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## ICU Volume 14 - Issue 3 - Autumn 2014 - Interview

### European Society of Intensive Care Medicine: President-Elect Professor Daniel de Backer

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#### Interview



**Prof. Daniel De Backer**

**President-Elect, European Society of Intensive Care Medicine**

Professor Daniel De Backer is President-Elect of the European Society of Intensive Care Medicine, and takes up his role as President in October 2014. He is Professor in the Intensive Care Department at Erasme University Hospital in Brussels, Belgium.

#### *What Motivated you to Stand for the ESICM Presidency?*

In my daily practice, I combine bedside clinical care, research and teaching, all these being the points of interest of ESICM. In the past I have been deeply involved in ESICM and other scientific societies as I consider that scientific societies are the best most suitable bodies susceptible to promote science and good clinical practice to young as well as older colleagues as well as older colleagues. As a Belgian, living in a small country open to the entire world, I rapidly understood that we should would better think better at the European level rather than at our limited regional/national level. In my past implications roles in the society, initially as National Representative to the ESICM Council, and later as Section Chair and Chair of the Research Committee, I realized what ESICM can bring to its members: opportunities to conduct high level science, promote collaborative projects, provide education and training by the best trainers in Europe, facilitate recognition of a specialty, promote awareness of intensive care medicine among the lay public and deciding decision-making bodies. Accordingly, I decided to apply as candidate for President-Elect, hoping that my experience in previous positions in the Society and other scientific societies, and my position as a renowned researcher and teacher, would be helpful for ESICM.

#### *What Are your Goals as ESICM President?*

- 1./ Encourage research, especially for young investigators. For decades, ESICM members have conducted high quality research. ESICM already offers various awards, and these should be multiplied. ESICM should facilitate mobility of investigators and collaboration of research groups within among its membership.
- 2./ Foster collaborative research (through ESICM Trials group). This trial group is now conducting large scale observational trials. ESICM should encourage this group to conduct large scale randomized interventional trials. Many of our interventions and practices are not supported by strong evidence. Investigator-driven research should grow and be supported by ESICM with the help of regulatory agencies (EC).
- 3./ Promote recognition of intensive care. Intensive care often lacks recognition by national and international (including EC) agencies. ESICM should also facilitate public awareness of intensive care. This would need lobbying and conduction of promotional campaigns.
- 4./ Facilitate teaching. In addition to the already existing facilities (EDIC course, new e-learning platform), ESICM should further extend the use of modern technologies. With the current economic crisis, many members from countries subject to economic restrictions will have more difficult access to existing facilities. ESICM should develop new modes of teaching (using online facilities). In this domain, web-based ICU rounds can be developed, with on-line discussions of cases from various ICUs in Europe.
- 5./ Develop a European diploma for advanced critical care echocardiography. Echocardiography is now part of our daily practice in the ICU. If most physicians now master basic echocardiography, which is now part of the critical care curriculum, advanced echocardiography is still restricted to a minority of experts, even though it can really be used (and is recognized) as a powerful monitoring technique. Recently, I was part of a group of experts representing several scientific societies around the globe, who defined the curriculum for training in advanced critical care echocardiography. In the next few years I would like to settle the bases for a European diploma in advanced critical care echocardiography.

ESICM should be a meeting point for clinicians, with creation of a clinician centre, online discussion of selected cases by renowned ESICM experts, and other related initiatives.

### ***What Are You Most Looking Forward to at the ESICM Congress in Barcelona?***

Once again the annual ESICM congress promises to be a great event, gathering more than 6000 attendees from everywhere around the globe. In addition to the many state-of-the-art meetings, the presentation of several thousand original abstracts covering most fields of experimental and clinical critical care medicine is one of the most important attractions of the congress. Young and as well as confirmed established scientists will present their brand new results and confront present it to the interested and critical minds of colleagues. I remember this important aspect when, as a young investigator, I was presenting my own data to the ESICM congress. In addition to the natural proud pride resulting from presentation of my data in front of renowned scientists, the comments raised were often very useful to in writing my papers.

Finally, Barcelona will be to for meeting colleagues, otherwise often very busy, in a friendly atmosphere.

### ***What Do You See as the Major Challenges for Intensive Care in Europe? How Do we Find Solutions?***

- Collaborative research in Europe: We have a long and glorious history of research performed by individual groups or by groups of friends. In the more recent years, national networks have arisen, but multinational collaborative research in Europe is still lacking. However, this would be absolutely mandatory if we wish to address questions requiring large sample sizes, in observational as well as in interventional trials. In addition, it would also address the issue of external validity of the results, as investigating patients from all parts of Europe would ensure that the results apply to all these.
- Mobility across borders: EU recognizes the right for any worker within the EU to move and work in another EU country. This is also true for medical doctors and specialists. Unfortunately, the intensive care specialty is not recognized as such (either as primary or secondary) by the European institutions. As, in addition, training in intensive care varies widely across Europe, certification acquired in one country is often not recognized in another one. ESICM has long worked on this topic, establishing first the picture of how training is performed in Europe and defining core competencies in critical care through the CoBaTrice program, through the European Diploma in Intensive Care, and working with European recognizing bodies to achieve recognition of intensive care competency.
- Recognition and awareness of intensive care medicine. Lobbying and having ICU survivors proudly testifying the usefulness of ICU.

### ***You Have Wide-Ranging Research Interests. Could You Tell Us About Your Current Research in One of These Areas?***

My main topic of interest for research is circulatory failure, from haemodynamic monitoring, including regional circulations and the microcirculation, to drug and mechanical therapies, including organ support.

These last 10-15 years I have been extensively focused on the microcirculation, being one of the first to describe these microcirculatory alterations in critically ill patients, demonstrating at the bedside the concept of microcirculatory shunt, and evaluating the effects of several potential interventions.

### ***You are Principal Investigator of the Fluid Challenges in Intensive Care (FENICE) Observational Trial. Can You Tell Us More About This?***

This multinational multicentre observational trial was conducted under the umbrella of the ESICM Trials group, for which it was its first large scale trial. This trial included more than two thousand patients in 311 centres in 46 countries. We addressed a very simple but important question: how do physicians conduct fluid challenge at the bedside? In particular, we were interested in defining what are the indications for fluid boluses, how these are indicated and monitored, what are the effects of fluids and whether these were tolerated. We are currently writing the manuscript and hope to publish soon the results soon.

### ***What Do You Think Should Be Priorities For Intensive Care Research?***

No great novelty here, we should continue to try to better understand the pathophysiology of the various diseases that contribute to a significant morbidity and mortality in the critically ill patient, and develop new therapeutic strategies.

Focusing on sepsis, one of my main fields of interest, we should really advance on the different stages: improve recognition, better antibiotic strategies (especially given the high resistance profiles encountered), better initial management (including resuscitation process), and optimize organ support. A crucial point is to understand what makes a patient recover from sepsis. We are often confounded with cases of patients with controlled source of sepsis but protracted organ dysfunction. Some of these patients suddenly improve, some worsen and die. We often fail to understand what are the factors contributing to the improvement or worsening, and better understanding these mechanisms may help to develop new therapies that could help to increase the number of survivors.

### ***This Interview Will Be Published In Our Autumn Issue With a Cover Story on Communication. What Do You See as the Main Issues with Communication in the ICU?***

Communication in the ICU is essential.

Communication within the ICU team has markedly improved, but progress can still be made. Communication with patients and relatives has been a topic of intense research and major improvements have been observed. Opening the ICU to relatives is probably the next frontier. Data support opening our ICUs to relatives, but implementation in practice is often complicated. I recently signed an editorial with Mitchell Levy (Levy and De Backer *ICM* 2013) on the advantages of an ICU open to relatives 24 h/24. We now welcome presence of relatives even during CPR (Jabre *-P et al. NEJM* 2013).

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Finally, communication with the lay public is minimal and contributes to a lack of recognition. Who knows exactly what is an ICU is if not having been confronted with it personally? We daily save thousands of lives throughout the world but do not receive deserve the credit deserved for it.

Published on : Wed, 24 Sep 2014