity scoring, something as I recall I did with Tim Yeh. Jack Downs, who I hope most of you will know as a former
winner of this award, and one of the originators of pediatric critical care, reviewed it. That year, they tried assigning a senior
person to make some poignant comments. Jack got up after my 10 minutes, and said something like, “great stuff, but I am not
sure what it really is and where it is going.” I think I really did know at least the direction this was going to go in. After
multiple versions of severity of illness scores, I have been privileged to investigate some of the factors that are associated
with quality of care, provide methodology for severity adjustment, and develop a quantitative quality assessment process for
individual PICUs. Looking back it is really quite amazing where we have come from.

I’ve tried to think what a distinguished career really is and why I have been so honored. I
know some of the things distinguished don’t mean: It doesn’t mean best since there are many with
better careers. Certainly many have written better papers, and have made more important contribu-
tions.

So what is distinguishing? I believe that there are at least 3 distinguishing things and in
every case, the pediatric critical care community is integral to all of them. The most distinguishing
feature is that I have been privileged to collaborate with so many PICUs. From the first 9 PICUs who
contributed data without any financial support to the 50 or so units now participating in Pediatric
Intensive Care Unit Evaluations, pediatric ICUs and their directors and staff have been very willing to
embrace multi-site studies. Even randomly selected units have been willing to participate. Of the 16
PICUs initially randomly selected in one study, all but one agreed to participate. And most signed up
with excitement and enthusiasm. Many sites over the years have contributed data without cost.

Many have actually paid me! So the first distinguishing thing is that I have been very fortunate to have the best and most
cooperative group of PICUs around.

The second distinguishing thing about my career is the number of people I have worked with. To be honest, I
haven’t counted them up, but about 10 years ago, I had been privileged to have over 100 different co-authors. And that didn’t
include acknowledgements. I have learned much from many of my co-authors. They have given of their time and dedication,
often only to be mentioned in the middle of an author list. So the second distinguishing thing is that I have been very
fortunate to have a very dedicated and most cooperative group of pediatric intensivists as co-authors and collaborators.

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Third, I have benefited greatly by the pediatric intensive care community’s acceptance of quantitative quality assessment. PICUs and the individuals who work in them have accepted that there are indicators of quality. They have collaborated, cooperated, donated, and participated in so many ways. But the most important thing is that pediatric ICUs want to provide the best care possible, and thus, they do the things necessary for self-assessments. They were willing to hear the bad news as well as the good news. And, they were willing to change if someone gave them a good reason to change. I was fortunate to be able to give them a good reason in terms of severity adjusted mortality, but they were the ones who changed. I am tremendously proud that I have been part of this process. I know that many many lives have been saved by the efforts to improve quality. I have seen the standardized mortality ratios before and after improvements were implemented. I have been able to measure these improvements that only come from saving lives. So the third distinguishing characteristic is the openness of Pediatric Critical Care to self-evaluation and self-improvement.

I have been fortunate to have participated in evaluations of what quality factors are associated with a good pediatric ICU. I also learned that quality factors do not substitute for an analysis of individual PICUs. So, I tried to find a way of evaluating individual PICUs. I hope this award means at least a tacit acceptance by many of the Pediatric Intensive Care Unit Evaluations (PICUEs) program. As I hope you know, this is a quantitative quality and efficiency assessment program, now in its third version of software, that has generated many manuscripts, several updates of the PRISM III score, many quality assessments, and some controversial discussion based on the premise that our prediction algorithms and some methods are patented and site licensed. I created PICUEs because I realized that pediatric critical care was advancing sufficiently rapidly that the algorithms get out of date rapidly. The important point is this: contemporary algorithms are required for quality assessments to have the credibility to influence care improvement processes in PICUs.

Once again, this is really a very significant honor for me.

Thank you very much.
Dr. Murray Pollack