The Society of Critical Care Cardiology—Rationale, blueprint, and lessons learned in the creation of a new multidisciplinary professional organization

Balimkiz Senman, MD[a], P. Elliott Miller, MD, MHS[b], Ann Gage, MD[c], David M. Dudzinski, MD, JD[d], Carlos Alviar, MD[e], Diego Araiza-Garaygordobil, MD, MSc[f], Alexandra Arias-Mendoza, MD[f], Alexis Barnes, MD[g], Christopher Barnett, MD[h], Mir B. Basir, DO[i], David D. Berg, MD, MPH[j], Samuel Bernard, MD[e], Samuel Brusca, MD[h], Kristin M. Burkart, MD, MSc[k], Francisco Chacón-Lozsán, MD, MEd[l], Neal F. Chaisson, MD[m], Michael Cutrone, DO[n], Garima Dahiya, MBBS[o], Cameron Dezfulian, MD[p], Allison Dupont, MD[q], Andrea Elliott, MD[r], Cate Enstrom, DNP, AG-ACNP[c,s], Luis Farfan, MSN, AG-ACNP[t], Amy Fiedler, MD[u], Ashley Franko, PA-C[e], Cory Fry, DNP, ACNP[v], Eric Hall, MD[w], Barinder Hansra, MD[x], Andrew Higgins, MD[y], Steven M. Hollenberg, MD[z], James Horowitz, MD[aa], Zachary J. Il'Giovine, MD[c], Marwan Jumean, MD[bb], Yoav Karpenshif, MD[cc], Adnan Khalif, MD[dd], Ajar Kochar, MD, MHS[ee], Vijay Krishnamoorthy, MD[ff], Sundar Krishnan, MBBS[ff], Patrick Lawler, MD, MPH[gg,hh], Ran Lee, MD[y], Boyangzi Li, MD[r], Adrianna Luk, MD, MSc[ii], Jordan McKenzie-Solis, APRN, AG-ACNP[jj], Laura Methvin, MD[aa], Nima Moghaddam, MD[kk], Sanjana Nagraj, MD[a], Connor G. O'Brien, MD[h], Deepika Potarazu, MD[x], Alyssa Rabon, PharmD[ll], Aniket Rali, MD[x], Israel Safiriyu, MD[b], Sinan Sayood, MD[mm], Hannah Schimmer, DNP, AG-ACNP[aa], Benedikt Schrage, MD, PhD[nn], Shashank S. Sinha, MD, MSc[oo], Lakshmi Sridharan, MD[z], Carolina Tennyson, DNP, AG-ACNP[pp], Rosy Thachil, MD, MBA[qq], Annemarie Thompson, MD, MBA[nn], Matthew I. Tomey, MD[rr], Saraschandra Vallabhajosyula, MD, MSc[ss], Sean van Diepen, MD, MSc[tt,uu], Thelsa T. Weickert, MD[vv], Brandon Wiley, MD[ww], Emily Zern, MD[ww], Yuhui Zhang, MD, PhD[xx], Yusuf Z. Sener, MD, MSc[yy], and Jason N. Katz, MD, MHS[e], on behalf of the Society of Critical Care Cardiology

From the [a]Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, NY, [b]Section of Cardiovascular Medicine, Yale School of Medicine, New Haven, CT, [c]Department of Cardiovascular Medicine, Centennial Medical Center, Nashville, TN, [d]Critical Care Cardiology, Massachusetts General Hospital and Harvard Medical School, Boston, MA, [e]Bellevue Hospital, New York University Grossman School of Medicine, New York, NY, [f]Coronary Care Unit and Emergency Department, Instituto Nacional de Cardiología Ignacio Chávez, Mexico City, Mexico, [g]Division of Cardiology, University of Pittsburgh Medical Center, Pittsburgh, PA, [h]Department of Medicine, Division of Cardiology, University of California San Francisco, San Francisco, CA, [i]Division of Cardiology, Henry Ford Hospital, Detroit, MI, [j]Cardiovascular Division, Brigham and Women's Hospital, Harvard Medical School, TIMI Study Group, Boston, MA, [k]Division of Pulmonary, Allergy and Critical Care Medicine, Columbia University Irving Medical Center, New York, NY, [l]Péterfy Sándor Hospital, Anesthesia and Intensive care Unit, Budapest, Hungary, [m]Department of Pulmonary Medicine and Department of Critical Care Medicine, Respiratory Institute, Cleveland Clinic, Cleveland, OH, [n]Department of Anesthesiology, Divisions of Cardiothoracic Anesthesiology and Critical Care Medicine, Duke University Medical Center, Durham, NC, [o]Division of Critical Care Cardiology, Department of Cardiovascular Medicine, Mayo Clinic, Rochester, MN, [p]Division of Pediatric Critical Care Medicine, Department of Pediatrics, Baylor College of Medicine, Texas Children's Hospital, Houston, TX, [q]Northside Hospital Heart Institute, Atlanta, GA, [r]Department of Medicine, Division of Cardiology, University of Minnesota, Minneapolis, MN, [s]Centennial Medical Center, Vanderbilt University School of Nursing, Nashville TN, [t]Department of Cardiology, Columbia University Medical Center, New York, NY, [u]Division of Cardiothoracic Surgery, Department of Surgery, University of California, San Francisco, San Francisco, CA, [v]Department of Anesthesiology and Perioperative Medicine, Oregon Health & Science University, Portland, OR, [w]Division of Cardiology, University of Texas Southwestern Medical Center, Dallas, TX, [x]Department of Cardiology, Vanderbilt University Medical Center, Nashville TN, [y]Departments of Critical Care Cardiology and Advanced Heart Failure and Transplant Cardiology, Cleveland Clinic, Cleveland OH, [z]Department of Cardiology, Emory University School of Medicine, Atlanta, GA, [aa]The Leon H. Charney Division of Cardiovascular Medicine, New York University Langone Medical Center and Bellevue Hospital Center, New York, NY, [bb]McGovern Medical School, UTHealth, Houston, TX, [cc]Division of Cardiovascular Medicine, Department of Medicine, Hospital of the University of Pennsylvania, Philadelphia, PA, [dd]Allegheny Health Network, Cardiovascular Institute, Pittsburgh, PA, [ee]Cardiovascular Division, Brigham and Women's Hospital, Boston, MA, [ff]Department of Anesthesiology, Duke University School of Medicine, Durham, NC, [gg]McGill University Health Centre, Montreal, Quebec, Canada, [hh]University of Toronto, Toronto, Ontario, Canada, [ii]Ted Rogers Centre for Heart Research, Peter Munk Cardiac Centre, University Health Network, Toronto, Ontario, Canada, [jj]Division of Cardiology, Duke University Medical Center, Durham, NC, [kk]Division of Cardiology, University of British Columbia, Vancouver, Canada, [ll]Department of Pharmacy, Oregon Health & Science University, Portland, OR, [mm]Division of Critical Care Medicine, Stanford University Medical Center, Palo Alto, CA, [nn]Department of Cardiology, University Heart and Vascular Center Hamburg, Hamburg, Germany, [oo]Inova Schar Heart and Vascular, Inova Fairfax Medical Campus, Falls Church, VA, [pp]Duke University School of Nursing, Durham, NC, [qq]Division of Cardiology, Elmhurst Hospital Center, Mount Sinai School of Medicine, New York, NY, [rr]Department of Cardiology, Mount Sinai Fuster Heart Hospital, New York, NY, [ss]Division of Cardiology, Department of Medicine, Warren Alpert Medical School of Brown University and Brown University Health Cardiovascular Institute, Providence, RI, [tt]Department of Critical Care Medicine and Division of Cardiology, Department of Medicine, University of Alberta, Edmonton, Alberta, Canada, [uu]Canadian VIGOUR Centre, University of Alberta, Edmonton, Alberta, Canada, [vv]Division of Cardiology, University of North Carolina, Chapel Hill, NC, [ww]Division of Cardiovascular Medicine, Los Angeles General Medical Center, Keck School of Medicine of USC, Los Angeles, CA, [xx]Heart Failure Center, State Key Laboratory of Cardiovascular Disease, Fuwai Hospital, National Center for Cardiovascular Diseases, Chinese Academy of Medical Sciences and Peking Union Medical College (CAMS and PUMC), Beijing, China, [yy]Department of Cardiology, Thoraxcenter, Erasmus MC, Rotterdam, The Netherlands

Submitted June 20, 2026; accepted June 21, 2026

Reprint requests: Jason N. Katz, MD, MHS, Bellevue Hospital, New York University Grossman School of Medicine, 462 First Avenue, Cardiology Dept, H-Building, 17th Floor, Room 17S5, New York, NY 10016.

E-mail address: Jason.Katz@soccc.org.

0002-8703

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https://doi.org/10.1016/j.ahj.2026.107521

ABSTRACT

Importance Since the cardiac intensive care unit was first introduced into the medical landscape, patient complexity, comorbidity, and illness severity have increased substantially over time. This evolution has required and informed the cultivation of new tools and an expanding skill set for those who deliver care in these units, and has paved the way for the emergence and growth of a distinct discipline—Critical Care Cardiology. With the genesis of this field and the need to care for *comorbid and critically ill* patients, numerous questions have been posed, including those related to optimal staffing models, appropriate training pathways, and the development of best practice principles to guide patient management. To address these and other challenges, to foster necessary collaborations, and to galvanize a maturing field, the Society of Critical Care Cardiology (SoCCC) was born.

Observations SoCCC was created to provide an independent, yet complementary home for stakeholders within this rapidly growing discipline. Its mission is to address the unique needs and concerns of Critical Care Cardiology through an inclusive approach that prioritizes the development of early career faculty, actively engaging them to help to shape the field and to strengthen its unique practice environment—the cardiac intensive care unit. While collaborations with larger professional societies remain essential, an independent subspecialty society like SoCCC intends to capitalize on the historical precedent and experiences shared by other successful organizations, while leveraging its nimble structure to advocate for and advance the needs of its constituency.

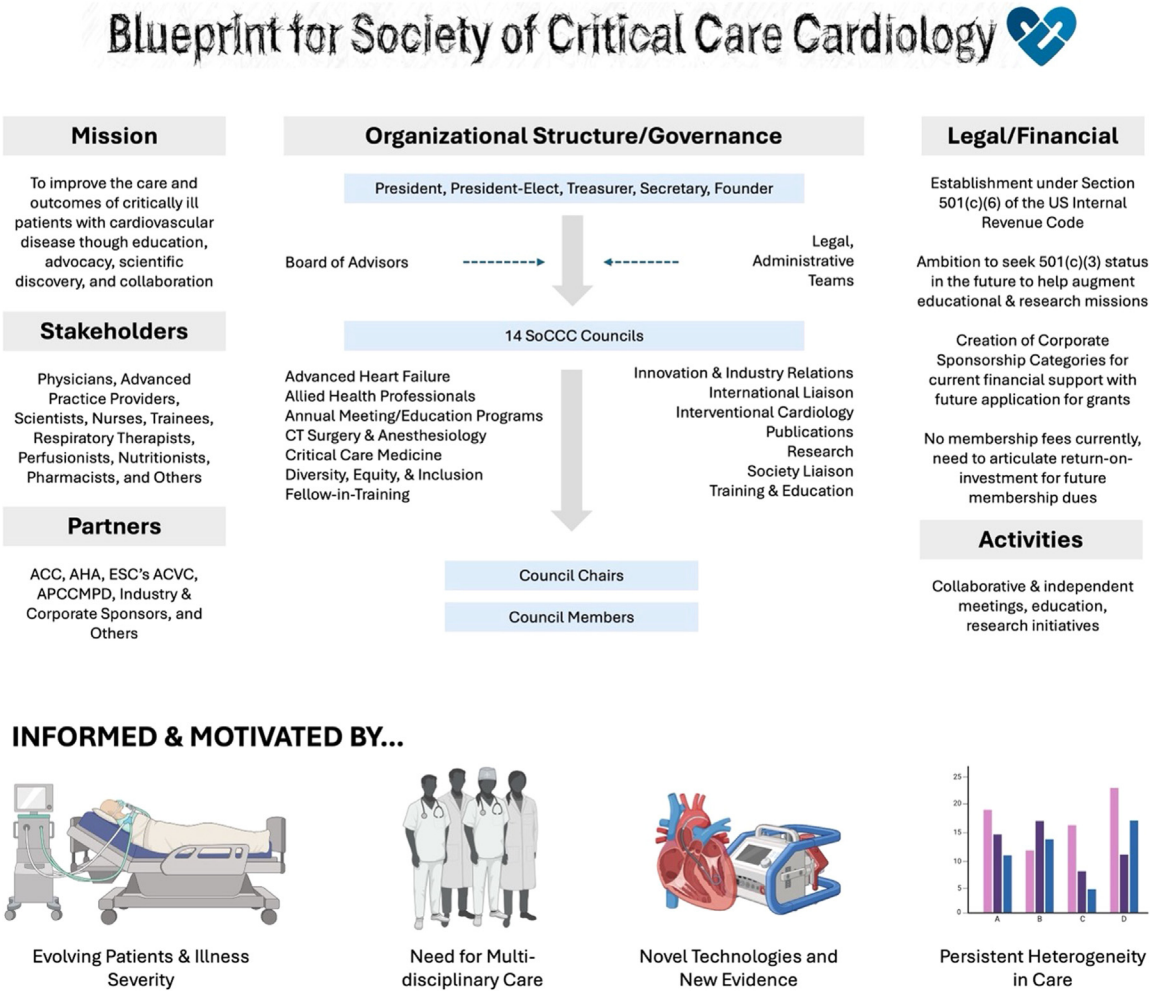
Conclusions/Relevance While this document primarily details the history and rationale that led to the establishment of SoCCC, it also endeavors to be a practical blueprint to support future leaders who might be considering a new society for their own subspecialty. (Am Heart J 2026;301:107521.)

Initially created and later promoted as a place to actively monitor and resuscitate patients following acute myocardial infarction (AMI), the modern cardiac intensive care unit (CICU) has since changed considerably, influenced in large part by expanding patient complexity, increasing multimorbidity, and escalating illness severity.[1-3] Respiratory failure is now the leading reason justifying CICU care,[4] and shock admissions are increasingly complicated by other insults, such as infection, often creating unique management challenges regardless of the primary driver of shock physiology.[5] In parallel with the changing demographic of the CICU patient, critical care support in these units has also changed substantially, including the increasing use of an expanding armamentarium of mechanical circulatory support (MCS) modalities—this despite limited data from which to define optimal timing, selection, or management of these devices and their complications.[6] These evolutionary changes in the CICU as a platform for high-intensity cardiovascular care delivery have led directly to a transformation in both the organizational structure and staffing of these specialized settings,[7,8] as well as in the skillset required to manage the critically ill patients that they currently accommodate.[2,9] In addition to the essential proficiencies learned as part of traditional cardiovascular medicine training programs, leaders of the modern CICU must now be facile with numerous critical care skills and technologies including the use of invasive and noninvasive mechanical ventilation, renal replacement therapy, airway management, and much more. Taken together, the changing patients, the evolving tools, and the expanding skillset have set the stage for the genesis and maturation of a unique discipline—that of Critical Care Cardiology (CCC).

The field of CCC now faces numerous fundamental and structural challenges that will demand both thoughtful and forward-thinking solutions in order to ensure its long-term stability. These challenges include the determination and vetting of optimal operational models for these evolving and often unique center- and region-specific CICUs, the alignment and optimization of robust training programs for practicing clinicians and leaders, the creation of tools necessary to ensure workforce sustainability and to reduce burnout, and the development of an evidence-base necessary to care for this distinctively complex patient population—especially since many of these patients have been excluded from critical care randomized controlled trials.[10,11] To address these challenges, advocate for this burgeoning discipline, and help shape the future of a field that—while still in its infancy—is crucial to the advancement of acute cardiovascular care in general, the Society of Critical Care Cardiology (SoCCC) was established (Figure 1).

This document outlines the formation of SoCCC, detailing in particular the history and rationale informing its creation, and the challenges and solutions we encountered (Figure 2). Additionally, recognizing that no such guidance currently exists, it also endeavors to serve as a practical blueprint for the development of a new subspecialty society. The process of establish-

Figure 1. Blueprint for the creation of the Society of Critical Care Cardiology (created in part using https://biorender.com).



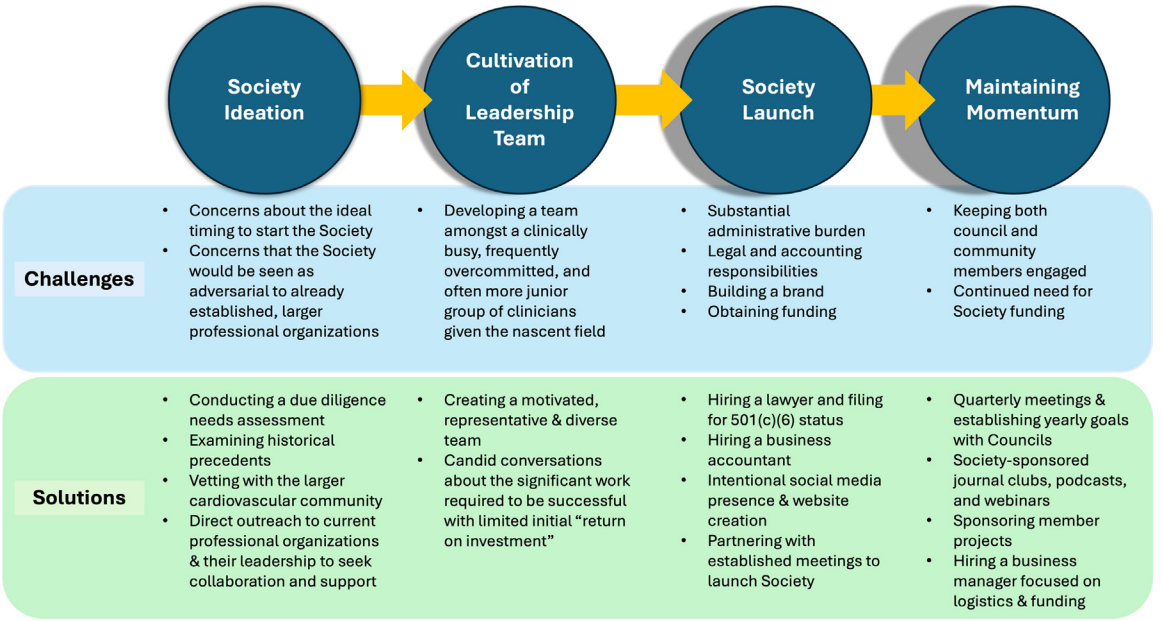
ing SoCCC required a unique set of expertise not typically a part of the academic physician's toolkit, highlighting therefore the need for structured resources in this domain.

Professional societies in cardiology—Historical perspectives and rationale

Virtually all sub-disciplines within cardiovascular medicine have successfully established their own subspecialty societies, reflecting the growing complexity and a subsequent commitment to adaptation within the field. These societies have played pivotal roles in advancing the unique needs of their respective disciplines through collaboration, research, advocacy, and education. While a comprehensive review of all such societies is beyond the scope of this paper, examining the historical background of several notable organizations highlights key components of their origin and development, and underscores the rationale for creating SoCCC as an independent entity with unique clinical, scholarly, and advocacy aims. Some of these are reviewed and summarized in Table 1.

These vanguard societies illustrate how independent organizations have helped strengthen their respective disciplines, while at the same time maintaining collaborative ties with larger professional homes like the ACC, AHA, and European Society of Cardiology (ESC). Furthermore, mirroring the focus of SCAI on the angiography suite and ASE on the echocardiography laboratory, SoCCC is also dedicated to studying and optimizing care within a specific clinical environment—the CICU. Multiple cardiology professional societies feature training and peer networking as part of their rationale, and this has been a key objective of SoCCC in its inaugural year. Innovation and development of training standards and credentialing represent another aspirational aim shared by SoCCC and other organizations. Downstream of those

Figure 2. Challenges and solutions encountered during societal development.



aims, many societies have also featured their own continuing medical education (CME) products and even subspecialty journals (including the *Journal of the Society of Cardiovascular Angiography & Intervention, Heart Rhythm Journal, Journal of the American Society of Echocardiography*, and *Journal of Cardiac Failure*), and these may represent another future goal for SoCCC. At the same time, interest has grown amongst practitioners, institutions, and hospital systems, in part reflecting the burgeoning healthcare needs and costs associated with caring for these uniquely complicated patients.

Taken together, these principles underscore the rationale for establishing a society dedicated to the field. With the increasing interest of CCC also comes potential unintended consequences given the limited number of cardiology training positions as well as the current and increasing shortages within cardiology. The growth of this field will also likely begin at Level 1 CICUs, which we estimate to be between 300 and 350 centers in the United States. Our goal is not to exacerbate shortages in any other field of cardiology, but to partner with each discipline and support the physicians, APPs, and nurses that care for patients in the CICU. Importantly, we hope to be a home for all of these providers regardless of the CICU level in which they practice.

The founding principles of SoCCC align completely with those of its aforementioned predecessors—aiming to foster collaboration,[12] improve care paradigms and quality in the CICU,[13] enhance the identity of the discipline, and promote the continued growth and integration of CCC into the broader medical and cardiovascular communities.

Value proposition for a unique professional society in critical care cardiology

Addressing gaps within the current landscape

The establishment of dedicated councils and/or committees for CCC within major professional organizations like the ACC, AHA, and ESC were pivotal milestones, underscoring the field's rapid evolution and highlighting many of the emerging priorities that came with such growth. It became increasingly clear, however, that the creation of an independent subspecialty society might be prudent—not only to complement the efforts of these larger professional organizations, but also to help develop a dedicated home, more agile and perhaps better suited to address the discipline's rapidly evolving needs which include advocacy, education, training standardization, mentorship, guideline development, quality, and research.

Representation within larger organizations offers undeniable benefits. They command significant influence within cardiology, internal medicine, and even within policy, regulatory, and legislative arenas, and are able to reach vast audiences while helping shape the broader medical landscape. However, being singularly represented by such a large organization also comes with inherent limitations, where sections dedicated to CCC

Table 1. Historical perspectives on the creation of several prior cardiovascular subspecialty societies.

Subspecialty society	Rationale + history	Constituency + care environment	Other notable features
Society for Cardiovascular Angiography & Interventions (SCAI)	• Founded in 1978. • Sole professional medical society in US dedicated to supporting invasive & interventional CV community. • Paralleled rapid development of interventional cardiology as both a discipline & therapeutic approach. • Goal to establish key quality standards, credentialing/training guidelines. • Early meeting held in collaboration with ACC and AHA.	• Addressing needs of patients and clinicians. • Focused on specific care environment—the cardiac catheterization laboratory.	• Over time developed collegial partnerships with other societies and ABIM. • Increased focus on guideline development, standardizing & enhancing care of patients requiring angiographic evaluation, along with coronary, structural, and MCS interventions.
Heart Rhythm Society (HRS)	• Originated in 1979 as the North American Society of Pacing and Electrophysiology. • Formed by several pioneering electrophysiologists in response to burgeoning field of EP and cardiac pacing. • Rebranded as HRS in 2004 with expanded society mission including education, investigation, & policy development. • Initially partnered with ACC Scientific Sessions for early meetings.	• Focused on patients with heart rhythm disorders. • Responding to increasing patient complexity and novel technologies in and out of the EP laboratory. • Emphasizes team-based professional care—to include non-EP members such as geneticists, pharmacists, device technicians, engineers.	• In parallel with growing prominence as independent discipline, HRS established its own independent meetings & events.
American Society of Echocardiography (ASE)	• Founded in 1975. • Designed to promote standards, quality and innovation in cardiac ultrasonography.	• Membership focused on multi-professional team members including physicians (echocardiologists, intensivists, anesthesiologists, pediatrician), sonographers, scientists, nurses, & even veterinarians. • Key goal to standardize care and improve quality in the echocardiography laboratory.	• Collaborates with multiple other professional societies including ACC, AHA, & SCAI on consensus guidelines.
Heart Failure Society of America (HFSA)	• Founded in 1995 by a group of academic cardiologists. • Mission centered on reducing burden of heart failure through improved treatment strategies, better care delivery, and commitments to research, education, & advocacy.	• Goal to include all stakeholders with interest in the care of patients with heart failure.	• Established in part based upon the need to recognize heart failure as a distinct subspecialty within cardiology. • Offers platform for collaboration and growth within a rapidly evolving field.

must operate under more rigid structure. This could lead to difficulties in the ability to align specific subspecialty goals and ambitions with the broader priorities of the parent organization. As a result, the pace of progress might be slow, making it challenging to address a maturing field's unique and often dynamic circumstances, all while cultivating and fostering timely partnerships. The potential advantage of an independent society is the ability to focus solely on the interests of the subspecialty, allowing collaborations to be cultivated and advanced more efficiently and effectively.

Promoting early career representation while leveraging experienced leaders

The rapid development of CCC has also brought forth emerging priorities that merit conversation, especially

those related to training pathways, optimal staffing models, and core clinical and cognitive competencies required for those taking care of the critically ill cardiac patient of today and tomorrow. These topics, while essential, cannot always be prioritized within larger professional organizations. As many of the foundational questions and priorities for the future of CCC will primarily impact those currently training or those who will be in the future, a principal goal of SoCCC was to prioritize these initiatives. In order to do so, we have purposefully included early career faculty and trainees in society formation and development. SoCCC believes that this approach will foster innovation, help bridge generational gaps, and cultivate a culture of inclusivity in a specialty that requires multidisciplinary teams to deliver high quality care. It is imperative for us to ensure that the future of this field reflects a professional environment in which our younger members can see themselves practicing and thriving. Moreover, the smaller, independent infrastructure of SoCCC will hopefully enable it to engage not only these early career members but also our most senior leaders who have helped shape the field as it exists now. This unique balance will allow the society to appropriately acknowledge and build upon historical events to address foundational challenges, while building a solid and enduring future.

Flexibility, partnership, and sponsorship

Independence provides considerable flexibility in being able to address current and emerging priorities in the field. Larger professional organizations often will have multiple significant matters to manage, which could inadvertently result in the priorities of sections or chapters not receiving immediate attention. The flexibility of SoCCC extends to its governance, allowing the society to cultivate a leadership team that is diverse, inclusive, adaptable, and representative of the specialty and its members. SoCCC strongly believes that incorporating the perspectives of early and mid-career professionals, along with trainees and other learners, is essential to shaping a field that can attract and retain talent, foster job satisfaction, and meet the evolving needs of its constituency.

At the same time, the CCC community deeply values the contributions of relevant CCC sections and councils within larger organizations such as the ACC's Critical Care Cardiology Council, AHA's Acute Cardiac Care Committee and the 3CPR Council, and the ESC's Association for Acute Cardiovascular Care (ACVC), along with established and likeminded critical care organizations including the Association of Pulmonary and Critical Care Medicine Program Directors (APCCMPD), American College of Chest Physicians (CHEST), and Society of Critical Care Medicine (SCCM), to name a few. The collective reach and influence of these multidimensional partnerships is essential to the full advancement of the CCC discipline, and SoCCC will continue to collaborate with them as partners in the larger mission. Such a collaborative focus mirrors the structure of other subspecialties, who have historically benefitted from both their independent society along with concomitant representation within larger organizations.

Establishing a new society—A blueprint realized

The mission of SoCCC is to improve the care and outcomes of critically ill patients with cardiovascular disease through education, advocacy, scientific discovery, and collaboration. The governing body of SoCCC includes a 5-member Board of Trustees, designed to promote transparency, inclusivity, and long-term sustainable solutions while ensuring effective decision-making. Four of the 5 board members hold the inaugural offices of President/Chair of the Board, President-Elect, Secretary, and Treasurer, and are joined by the SoCCC Founder as a fifth member. Recognizing the importance of strong, relevant leadership, our board is composed entirely of those trained and certified in both Cardiology and Critical Care Medicine. The leadership team reflects the diversity of the CCC community, including men and women, members from academic institutions and private practice, those at various stages in their careers, as well as clinicians, educators, and researchers. Furthermore, the majority of board members have additional training and credentialing in other subspecialties of cardiovascular medicine. This balanced, inaugural group represents well-regarded voices in the field, chosen in particular for their strong communication skills and unwavering commitment to advancing CCC, and with planned officer rotations via election at scheduled intervals.

The founding members of SoCCC conducted extensive due diligence efforts to understand the historical context, mission, governance structures, and regulatory frameworks of comparable professional organizations. This methodical approach informed the strategic plan, operations, and vision of SoCCC, ensuring a robust and well-vetted foundation for its success. The society's leadership extends beyond the Board of Trustees and is supplemented by an Advisory Board, carefully selected for their expertise in clinical care, research, education, leadership, mentorship, and advocacy. Together, these groups work collaboratively to guide SoCCC and to advance its multi-faceted mission.

Legal and financial considerations

It is important also to acknowledge that establishing a society and navigating the regulatory complexities of starting a business may not be part of the typical physician skillset, and have in this case represented entirely new proficiencies for the inaugural SoCCC leadership team to cultivate. From inception, SoCCC has relied on

the expertise of corporate, tax, and legal advisors to guide its development. Legal counsel has played a pivotal role in every step of the process, from incorporation to the creation of regulations and bylaws, filing for tax-exempt status, drafting a conflict-of-interest policy, and ensuring compliance with banking regulations to lay a strong and compliant foundation for the society.

SoCCC is being established under Section 501(c)(6) of the US Internal Revenue Code which provides tax exemption to business leagues that are not organized for profit. Professional associations are business leagues, with activities devoted to improving business conditions, or for SoCCC, representing and improving the profession of CCC. This is consistent with the tax-exempt status of cardiology professional organizations that predate SoCCC, including ACC, SCAI, and ASE. However, it contrasts with organizations formed under Section 501(c)(3) of the Internal Revenue Code, which prioritize the advancement of education or science. In the future, SoCCC anticipates seeking 501(c)(3) status for a portion of the society's activities linked to its educational and research missions.

Society councils and their roles

Beyond the foundational steps of incorporation and the establishment of the governance structure, the society's short-term goals included: (1) developing a leadership framework beyond the Board of Trustees, (2) appointing subject matter experts and members of the CCC community to this leadership structure, and (3) empowering the inaugural leadership team to define both short- and long-term objectives for SoCCC. These objectives were realized through the creation of 14 Councils, each led by 1 or more Council Chairs and populated by multiple Council Members, and thereafter through both in-person and virtual meetings (Figure 1). A representative sample of these goals is outlined in Table 2.

Communication, community, and the generation of a constituency base

The demand for community development, mentorship, and advancement in CCC is clear and growing. The society recognizes, however, that in order to attract and retain membership, SoCCC must offer tangible benefits and deliverables that provide value to its members. Beyond being forward-thinking and agile, a core mission for SoCCC is to be inclusive and responsive – to those who have perhaps felt marginalized within the CCC community and to trainees eager to contribute. Many of these individuals will play a pivotal role in diversifying this emerging field. It is important to note that SoCCC is committed to being a home for all professionals involved or interested in the care of patients with acute cardiovascular disease, including nurses, learners, pharmacists, nurse practitioners and physician assistants, those dual-boarded or not yet boarded in critical care or cardiovascular medicine, nonclinicians with policy, engineering, and business expertise, along with many others.

Communication with CCC colleagues has been paramount to early outreach, membership and the initial launch of SoCCC. The role of grass roots communication, email chains, and social media has been especially crucial, providing SoCCC with a powerful and cost-effective means to engage with medical students, residents, fellows, allied health professionals, and practicing physicians. Social media (Twitter/X: @SocietyofCCC; Instagram: @SocietyofCCC; websites: www.SoCCC.org and www.ccc1stop.com) enables rapid dissemination of information, raising awareness of the organization and its early initiatives.

SoCCC has made significant strides in outreach, attributable to its agile governance structure and technologies including remote-meeting software. On a monthly basis, SoCCC, in collaboration with CCCEnthusiasts, LLC (a pioneering educational platform led by trainees in the field), hosts a CCC journal club as a webinar. Each session focuses on a different seminal paper or topic, presented and discussed by both a trainee and faculty member. Faculty are strongly encouraged to pair with a learner that they do not know (ideally from a different institution) in order to build networks across the nation and world. These journal club sessions are designed not only to be led by the discussing trainee and faculty, but also to foster active participation from a live audience.

This interactive format was intentionally created to bridge gaps between trainees and established physicians, while also providing valuable access to CCC mentorship for those who may not have a critical care cardiologist at their own hospital.

Community development and mentorship remain foundational to the society's mission. Whether practicing as a senior clinician or as a junior faculty transitioning into their first independent job, the lack of robust evidence in CCC has resulted in many areas of diagnostic and therapeutic uncertainty. These knowledge gaps have been particularly challenging for CCC to overcome, despite best efforts from the cardiovascular community, due to the time sensitive nature and heterogenous presentations of many patients in the CICU. SoCCC aims to provide a centralized platform to ask questions, share knowledge, identify collaborators, and to lay the groundwork for future evidence generation—a key long-term priority for the society, including the development of surveys to better define standards of care, disease- and process-specific registries, societal statements to improve definitions, and ultimately participation and funding of prospective trials.

Reflections

SoCCC now follows a path created and navigated by pioneering subspecialty organizations including SCAI,

Table 2. Aspirations and key deliverables for the Society of Critical Care Cardiology by category of strategic aim.

Short-term goals	Long-term goals
Membership • Delineate forms of professional membership and begin enrollment for SoCCC membership. • Increase engagement within the Critical Care Cardiology Community.	Membership • Recruit, expand and retain a robust membership base.
Strategic Partnerships • Partner with existing cardiology societies including the American College of Cardiology, American Heart Association and the European Society of Cardiology's Association for Acute Cardiovascular Care.	Strategic Partnerships • Seek Critical Care Cardiology leadership roles in Critical Care Medicine societies. • Partner with Critical Care Medicine training programs to develop additional opportunities for enrichment and exposure to cardiac conditions and patients.
Fellows-in-Training and Early Career • Develop an online resource for trainees to identify training programs. • Sponsor trainees to attend national CCC conferences. • Establish a Critical Care Cardiology Faculty Mentorship program.	Fellows-in-Training and Early Career • Organize and sponsor fellow-in-training sessions at major Cardiology and Critical Care meetings.
Critical Care Medicine • Form partnerships with key Critical Care Medicine stakeholders including the Association of Pulmonary and Critical Care Medicine Program Directors, The American College of Chest Physicians, and the Society of Critical Care Medicine.	Patient-Facing • Create online resources for common CICU conditions. • Provide CICU/Cardiogenic Shock patient advocacy.
Meetings and Education • Create a Critical Care Cardiology Journal Club. • Develop Critical Care Cardiology Case Conferences. • Conduct webinars on wellness for CCC clinicians • Cultivate educational meetings or programs on behalf of the Society of Critical Care Cardiology.	Meetings and Education: • Partner with existing Cardiology and Critical Care meetings to increase and support CCC content there. • Develop a SoCCC annual meeting.
Allied Health Professionals: • Introduce SoCCC to allied health fields and professionals. • Encourage allied health professionals to join webinars and SoCCC activities. • Survey allied health practice in contemporary CICUs.	Allied Health Professionals: • Help to define allied health roles in CCC interprofessional teams. • Create SoCCC allied health education, mentorship and networking opportunities. • Develop CICU-specific education platforms for allied health professionals.
CCC Training: • Connect with leadership of major and specialty cardiology and critical care organizations to set foundation for collaboration on training and standards.	CCC Training: • Help to develop standardized training guidelines and competencies. • Create CICU visiting rotations for US fellows to access Level 1 CICUs.

HRS, ASE, HFSA, and others. Despite its brief existence, the society has made important progress (Figure 1); although there is still much to learn and accomplish. SoCCC recognizes the myriad possibilities that lie ahead, while also preparing to address the unique challenges faced by burgeoning organizations and disciplines. SoCCC hopes that by leveraging lessons learned from predecessors, harnessing the talents and enthusiasm of emerging leaders, and embracing opportunities for innovation and collaboration, a valuable and durable professional home for multidisciplinary stakeholders in CCC will result.

Conflict of interest

Balimkiz Senman has received research funding from Datascope Corp. Ann Gage has received honorarium

for Zoll Inc and was previously a member of Abiomed Inc Speaker's Bureau. Diego Araiza-Garaygordobil has received speaking fees from: Abbott, Asofarma (Adium), Astra Zeneca, Bayer, Boehringer Ingelheim, Chiesi, Menarini, Novartis, Novo Nordisk, Silanes, Servier, Viatris. Advisory board fees from: Silanes, Servier, Novartis, Novo Nordisk, Chiesi, Viatris. Research grants from: Bayer, Boehringer Ingelheim, Novartis, Novo Nordisk. Alexandra Arias-Mendoza has received speaking fees from: Asofarma (Adium), Bayer, Boehringer Ingelheim, Chiesi, Menarini, Novartis, Servier, Silanes. Advisory board fees from: Novartis, Chiesi. Research grants from: Bayer, MSD, CSL Behring, Novartis, Novo Nordisk. Patrick Lawler is supported by the Fonds de Recherche du Quebec. receives personal fees from the American College of Cardiology. Connor G. O'Brien is a Consultant for Johnson and Johnson is my only disclosure. Aniket Rali has received speaker honoraria from Zoll Inc, Abiomed Inc, Volumetric, Caretaker Medical. Benedikt Schrage has received speaker fee from Abbot, Abiomed Inc, AstraZeneca and Inari, as well as research funding from Abiomed Inc. Lakshmi Sridharan has received speaker fee from Abiomed Inc. Matt I. Tomey has received fees for editorial service from McGraw-Hill Education and his spouse received consulting free from Medtronic. Jason N. Katz has received speaker honoraria from Zoll Inc and Abiomed Inc. No other authors report conflicts of interest.

CRediT authorship contribution statement

Balimkiz Senman: Conceptualization, Writing – original draft, Writing – review & editing. **P. Elliott Miller:** Conceptualization, Writing – original draft, Writing – review & editing. **Ann Gage:** Writing – original draft, Writing – review & editing. **David M. Dudzinski:** Writing – review & editing. **Carlos Alviar:** Writing – review & editing. **Diego Araiza-Garaygordobil:** Writing – review & editing. **Alexandra Arias-Mendoza:** Writing – review & editing. **Alexis Barnes:** Writing – review & editing. **Christopher Barnett:** Writing – review & editing. **Mir B. Basir:** Writing – review & editing. **David D. Berg:** Writing – review & editing. **Samuel Bernard:** Writing – review & editing. **Samuel Brusca:** Writing – review & editing. **Kristin M. Burkart:** Writing – review & editing. **Francisco Chacón-Lozsán:** Writing – review & editing. **Neal F. Chaisson:** Writing – review & editing. **Michael Cutrone:** Writing – review & editing. **Garima Dahiya:** Writing – review & editing. **Cameron Dezfulian:** Writing – review & editing. **Allison Dupont:** Writing – review & editing. **Andrea Elliott:** Writing – review & editing. **Cate Enstrom:** Writing – review & editing. **Luis Farfan:** Writing – review & editing. **Amy Fiedler:** Writing – review & editing. **Ashley Franko:** Writing – review & editing. **Cory Fry:** Writing – review & editing. **Eric Hall:** Writing – review & editing. **Barinder Hansra:** Writing – review & editing. **Andrew Higgins:** Writing – review & editing. **Steven M. Hollenberg:** Writing – review & editing. **James Horowitz:** Writing – review & editing. **Zachary J. Il'Giovine:** Writing – review & editing. **Marwan Jumean:** Writing – review & editing. **Yoav Karpenshif:** Writing – review & editing. **Adnan Khalif:** Writing – review & editing. **Ajar Kochar:** Writing – review & editing. **Vijay Krishnamoorthy:** Writing – review & editing. **Sundar Krishnan:** Writing – review & editing. **Patrick Lawler:** Writing – review & editing. **Ran Lee:** Writing – review & editing. **Boyangzi Li:** Writing – review & editing. **Adrianna Luk:** Writing – review & editing. **Jordan McKenzie-Solis:** Writing – review & editing. **Laura Methvin:** Writing – review & editing. **Nima Moghaddam:** Writing – review & editing. **Sanjana Nagraj:** Writing – review & editing. **Connor G. O'Brien:** Writing – review & editing. **Deepika Potarazu:** Writing – review & editing. **Alyssa Rabon:** Writing – review & editing. **Aniket Rali:** Writing – review & editing. **Israel Safiriyu:** Writing – review & editing. **Sinan Sayood:** Writing – review & editing. **Hannah Schimmer:** Writing – review & editing. **Benedikt Schrage:** Writing – review & editing. **Shashank S. Sinha:** Writing – review & editing. **Lakshmi Sridharan:** Writing – review & editing. **Carolina Tennyson:** Writing – review & editing. **Rosy Thachil:** Writing – review & editing. **Annemarie Thompson:** Writing – review & editing. **Matthew I. Tomey:** Writing – review & editing. **Saraschandra Vallabhajosyula:** Writing – review & editing. **Sean van Diepen:** Writing – review & editing. **Thelsa T. Weickert:** Writing – review & editing. **Brandon Wiley:** Writing – review & editing. **Emily Zern:** Writing – review & editing. **Yuhui Zhang:** Writing – review & editing. **Yusuf Z. Sener:** Writing – review & editing. **Jason N. Katz:** Conceptualization, Supervision, Writing – original draft, Writing – review & editing.

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