

ESICM Takes Stock During Silver Anniversary in Berlin



By Jeannie Wurz, BA

Introduction

More than 4900 intensive care practitioners converged on Berlin between October 6 and 10, 2007, for the 20th Annual Congress of the European Society of Intensive Care Medicine (ESICM). The congress, which also provided an occasion to celebrate the 25th anniversary of the founding of the society, included a varied program, ranging from oral and poster presentations of new research to interactive educational sessions to technical sessions sponsored by industry. The society's Silver Anniversary was highlighted by thematic sessions looking at developments in intensive care and by the publication of a book titled *25 Years of Progress and Innovation in Intensive Care Medicine*, edited by society members Ralf Kuhlen, Rui Moreno, Marco Ranieri and Andrew Rhodes.

At the opening session, ESICM President Marco Ranieri reminisced about the society's beginnings. He shared a photo from the 1982 founding, which took place "essentially in Peter Suter's office," and joked that although the founders—now the seasoned leaders of intensive care—are perhaps no longer quite as young as they were, the society continues to be dynamic and alive. The winners of the 2007 educational awards, one of whom was an "embryo" at around the same time the society was born, are now showing their potential as future leaders. In the past 10 years, membership in ESICM has increased from 1876 to 4500, and the scope of the annual meeting has grown in parallel (see table below). According to Dr. Ranieri, the society "has a great future because it's young." But he called on members to support their society, saying that ESICM "needs investment—needs your heart, needs your brain, needs your energy."

ESICM Annual Congress 10-Year Comparison

	1997	2007
Number of attendees	2170	4900
Number of countries represented	55	92
Number of sessions	68	6 PGs + 149
Number of speakers and chairpersons	170	245
Number of abstracts submitted	813	1211
Number of abstracts selected	678	1046
Number of posters	309	862
Number of exhibitors	52	84

Amount of exhibit space	945 m2	1634 m2
Number of major sponsors	4	11
Number of educational awards	12	4
Total monetary value of awards given	6000€	6000€

PGs = postgraduate courses

The past: What has changed in 25 years?

Technology

One of the obvious ways that intensive care has changed since the founding of ESICM is in the development of technology. Technology is a key component of intensive care unit (ICU) care today, said David Goldhill of the United Kingdom. As examples, not only computed tomography (CT) and bedside computers but also enormous advances in the design of patient beds are changing ICU care. According to Michael Imhoff of Bochum, Germany, developments in early ICU technology were triggered by medical and organizational demands but limited by a lack of pathophysiological knowledge. Today, new concepts are both driven by and limited by financial constraints.

Nursing

Many aspects of critical care nursing have also changed. In 1981, said Sheila Adam of London, 91% of ICU's regularly used neuromuscular blockers, and nurses were accustomed to caring for patients who were completely unresponsive. Reductions in the use of sedation have led to a different style of practice and increasing workload. "We must be much more communicative," Adam said. Stijn Blot of Belgium pointed out that today's nurses are required to master an increasing number of skills, which has placed a great burden on young nurses just beginning their careers in the ICU. Luckily, educational opportunities for ICU nurses have increased. Whereas in 1998 64% of European ICU's offered specialist ICU training for nurses, said Sheila Adam, by 2003 specialist training was offered in 15 of 17 European countries. ESICM now counts +/- 94 nurses among its members, and more than 10% of attendees at this year's annual congress were nurses and physiotherapists.

Multidisciplinary care

The number of allied healthcare professionals belonging to ESICM has grown as well, reflecting the growing trend in medicine toward multidisciplinary care. The term "allied health" covers as many as 100 different professional titles, said Michelle Norrenberg of Brussels. Pharmacists, dieticians, psychologists, and physiotherapists are just a few of the specialists contributing to the ICU team. These professionals can make major differences in the quality of care. For example, the participation of a pharmacist in ICU rounds has been shown to reduce adverse drug events by 66%, Norrenberg said.

Paternalism vs. autonomy

Families have also become participants in ICU care in the past few decades. We are reaching the end of paternalism, said Elie Azoulay of Paris: "Most healthcare providers are able and are willing to let the family members share in the decision-making." Today the trend in the ICU is toward provision of basic information, effective communication, and shared determination, he said.

The shift away from paternalism has also had a major effect on clinical research, according to Francois Lemaire of Créteil, France. Back in the 1980's there was no such thing as informed consent. "We did not ask for consent from anyone—patients or families," he said. "There were no laws, no regulations of any type, and we could do whatever we wanted." Studies were conducted which would be impossible to conduct today, said Lemaire, such as the 1988 introduction of the left ventricular catheter at the bedside. "I still believe it was good research," Lemaire said, but what was disturbing was that "there was no debate of any type," particularly concerning ethics.

The present: Current issues in intensive care

Conflict of interest

Today, there is much debate over how research is conducted, or should be conducted, and increasingly over how it should not be conducted. ESICM called attention to the issue of conflict of interest with a keynote address delivered at Sunday's opening session by Jukka Takala of Bern, Switzerland.

Collaboration between medical research and industry is essential, said Dr. Takala, and has produced major advances. Yet research involving major conflicts of interest—and promotion of drugs by medical professionals with financial stakes in the drugs' success—has "badly eroded public trust in medicine and industry." Why are conflicts of interest so common, and why are they taken so lightly within the medical community? asked Dr. Takala. "Why do we accept or even expect that somebody else pays our lunch, travel, hotel, congress, et cetera?"

It is not immoral or unethical to have a conflict of interest, Dr. Takala said. What is unacceptable is to take inappropriate action as a result of the conflict. Direct financial incentives, vested interests, patents, study designs deviating from common practice, and lack of access to source data are all examples of areas in which the potential for a conflict of interests exists, he said.

How should the issue be addressed? Full disclosure of conflicts is popular because it provides no substantive change, said Dr. Takala. Instead, he made several recommendations: 1) practice guidelines should be developed by experts who do not have conflicts; 2) source data from completed clinical trials should be made available to an external academic coordinating center for systematic analysis, 3) journals should require statistical confirmation of clinical trial results by external academic sources for all industry-sponsored studies, and 4) research institutes should require unrestricted access to the trial database and unlimited rights to publish the results.

At the close of the keynote address, ESICM President Marco Ranieri stressed that "the Society is working on these issues, and the clinical community is working on these issues. What is important is that the clinical community is reacting and industry is reacting. All are making an effort to rebalance the system." Dr. Takala thanked ESICM "for having the guts to bring this difficult issue to the forefront. It's a bold move," he said, "and this needs to be done."

Improving Care

No one is likely to dispute the fact that healthcare professionals want to improve the care of their patients. However, there are different opinions about the best approach.

Jean Carlet of Paris spoke about what is needed to convince clinicians to change their practice. Many are resistant when it comes to following proposed new guidelines, he said. “They are critical doctors. They are not easily convinced.” Guidelines should be created by a very multidisciplinary group, said Carlet, “if possible including bedside clinicians and not only superstars.” The guidelines should be based on logic and easy to implement.

Derek Angus of Pittsburgh highlighted the need for compromise and openmindedness in the search for ways to implement evidence-based medicine. “There’s almost been battle lines drawn,” he said, “where on the left we have the pro-adoption lobby of people promoting guidelines, identifying and overcoming barriers, preaching safety, pushing bundles” and on the right “there’s this anti-adoption lobby” saying “ ‘We don’t believe the evidence and you don’t need to either. You can rely on your existing knowledge and wisdom.’ ” Angus called this “a paralyzing polarization.” In fact, he said, “there’s room in the middle. . . .You can be skeptical, but still intent on trying to adopt the evidence.”

In the opinion of Philipp Metnitz of Vienna, a huge part of the medicine being practiced today is not based on evidence. In a recently published study, partially supported by ESICM and based on SAPS 3 data (Rothen et al. 2007, “Variability in outcome and resource use in intensive care units”), intensive care units were characterized based on measures of efficiency (the well-established standardized mortality ratio and the newly developed standardized resource use). The authors sought to identify processes of patient care that could potentially be modified. The paper was cited in multiple sessions at the 20th annual congress, with Jean-Roger Le Gall of Paris stating: “I think it is a very good way, a new way.”

With regard to research, Djillali Annane of Garches, France, who is a member of the editorial board of the Cochrane Collaboration, stressed that it is “scientifically and ethically bad to conduct a randomized clinical trial without first performing a systematic review of the available evidence.” Intensive care physicians should be aware that the Cochrane Library is a source of evidence-based medicine in their field, he said. However, although the Collaboration has almost 50 review groups, there is no group specifically devoted to intensive care. Annane suggested that ESICM and the Society of Critical Care Medicine contact the Cochrane Collaboration to discuss setting up an Intensive Care Network within the Cochrane Collaboration, and ESICM President Ranieri pledged that ESICM would take steps to develop a plan. According to Annane, the formation of such a group would ensure that relevant topics are included in the Cochrane Collaboration and that ICU physicians are regularly updated on the evidence-based conclusions of Cochrane systematic reviews.

Communication

There is general agreement that improvements in communication will lead to improvements in patient care, and that a failure to communicate can have drastic consequences in the ICU. Communication problems can occur between staff and patients, between staff and families, among family members, and between different staff members. For example, nurses and attending physicians have very different assessments of the quality of their communication with each other, said Andreas Valentin of Vienna, President of the ESICM working group on Quality Improvement. One study found that 73% of physicians rated the quality of communication with nurses as good, whereas 33% of nurses rated the quality of communication with physicians as good, he said. As pointed out by a member of the audience, a former nurse manager from Pittsburgh, it is difficult to communicate a message to an entire group of nurses because there are so many on staff and they have such varied working hours: “Sometimes a physician would say to me, ‘Well, I told the nurse,’ and I’d say, ‘Well you told

1/79th of the nurses on my staff.’ ” A collaborative relationship between the ICU unit director and the nurse manager can help optimize communication, she said.

Communication with laypersons is also an issue in intensive care. Much health information reaches the public through the print and electronic media. But according to Adrian Frutiger of Chur, Switzerland, “the media usually simplify things.” Although consumer organizations support dissemination of benchmarking data as a way to protect the public from poor performers, this can have disadvantages in healthcare. For example, following publication of risk-adjusted outcome data for coronary artery bypass graft surgery in New York State, broken down by individual surgeons, 59% of cardiologists reported increased difficulty in finding surgeons willing to perform CABG surgery. The media can also be used to raise public awareness of medical issues, however. As part of an interim analysis of the Surviving Sepsis Campaign, Mitchell Levy of Providence, Rhode Island, showed a short video clip from the television series “ER” in which a character refers to the evidence-based guidelines for sepsis. “If ER is talking about us, I think we’re making a difference,” he said.

The future: Preparing for the next two decades

Education

ESICM and its members will certainly make a difference in the field of intensive care in the years to come. Exactly how remains to be seen. Certainly, the Society will continue to play a role in educating intensive care professionals. Graham Ramsay of the United Kingdom, chairman of the steering committee for ESICM’s distance learning program, PACT (Patient-Centred Acute Care Training), announced at the congress that production of the last PACT modules would be completed in the coming months, and that an Internet-based package would be available to new subscribers at a greatly reduced price. The PACT program was designed in part as a tool to help intensivists prepare for the European Diploma in Intensive Care Medicine (EDIC). Two hundred thirty-six candidates took the EDIC exam in conjunction with the congress in Berlin. Dermot Phelan, outgoing chairman of the Division of Professional Development and of the EDIC Subcommittee, said that the Society hopes to integrate an awards ceremony into the congress in 2008.

Building networks and sharing knowledge

Through its annual meeting and its working groups, ESICM provides a forum for intensive care professionals to work together in addressing issues of common interest. This cooperation and collaboration will be crucial should it become necessary to address a global problem such as pandemic influenza. “It’s likely that we’re going to need to work as an overall critical care community rather than as local critical care units,” said Lewis Rubinson of the Centers for Disease Control (CDC). The CDC has no protocols available for noninvasive ventilation, bronchoscopy, or tracheostomies in the case of pandemic flu, Rubinson said. “You all as ICU directors and ICU clinicians are going to be expected to make these decisions based on a lot of uncertainty.” Colin Ferguson of Plymouth, UK, said that there are also almost no guidelines available for allocating scarce resources such as mechanical ventilators. It will be necessary to triage every patient who comes into the hospital, he said, and not all who would benefit will have the option of treatment. “It’s going to be rather like the stock exchange,” he said, “with the stocks of individual patients going up and down, and the physician treating them is going to have to say, ‘I’m sorry, Mr. Snooks, your time is up, and Mr. Gomersall is going to come onto your ventilator now.’”

Rubinson stressed that now is the time to design protocols for prospective randomized studies, to identify peer reviewers willing to return reviews in 24 hours, and to designate journals that can electronically publish research in a matter of days, so that crucial treatment information can be made available worldwide in the event of a flu pandemic. The rules of publication will change during a pandemic, he said. “We need to be a community. We need to get the information out. And sometimes that means sharing information, knowing that you won’t get credit, just that you did the right thing.”

Change

Cooperation is likely to feature in ESICM’s future. But in order for an organization to grow, it must also change. Robert Strack Van Schijndel of Amsterdam pointed out that there are also advantages to conflict. Optimal conflicts lead to creativity, problem-solving and a strong team spirit. If there are no conflicts, you will see no changes. Things will be dull and predictable. “In Holland this is the average post office,” he said.

There have been many changes in intensive care as a profession and in ESICM as an organization over the past 20 years. At the opening session, the third ESICM Society Medal was awarded to Francois Lemaire, one of the society’s founders. “I want the Society to keep that taste for science and that spirit of rebellion,” Lemaire said on accepting the award.

If the new generation of intensivists is anything like the last one, Lemaire’s wish is likely to be fulfilled in the next 20 years.

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