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30th ISICEM: Reflecting on Three Decades of Emergency and Intensive Care Medicine

It has been 30 years since the first International Symposium of Intensive Care and Emergency Medicine was held. The Founder and Chairman of the meeting, Jean- Louis Vincent sat down with ICU Management Managing Editor Sherry Scharff to reflect on the early beginnings of ISICEM and to discuss the future of the symposium and the broader field of intensive care.

S.S.-30 years, three decades… That's quite a long time! Can you believe it?

J.L.V- No, no, no- I can hardly believe that this child – that is the way I think about it, like another child, is thirty! I remember those early days like they were yesterday… I did the completion of my training in critical care medicine in the U.S. under Dr. Weil in Los Angeles (from 1977-1979). Dr. Weil already had quite a successful symposium set up to update all aspects of critical care medicine and when I came back, I recognised that there was nothing similar in Europe, so I thought I should start the same thing here. So without any budget, without anything- I decided that I would plan it for March, and in 1981 I held the first International Symposium of Intensive Care and Emergency Medicine. At that time, it was possible to get some sponsorship from companies, and so I could invite 5 or 6 friends from abroad to join the faculty.

The first symposium was at the Erasme hospital and we used the 200-seat auditorium. In the end it was too small, so we organised a video transmission for another 20-30 people. I believe we were altogether around 250. In the second year, we moved to the University of Brussels, where they have two auditoriums, and we started simultaneous sessions with about 300, 400, 500 people. After a few years we moved to the congress centre in the middle of Brussels, and we continued to grow there until that place also became too small- so we moved the Exhibition Centre just outside the centre of the city.

S.S.- Were you surprised by the success of the initial years?

J.L.V- No, to be honest, I wasn't really surprised because I knew that there was really a need for this. Intensive Care was a new specialty, rapidly growing and ISICEM started at the right time so there was a supply and demand scenario at play. People wanted information and networking and it was available at the right time. It was, in fact, a kind of snowball effect, as the participants grew, so too did industry interest. Every year we had more people, and more industry support, which allows for a better faculty from varying areas, among other things.

S.S.-What sets ISICEM apart from all of the other congresses and meetings?

J.L.V- The key to our success is clearly the high quality of the programme, the low registration fees, the good organisation of the meeting as a whole and specifically of the programme, so that participants have a variety of interesting sessions to choose from at all times. In addition, the talks are relatively shortwe went from 25 minutes to 20 minutes, to now- on average, 15 minute talks, so speakers must focus on their best material, condense their introduction and background and presentation as a whole and that improves the quality and makes the material more "crispy" if you will.

S.S.-This 30th Anniversary ISICEM has returned to the centre of your favourite city…

J.L.V- I am very pleased that the old congress centre could reopen under the name of 'Square' in the centre of the city and is larger than before. Of course it is still too small for us and we need to utilise additional sites as well, but with more than 5000 participants, there really are few congress centres that can accommodate so many people. As intensive care as a speciality continues to grow, so too does our meeting which focuses on this field specifically.

S.S.-How has industry involvement changed over the years and where do you see it going in the years ahead?

J.L.V- Industry support has continued to grow substantially and steadily over the years. In recent years there is an interesting process that has taken place and that is that support and attendance by companies at larger meetings like ours has either been stable, or in our case, actually increased- in fact we have more industry support for this one than last year. But for smaller meetings the support has really dissipated. What

happens is, as you can imagine, when these companies establish their budgets for the next year, they start from the top down with regards to which meetings they will attend and support. Often the smallest, although they are specialised and interesting, just don't make the cut and they are suffering during this period of financial crisis as a result.

I'm not sure how this will follow in the coming years, as I am still continuously surprised at the desire of companies to exhibit in big spaces given the era of Internet and the fact that people can easily find the information on their computers. So perhaps in the years to come the exhibition may shrink somewhat but for this 30th Anniversary meeting, we do not have enough space available for all the companies that wanted to exhibit.

S.S.-Could you reflect a bit on the biggest changes in the field of critical care in general over the past 30 years, and how this has impacted on the topics featured in sessions at the meetings since 1981?

J.L.V- Well, interestingly enough, our specialty has evolved considerably over the years, but in terms of topics- I must say that the challenges in critical care and as a result, the topics featured at our meetings have more or less stayed the same. From the very beginning, intensive care as a field has covered a very broad range of topics from respiratory failure to diabetes via cardiopulmonary resuscitation and neurological aspects… IV fluids, of course have been our bread and butter since the very beginning in addition to topics like shock and its treatment. You may think that topics to do with management, such as cost benefits or budget issues would have expanded over the years, but in fact that is not the case these topics, while important and increasingly so, have never been very popular. In terms of an international meeting, I think this may have much to do with the fact that it is difficult to generalise when it comes to these topics, because of local rules and the like- what may work in Belgium may not be pertinent or effective in the UK or in Spain. It is notable, though, that while the ethical issues have remained popular throughout the years, they have become less so recently. We can continue to teach about these things, of course, but there is little left with regards to progress in this specific area of ethical aspects.

What has become a bigger topic of late is the use of computerised systems. As intensivists who are working in a highly technical environment, we are naturally interested in how to integrate these systems into our units.

If you want to look at the field over time, 30 years ago people were focused on what can I do, such as I can intubate the trachea, I can resuscitate, I can do this, I can do that… Over time, the word "can" started to be replaced by the word "should". Now it is more should I intubate? Should I resuscitate? And of course there are some ethical issues associated with that, but it is also related to the process of care, and how to improve the management of patients.

I think the overall feeling is that we know and understand what to do, but it has become more about how to treat patients in the most effective ways, while avoiding errors and improving communication. Communication wasn't really discussed years ago, now we have pinpointed the importance of these types of things- whether it be how to communicate with the team or families; these issues have become much more important because we recognise that these things improve the quality of care.

Quality of care was not really in the forefront 30 years ago because the core of our field centred on the basic belief that it was natural to do what is necessary to save a life. Resuscitate? Of course! Save a life, no question- it is a good thing. Whereas now, we do sometimes question it, we ask: Did we do the right thing? For example, if we resuscitated a patient, but now the patient remains comatose… Have we made the best choice? What could we have done differently?

Another aspect, which is somewhat related in the evolution of our field over the years is that we tend to do less and less in many aspects. In the beginning, we were quite aggressive with our mechanical ventilators now we try to ventilate gently; we also used to push nutrition on our patients, thinking they need a lot of calories – now we have realised that regardless of the number of calories we give, patients will lose weight and now we refrain from overfeeding them…

It is no longer trendy to do endless procedures either- following the idea that blood is good and serves to bring oxygen to the cells, we used to transfuse patients now we are much more likely to stand back rather than transfuse. With regards to sedation, in the past, the belief was that it was better to keep patients totally asleep in the ICU because of all of the machines and the noise- and this has gone by the wayside in favour sedating minimally; keeping the patients awake so that you can improve the process of care – by communicating directly with the patients. When you sedate, there is a period when patients must wake up from this state, and recover somewhat before they are able to leave the ICU- and this can be a very difficult period, so it is better to avoid this altogether and to try to mobilise the patient and support rapid healing.

With nearly everything, the current thinking is try to do less. This is quite an interesting phenomenon, as in general you would anticipate that people would want to do more and more over the years, but in fact we have found that indeed less is often more. In fact reflecting on the whole field of intensive care, it is challenging to think of any one thing that we do more now than 30 years ago. For all the procedures and treatments we have done, we have rather decreased the intensity of our interventions.

S.S.-Has this been a cultural shift across the field?

J.L.V-Yes, but this is a cultural change based on good science. The studies have shown that often we were harming our patients by over aggressively treating them, and consequently we do less harm by doing less. I am not suggesting, of course, that we withhold needed interventions, I am not saying that we should not feed or transfuse if it is necessary and certainly we must utilise our ventilators when they are required, but I urge gentle usage and restraint.

S.S.-So after 30 years, it begs the question- Will the ISICEM continue indefinitely with you at the helm?

J.L.V-Well, it will continue definitely for the next 100 years, and then I will retire! (laughs) No, I hope that the symposium will continue forever, and despite all of the new developments with regards to information in our modern lives, I think it we will continue to need this kind of meeting, because there is nothing that can replace a face-to-face meeting and dialogue. At the symposium, as we recognise, it is not only in the rooms that networking and dialogue happens, it's also in the corridors or at the bar or restaurant and these informal discussions can bring a lot as well. This is part of why we mix different types of sessions informal roundtables and meet the expert sessions or pro/con debates with the standard presentations.

Some time ago, people were thinking that with the development of new technologies we could stay in our countries and communicate and interact with telecommunications but this has not been the case, because people continue to travel, even in the era of the Internet and I think this need to explore and move outside our daily lives will continue and I am quite confident that the recent past proves this with regards to the high number of participants at the symposium.

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