NEICS Spring meeting – Wynyard Hall – 24th March 2015

The idyllic location of Wynyard Hall was once again the setting for the NEICS Spring meeting. World-renowned speakers from as far a field as Toronto discussed many interesting and thought provoking topics.

Professor Brian Kavanagh from Toronto who did a very interesting talk on 'Treatment of parameters' opened the meeting. In this he spoke about the risks of just trying to normalize physiological parameters and actually ignoring the underlying problem. If we act as technicians rather than thinking as doctors potential harm can come to our patients.

Professor Gavin Perkins from Warwick followed this talk with an up date on mechanical devices and pharmacological treatments in cardiopulmonary resuscitation. Studies have shown there to be no significant difference in 30 day survival or rate of return of spontaneous circulation with mechanical versus conventional CPR. Routine use of mechanical CPR devices is not recommended but there is thought to be a role for them in certain situations i.e. as a bridge to other interventions and prolonged CPR. He also spoke about adrenaline, which has been shown to have benefits in starting the heart but to have adverse effects on the cerebral circulation leading to worse outcomes in patients that have received it. Prognostication in post cardiac arrest should be delayed until 72 hours after the cardiac arrest and that neuroprognostication is the key.

Next up was Professor Harold Thimbleby from Swansea on 'How safe is our equipment'. His key messages were that human errors do happen but the equipment that we are using is not perfect and its faults can lead to errors! Faults are happening all the time but since most get fixed or worked around without reporting, nothing changes. Sometimes things do go wrong, however most of the time they don't. Acknowledgement of errors and learning from them helps to prevent further errors in the future.

Professor Kavanagh then returned to discuss the 'Use and Abuse of Protocols'. He argued that protocols do have their uses for simple repetitive issues, which demand explicit knowledge and minimal variability. However they can be bad in situations, which are more complex and require implicit knowledge and experience (i.e. lots of medicine). Care that works in one sophisticated context might not translate into another. If a protocol is being instituted because of lack of staffing or lack of expertise – consider fixing the primary problem first instead of instituting the protocol. Our patients need all the tools that we have available to us and we shouldn't just blindly follow protocols!

A delicious lunch and the trainee poster presentations followed this. Eleven trainees presented various topics including case presentations, audits and surveys.

Dr Valerie Page from Watford was the first speaker after lunch. She spoke about recognition and management of ICU delirium. Delirium is severely underestimated in critical care and it is bad for the patient both in the short and the long term. Identification of delirium is not always easy. If you don't look for it, you won't know it's there and you therefore can't treat it. Screening should take place in all critical care units. Remember delirium fluctuates over time, so you may miss it, so it's essential to recheck. The key to the management of delirium is to acknowledge its presence and to treat the precipitating factors. Don't forget that drugs are a common cause of delirium! There is no current evidence to support drug treatment to prevent the development of delirium, although trials are underway. For more information go to www.icudelirium.co.uk or www.icudelirium.org

Then Dr Nazir Lone from Edinburgh spoke about the 'Costs of surviving Intensive Care'. There is increasing awareness now that there is loss of independence amongst survivors of critical care post discharge. The cost (financially, functionally and psychologically) of ICU survivorship is more strongly linked to premorbid state than acute factors during admission. Even if you survive to hospital discharge, ICU patients have a 10-30% increase in mortality at 1 and 5 years. Patients > 70 years old with > 1 comorbidity continue to cost substantially more and often don't return to their functional baseline. If it were a new therapy, would ICU be approved by NICE in terms of cost per QALY?

The final session of the day was by Mr Andrew Andrews MBE from London who did an interactive session discussing medico-legal hot topics. The first question surrounded the deprivation of liberty and ICU patients who lack capacity. Most ICU patients do not require deprivation of Liberty safeguards and we can practice according to the Mental Capacity act. The next question focused on end of life issues. There is no such thing in UK law as 'wrongful life'. We have a duty to preserve life, but not to do so officiously. Death is a certainty and the dying process should not be prolonged. Actions to accelerate death remain illegal, but withholding or withdrawing treatment is permitted. The final question concerned issues surrounding organ donation. Legally, organ donation may proceed despite family objections if the person is on the organ donation register. However, UK practice is to gain assent and agreement from the family. The final point from the discussion was that if it's not documented it didn't happen so don't forget to document everything you do!

Thank you to all the committee for organizing a very successful meeting and I'm looking forward to the NEICS Winter meeting at the Freeman hospital on 20th November 2015!

Dr Jane Gibson
NEICS Trainee Representative