Newsletter 2000

SICS Annual Scientific Meeting 1999

The Society's eighth annual scientific meeting was organised by Roger Hughes and Nigel Leary, and was held on Friday 30th January 1999 in the Postgraduate and conference centre at Stirling Royal Infirmary.

The change of venue from the University was necessitated by an anomalous booking and had advantages and disadvantages. The lecture theatre was comfortable with good acoustics, and had good facilities including computer projection. Altogether it was a friendly and comfortable venue but it was unfortunate that there was not more space for lunch and for trade exhibitors. These were crammed into the same area; however this may have contributed to the fact that the many trade exhibitors to whom I spoke felt that they had had a good meeting, with lots of interest from delegates! Parking was problematical; some of those who drove down from the hotel ended up walking further than those who opted to walk in the first place!

A satellite meeting on ARDS in the Stirling Royal Highland Hotel took place on the Thursday afternoon preceding the meeting proper; and a report of this appears later in the newsletter. The programme followed the tried and generally approved format of some plenary lecture sessions and

a choice of workshops and case presentations. It was well balanced with local and international speakers, and whilst including some news of cutting edge research, it concentrated mainly on subjects that were of topical and practical interest to clinicians working in the field.

The meeting was opened by Nigel Leary who presented details of the latest programme change of which there had been several since the previous afternoon. It was miraculous that he had any hair left by that stage! I hasten to add that none of these changes occurred as a result of poor organisation by the committee, but occurred as a result of various speakers' changing work commitments and flight arrangements. Dr Howie then introduced Dr Rachel Green, Director, West of Scotland Blood Transfusion Service who wryly observed that she was the 'warm-up' act for Jean-Louis Vincent speaking after her. She did however far more than just this, and outlined the problems (or rather, lack of problems) with albumin, gave us a quick run down on current thoughts relating to CJD and variant CJD in relation to blood products, and produced a resume of the 1996-97 SHOT (Serious Hazards of Transfusion) report. This latter included the incidence of serious transfusion reactions and the incidence of HIV, HCV and HBV infection found in donated blood. She concluded by outlining the problems facing the BTS as we move into the new century, but ended on a reassuring note by telling us that all British blood products would be leucodepleted (at phenomenal cost) by the end of 1999.

Having thus warmed us up, Dr Green then introduced Professor Jean-Louis Vincent from Brussels who was scheduled to speak on, "Haemoglobin Replacement - What Threshold, Which Solution", and he did just that.

He started by suggesting that we transfuse patients too readily and suggested that we might reset our threshold for transfusion to a lower value and relate it more to measurable changes in the patient's physiology than to an absolute figure. He then addressed the thorny question of blood transfusion and immunosuppression, outlining the evidence in terms of increased transplant survival, tumour recurrence and infection, concluding that most of the problems appear to be related to leukocytes in transfused blood. It sounds as if the cost of leukodepletion of blood for transfusion in the UK may prove to be money well spent. Before closing, Professor Vincent gave us a quick history of the use of bovine blood haemolysate and of polymerised pyridoxilated haemoglobin solutions and concluded with a discussion of the relative values of nitric oxide scavenging solutions Vs non-scavengers.

It has to be said that whilst Professor Vincent always speaks with great erudition and with great clarity, it would not matter two hoots if he did not, as his delightful accent, his extrovert style and expressive gestures always make it a treat to be in his audience!

Dr Chris Garrard then treated us to a dissertation on ICU acquired pneumonia. This was a very well balanced talk, touching on research showing the protective effect of anti-IL10 in mice with pneumococcal pneumonia, a quick review of current research in the cytokine field as it relates to ventilator acquired pneumonia and a brief sortie into clinical infection scores. This was followed by lots of useful practical information about bronchial lavage and the microbiological interpretation thereof and an evaluation of measures to reduce ventilator acquired pneumonia.

It should be noted that during the previous night's dinner Dr Garrard had also demonstrated an authoritative knowledge of Chicago architecture, a city in which he spent some years before returning to Oxford.

Professor Joachim Boldt seemed to have suffered all the travel related ills that can befall a man endeavouring to get from Ludwigshaven to Stirling, including late planes and a visit to Manchester

en-route. Unfortunately he did not arrive until after the meeting-proper was over, and the audience had been much depleted - indeed Cameron Howie was winding up the meeting when Professor Boldt appeared behind him! It was a great shame that this speaker had so many problems reaching Stirling as when he did arrive, he delivered a very well thought out and carefully rehearsed talk on that thorny old question - 'Crystalloids, Colloids or Albumin' in relation to hypovolaemia, coagulation, side effects and finally how to divine the optimum volume of replacement.

The Workshops were as popular as always. There was standing room only at that on Prone Ventilation, sponsored by Hill-Rom which was presented by Jane Clayton, David Down and, Phil Haji-Michael, from Manchester. This was a very popular choice with delegates from the nursing profession, not only because there was a bit of knock-about comedy when we were shown what could go wrong when attempting prone ventilation, but also because the presentation combined a short review of the underlying principles with a demonstration which clearly revealed a lot of practical expertise.

The Case Presentations were held in the main theatre as they invariably attract a large audience, as they did on this occasion. Chaired by Graeme Nimmo and Chris Garrard, these were well presented by Philip Korsar and Sandy Binning. They were made all the more interesting by being interactive, a facility made available to us by Baxter Healthcare, and were attended by some fairly searching questions about management (a wonderful thing, the retrospectoscope!). It takes courage to 'bare one's chest' (clinically speaking) in public, and the presenters showed this quality admirably.

Evidence-Based Intensive Care is a topical and, rather difficult subject that was explored by Professor Nigel Webster in another workshop. Despite being asked at very short notice, Prof. Webster gave an open, balanced overview of evidence based practice as it relates to several areas of current interest such as ARDS treatment strategies, administration of albumin and the role of pulmonary artery catheters. He also presented an excellent critique of metaanalysis, outlining potential pitfalls.

Dr Richard Beale, in the workshop on immunonutrition, (sponsored by Novartis) reviewed the published literature, and concluded that whilst it was cost-effective practice in that it reduced infection and shortened hospital stay it did not reduce overall hospital mortality.

After the meeting, the AGM of the Society was held, and was rather better attended than it sometimes has been in the past. This was followed by a most enjoyable dinner and then a valiant attempt by David Swann and I, in the company of several other revellers, to drink the bar dry of Laphroaig. I don't think we were successful, but a very good time was had by all, and many formerly well guarded intensive care secrets were revealed!

Overall the meeting was well received, but we will, for reasons of space, return to our usual venue in Stirling University conference centre for the meeting in 2000. After last year's difficulties over getting speakers from abroad to the meeting in time, our next meeting will have greater emphasis on home-grown talent!

Poster exhibitions

The poster exhibition was smaller this year than usual, but was certainly not lacking in quality. Among the more interesting posters to me were:

"Assent for Patients in the Intensive Care Unit", from a group at Aberdeen Royal Infirmary (and a visiting clinician from New South Wales.) and "Patients' Memories of the Intensive Care Unit", by Stephen Marjoribanks, also of Aberdeen Royal Infirmary.

There was an elegant & erudite poster from the Western Infirmary, Edinburgh entitled, "Brain IL6 Production during SIRS is of Extra-Neural Production" and a group from Edinburgh Royal Infirmary presented a poster on "Femoral Artery Bolus Thermodilution Cardiac Output in the ITU"

The prize was won by the beautifully presented poster by Stephen Marjoribanks.

ARDS satellite symposium

The Audit Group was initially contacted by Zeneca Pharmaceuticals who were seeking collaboration with ICUs to provide baseline data concerning resource usage by ARDS patients. Following several meetings, the Company confirmed its interest in using the 'impressive' Scottish database to achieve goals which would be beneficial to both the Company and the Society. To this end Zeneca sponsored the Satellite Symposium held on the evening preceding the Annual Scientific Meeting.

The aims of the symposium were to provide an up to date review of ARDS in terms of epidemiology, pathophysiology and therapeutic strategies, and to outline a projected, prospective, observational study of ARDS utilising the SICS database. Three eminent clinicians, Professor C Hasiett, Professor of Respiratory Medicine in Edinburgh, Professor N R Webster, Professor of Anaesthesia and Intensive care in Aberdeen, and Dr IS Grant, Director of Intensive Care at Edinburgh's Western General Hospital provided us with the fruits of their research and their knowledge. The symposium was well-attended and received with great interest.

Installation of modified Ward-Watcher software, which enabled both identification of ARDS patients and prospective daily data collection on them began in May. At the time of writing, the study is proceeding well. Although identification of ARDS patients will cease in the New Year, data validation and collation of additional data by Audit Group staff will continue well into 2000, and it is hoped that the report will be issued that summer.

The success of this study is due to the diligent data entry by ICU staff (both nursing and medical). Our appreciation is extended to Astra-Zeneca for their continued support in what should be a very worthwhile project.

Fiona Mackirdy Project Director, Scottish Intensive Care Audit Group.

Reports from the regions

South east of Scotland Intensive Care Society

The first session of 1999 was at the Western General where Dr Bellingan discussed the proliferative phase of ARDS, with other contributions from Neurosurgery and ICU on Meeting the Needs of Relatives. At the Royal Hospital for Sick Children in April, Dr Dave Simpson kept us up to date with the Scottish Paediatric Intensive Care Audit and we had a lively discussion on the Use of Early Haemofilration in Meningococcal Septicemia. Moving on to St John's, Livingston, in May, we discussed the Appropriate Management of Severe Burns of the Neck as well as Hebert's article on Transfusion Practice in the Critically ill and a short report on Iron Poisoning. In August, at Melrose,

we discussed the Management of Trauma and in October at the Queen Margaret Hospital, Dunfermline, we were treated to some unusual case presentations - Sodium Valproate poisoning and Unusual Infections Following Dog Bites. The year concluded with a November meeting at the Royal Infirmary, Edinburgh when we achieved some consensus in our debate on How Best to Feed the Critically Ill and on the Merits of Immunomodulatory Feeds. Meetings of the Group are usually very well attended and discussion continues unabated after the main meeting in a local hostelry.

West of Scotland Intensive Care Society

The 98/99 session was particularly successful for the West of Scotland Intensive Care Society. Once again there was an increased membership with good attendance at all the meetings.

Excellent presentations were made by Dr John Griffiths on Nutritional Support in ITU and Dr Andy Webb on the Optimal Resuscitation Fluid for use in the Intensive Care Unit, but arguably the highlight of the calendar was the Registrars' meeting at which there were three presentations of extremely high calibre, ranging from a snapshot of intensive care medicine in Malawi, the management of a patient with HOCM and sepsis and discussion on inter-hospital transportation of patients.

The first meeting of this session was held on 18th November at which Mr Giles Peek form Leicester introduced the concept of a national ECMO centre for adult patients with ARDS, and discussed previous trials and results and the forthcoming trial sponsored by the Home and Heath Department.

Forthcoming meetings have been provisionally scheduled for 22nd February (Registrar presentation evening) and 6th April (discussion of medical ethical issues in the ITU).

The meetings are preceded by a buffet supper, and non-members from all non-anaesthetic disciplines are particularly welcome.

Editorial-the end of the beginning

Alf Shearer decided that the Scottish intensive Care Society needed a newsletter, and as so often when someone has a great idea, he was encouraged to get on with it. The result was Newsletter No. l published to great critical acclaim in January 1996. Alf has worked very hard (I now know how hard!) to produce a newsletter every year since. I marvel at his ability to gently persuade colleagues to write things for him, to grasp so well what should be in the Newsletter and what would be better left out, and to pull it all together in time for the Annual Scientific Meeting deadline each year.

I do not know if he decided that it was no longer a sufficient challenge, or whether he had just plain "had enough", but he handed over the responsibility to me last year. I shall try hard to justify your trust Alf! Not having known Alf for very long, I did not feel up to writing an appreciation, so Ian Grant was very happy to do so.

Dr Alf Shearer-a note from Ian Grant

The Scottish Intensive Care Society Newsletter is now in its 5th Annual edition as a conduit of news to members of the society. We are tremendously appreciative of Alf Shearer's work in establishing

and developing it. The newsletter is of course only a small part of Alf's contribution to Intensive Care in Scotland over the 20 years since he was appointed Consultant in Ninewells Hospital in May 1979.

He was a pioneer of computerised intensive care audit, establishing a computer database on a Sirius computer (remember them? - 16bit, 128k RAM, twin 51/4 floppy, 1.2 megabyte disc drive) in 1984, and later extended his data-base to include the follow-up to one year after ICU discharge through his locally designed 'CRAFT' system. One of many results of the Dundee ICU audit was the prize-winning presentation at the 1997 Intensive Care Society meeting which suggested that increased ICU workload was associated with increased mortality.

With the advent of percutaneous tracheotomy, Alf used the Surgical Skills Centre at Ninewells to establish a course on the technique, which is popular with intensivists from all over the country. Another very practical contribution benefiting us in the Western General ICU in Edinburgh has been the 'SRIVID' slide rule which nurses use to control blood sugar in patients receiving TPN. This a very labour-saving device for medical staff - no more sliding scales to re-write, and it controls blood sugar very well into the bargain.

It is also worth reminding readers that Alf Shearer's role in the birth of this society was pivotal. He was the organiser of the first Scottish intensive care meeting, sponsored by Lilly, which was held in January 1988 in Perth. This led to the formation of the Scottish Intensive Care Society three years later. That first meeting - on infection in the ICU - had celebrities such as the late Gillian Hanson and Iain Ledingham as well as local speakers.

One has a shrewd suspicion that, having finished his stint as editor of the Newsletter, he will re-appear in a new and equally important role in Scottish Intensive Care. Many Thanks Alf.

Percutaneous Tracheostomy Course

The Departments of Anaesthetics and Otolaryngology, and the Surgical Skills Unit in Ninewells Hospital and Medical School Dundee, have developed a one day course on Percutaneous Tracheotomy Under Endoscopic Control.

There are 2 courses per year, usually in May and November. Since the first one in 1996, there have been 9 courses with a total of 87 participants. These have included 55 anaesthetists, 31 ENT surgeons and 1 general surgeon. Twenty four were consultant career grade, and 55 trainees. Fifty three came from outwith Dundee and of those 34 came from outwith Scotland. It is predominantly a practical course with 1 trainer to 2 participants. After an initial introduction and training/refreshing on the use of the bronchoscope they are introduced to the percutaneous tracheotomy kits on basic models. Alternating the role of operator and endoscopist with a partner, each participant then has the opportunity to perform 4-6 tracheostomies with each method on a realistic model.

The methods taught currently are the Giggs forceps method (Portex kit) and the Ciaglia serial dilator method (Cook kit). The Ciaglia single tapered dilator method may be introduced in the next course, depending on clinical experience with the method in Dundee.

The courses to date have been sponsored by Kari Stortz, Sims Portex ltd and Cook UK Ltd.

The next course is to be held on 24th May, 2000 and will accommodate 10 participants.

President's report

Inevitably a time for reflection without giving an impression of self satisfaction. In the two years of my presidency I believe we have continued to progress as a society. Well established undertakings such as postgraduate courses driven by Dave Swann, and the newsletter, now in Bill Easy's capable hands, have continued apace.

The audit has diversified with a separate research group established and a funding base generated by collaborative research done in conjunction with both Zeneca and Glaxo Welcome. A separate group has now been established to make a study of ICU deaths utilising some aspects of the SASM methodology. With the ARDS study now nearing completion Fiona will be undertaking a quality of life follow up on the survivors. Simon MacKenzie continues to nurture the diagnostic list conceived almost one year ago. He is now working with ISD, with the intention that the audit facility will generate an ICU SMR return. This will allow the contribution of intensive care to national priority areas such as cancer to be fully recognised. In the wake of the Audit Commission Report on intensive Care in England and Wales, I was contacted by two newspapers. I described the success of our adjusted outcomes, compared with those published by the Audit Commission. Sadly a good news story is not a story in the NHS as far as the media are concerned. In general I think Scottish Intensive Care is a good news story.

Much thought and a little effort has been expended on developing a web site for the society (scottishintensivecare.org.uk). We have been guided in this by Steve Kettlewell, a fine chap in spite of his surgical background, who has already set up a breast cancer site. Like stars in the night sky this is an undertaking which appears to offer more and more opportunities the more we look at it. To date we have a site established with funding support in place from Bayer Pharmaceuticals. The newsletter and the annual audit report will be displayed and we will advertise forthcoming, meetings, moving towards offering registration on line. I am currently attempting to 'commission' work for a number of individuals on aspects such as the history of the society, guidance for trainees aspiring to a career in intensive care and the origins and early development of intensive care in Scotland, to which end I am seeking the names of medical staff who were involved in this and who might be able to provide impressions of that period.

If you have any suggestions regarding the site, or would like to contribute, please contact fiona@scottishintensivecare.org.uk.

I believe the web-site will offer us improved communication with our members in a far more interactive manner than has been the case to date and possibly a mechanism for interacting with patients, where it could offer both information and an opportunity for patients to communicate their experiences. Finally we intend to have the site offer a gateway to other relevant sites. Other ideas will be welcomed. Our intention is for the site to be self-funding; however, once fully established, it may offer revenue opportunities to further underpin our research activities. At present we have not attempted to limit access to the site so that all 'publications' will have to take this into account.

At the time of writing, the programme for the Annual Scientific Meeting has been published thanks to Louie Plenderleith, with some help from friends. Quite by chance, this year we do not have the usual smattering of international "stars". Over the years they have enhanced our meetings, though not infrequently requiring last minute programme adjustments to accommodate late travel changes or in some cases "no show". Consequently the forthcoming meeting should run like clockwork? I

don't think I will ever forget attempting to bring the last meeting to its conclusion as Professor Boldt appeared behind my back.

At long last we appear to be at the brink of an operational Bed Bureau for Glasgow. The most recent stumbling block has been the creation of the NHS Net which has precluded communication of Trust computers by modem. Although it was anticipated that the Glasgow Trusts would be connected to the NHS Net by the summer of this year, at the time of writing the connection is incomplete. However concerns over intensive care services around the New Year period have had the benefit of priortising this area of work, and it is possible that a functional bed bureau, communicating through a secure network, may be in place soon.

I now hand over to Peter Wallace. Though, unlike me, the presidency of our society might not appear to be the pinnacle of his career to date, I know how delighted he was to be invited to take it on. He brings unrivalled experience at a time when a distinct identity for intensive care in Scotland is so important in the context of devolution.

Finally thank you to all my colleagues in ICUs across the country who invariably took on, with enthusiasm, the additional work, that underpins the burgeoning activities of our society.

Cameron Howie

Annual audit meeting 1999

The Scottish Intensive Care Society Audit Group (Ah... that wonderful acronym!) has relied heavily on the talents, hard work and not inconsiderable charm of Fiona MacKirdy not only for the collation and verification of the data which makes our database of patients the biggest in Britain, but also largely for the organisation of the annual audit meeting. This load was initially shared by Mark Livingstone, later by Sandra Donaldson, and now by Jane Ross, research sister, to whom I am indebted for this summary of the last meeting.

The Society's 5th Annual Audit meeting was held on Friday 29th October 1999 at the education and Conference Centre Stirling Royal Infirmary. The audit meeting was sponsored by Glaxo Welcome, which enabled the nursing delegates to attend free of charge.

Cameron Howie opened the meeting with an introduction to the first of two hot news items, the recently debated 'Consent in Incapable Adults" Bill. He explained that the Society had been in discussion with the Scottish Office in relation to proposed legislation on the treatment of incapable adults. Broadly speaking the legislation was welcomed, in particular bringing clarity to the issue of consent provided by relatives for research in intensive care. However, things are not finalised yet, and Cameron will continue to represent our interests and those of our patients at the (now) Scottish Executive.

Simon Mackenzie discussed linking data from the SICS diagnosis list with the information and Statistical Division (ISD) at the Scottish Executive. The adoption of new diagnostic classifications for Scotland had first been suggested at the 1997 meeting with the aim of improving the inadequacies of the current 'APACHE' classification in describing Scottish case mix and hospital coding. Since then the diagnostic group have met and developed a hierarchical diagnoses system, which has now been included in Ward Watcher. Simon discussed this system and proposed two modifications that will help alleviate some of the coding confusion. These are firstly, to add the diagnoses that have been most frequently found to be missing, and secondly, to add an 'Other' option for infrequent

diagnoses. He reminded us that use of this latter should be rare as it makes subsequent searching of the database less satisfactory. These diagnostic modifications will be available with the next software update. Simon then reviewed the establishment of links with ISD, a requirement for the Audit's continuation of central funding. He reiterated the importance of improving ISD data that describes intensive care, perhaps with the addition of ACP fields from Ward Watcher to the SMR 1 return, but intimated that automating the SMR 1 returns is still some way off.

The third speaker of the morning, John Kinselia, introduced us to the SICS Research Group, as yet in its infancy. He proposed that this would be a resource and registry for multi-centre clinical trials within Scottish ICUS. The group, which currently includes John Kinselia (Glasgow), Simon Mackenzie (Edinburgh), David Noble (Aberdeen), Mark Worsley (Stirling), lan Grant (Edinburgh), John Colvin (Dundee) and Fiona could provide advice on study design and ethics approval application. Financial support for agreed projects might be forthcoming from SICS funds that have been generated from sponsored SICSAG studies. It was suggested that it would be of value to have a clinical nursing member in the group; any ICU nurse who may be interested should contact Dr Kinselia directly at the Glasgow Royal Infirmary.

Simon Mackenzie then returned for his second performance of the day and presented a proposal that a group within the Scottish Intensive Care Society should conduct selective external case note reviews of mortalities. The process would be not unlike the Scottish Audit of Surgical Mortality. We were reminded that case note review was discussed in the early days of the SICS audit and was also included in the current CRAG funding application. The proposal was for a three-stage process.

1.Identification of patients for review.
2.ICU comments on a clinical form relating to care given and adverse events.
3.The external review.

This proposal generated plenty of discussion from the floor with particular reference to the potential workload. It was suggested that any unit should be able to opt out if they felt that their workload was too great. It was emphasised that this would be a valuable quality exercise in clinical ICU practice.

After lunch Cameron Howie introduced 'League Tables Revisited', and this stirred discussion in the light of the second hot news item of the day, the Audit Commission's Report, 'Critical to Success'. In contrast to comparable data published in this report relating to 50 English and Welsh ICUS, our analysis of the SMR tables for ICUs in Scotland for the years 1996 to 1998 demonstrated a strikingly narrow range. Cameron then went on to discuss the follow up of our study into hospital deaths following ICU discharge. Previous results had demonstrated that this peaked within 48 hours of ICU discharge. The data have now been examined in relation to expectation of likely survival and expressed intention in relation to readmission. This demonstrated a remarkable stratification with a 5% mortality in the group expected to survive who would have been readmitted if necessary, compared with a 75% mortality in the group expected to die who would not be readmitted. It was suggested that this categorisation would facilitate meaningful audit of this population.

Dr Martin Hughes spoke next reviewing the current prospective, observational study in ARDS patients in Scottish ICUS. He explained the methodology used and presented preliminary, provisional analysis of the subject set to date. The results discussed were generated on data collected on the day of the diagnosis. As expected, isolated respiratory failure accounted for 30% of patients with 70% having two or more organs failed. The mean ICU stay was 12.2 days, with an ICU mortality of 54.5%. This critical analysis would appear to show a mortality for Scotland which is higher than that

in recent publications from elsewhere. Martin went on to examine these publications and discussed subject selection, methodology and analysis of them. He concluded that the mortality would be similar if the same criteria had been used.

Stephen Noble gave the first presentation of the 'renal' section. He reminded the audience of the earlier Renal Respiratory Failure audit, which looked at outcomes of patients receiving renal and respiratory support in Scotland. His presentation then continued with the results of a survey of the structure and process of renal replacement therapy (RRT) in Scottish ICUS. The survey took place across 19 ICUs providing RRT at that time and included audit data of RRT activity between July 1998 and June 1999. Research Sister Jane Ross administered a structured questionnaire to one consultant per unit. The results showed an incidence of RRT within the time period of 5.17%. Modalities varied widely as did the RRT techniques used. There was an absence of formal protocols and audit therapy. The predominant techniques were continuous or intermittent haemofiltration (CVVH/IVVH) and the commonest anticoagulant, heparin, which was perceived as cheap, convenient and effective.

Jane Ross then presented the nursing aspects of the renal survey. She examined by questionnaire the education of ICU nurses in RRT, their role in the therapy and finally specific aspects of renal patient care. In 3 units renal support was still provided solely by renal nursing staff and this had a noticeable effect on job satisfaction, finances and staffing levels within the renal department. Education and training was seen as essential in the establishment of ICU based RRT and was predominantly clinically developed. There was a definite void in the provision of professional certified courses since the abolition of Professional Studies courses. Patients care styles varied across the units and the increasing use of support workers in the provision of the therapy was noted. Jane concluded that ICU nurses had generally incorporated RRT into their role and showed a keenness to continue the development.

The final renal session before coffee, was delivered by Dr Paddy Gibson, Renal Consultant who entertained us with his talk entitled "The Old and New In Renal Anticoagulation" He explored the idea of an ideal anticoagulation regime and discussed those available at the moment. He then introduced several new pharmacological and non-pharmacoiogical therapies, from citrate infusion to pre-filter saline dilution. Paddy stressed that there were limited objective clinical studies to help clinicians in their choice of anticoagulation therapy and concluded that the best solution was to stick to what works for you and for your patients.
Brian Miller rounded off the afternoon with an open session entitled 'Searching and Reports using 'Wardwatcher'. Brian guided the audience through various searching processes and provided a booklet for delegates to take back to their units. More copies of this can be obtained from Fiona or Jane on 0141 201 5271. He suggested that the next software update would give much more expanded and sophisticated searching and reporting facilities.

Fiona closed the meeting by thanking all speakers for their contributions and GlaxoWelcome for their sponsorship.

Training in Intensive Care Medicine

Training in Intensive Care Medicine has been run under the umbrella of anaesthesia for 30 years. Whilst it requires restructuring, it has not, contrary to what some would have you believe, just been invented!Training has recently been in turmoil, with conflict between the Intercollegiate Board for Training in Intensive Care (ICB) and the Royal College of Anaesthetics (RCA). Some may wish to represent this as an attempt by the College to turn back the clock, but I believe that most intensivists

in Scotland would see it as a return to reality. Over 90% of consultants working in intensive care in Scotland are anaesthetists, and the vast majority of trainees wishing to pursue a career in ICM choose to do so through anaesthesia. The direction taken by the ICB was in danger of destabilising current training arrangements. However a multidisciplinary approach is generally to be welcomed, improvements need to be implemented, and much of the work of the ICB has been positive. Nevertheless an agenda which discriminates for a very small minority of trainees does not, I believe, carry the support of the majority of Scottish intensivists - the silent majority. The activity of whose members, not all of whom practice intensive care medicine, requires to be brought back into balance. Some Royal Colleges may have an interest in controlling training that is disproportionate with their clinical contribution. Intensive Care Medicine continues to develop towards an independent speciality. While intensive care remains, de facto, a sub-specially of anaesthesia let us hope that progress can be orderly. Meantime, trainees should consult with their Regional Advisors of both the ICB and the RCA.

SICS Intensive Care Medicine courses 1999

After an initial flurry of courses, your Council have decided that there are probably not sufficient potential delegates to hold courses in each centre every year. A course was therefore not held in Aberdeen in 1999. However, two courses were held during the year, in Edinburgh in June, and in Glasgow during November. Each course had 19 students ranging from SHO to Consultants. As usual , anaesthetics was the primary specially for all the students. The format of the courses was unchanged using a mix of lectures, workshops and symposia. In addition to what might be considered to be 'core topics' the Edinburgh course covered community acquired pneumonia, pancreatitis and electrolyte problems in the ICU, whereas the Glasgow course also encompassed the use and application of evidence-based medicine, which stimulated much interest.

Since the Society has now run seven courses in more or less the same format, it was decided to invite an educationalist to do a SWOT analysis of the Glasgow course. Melanie van der Woning is based at Wolverhampton University, has a critical care nursing background, and is heavily involved in other areas of medical education such as ALS courses. Her report, to David Swarm was generally very complimentary, but did identify some points that would benefit from fine-tuning.

The success of these courses depends on all the contributors, but especially on those who come and teach. In 1999 this was a total of 33, and their hard work is gratefully acknowledged by the Society. Plans are already in hand for two courses in 2000; the first in spring or early summer in Edinburgh, and an autumn course in Dundee, organised by Sally Crofts. Anyone wishing to participate as a student, or, especially as an instructor, should contact Sally in Dundee or David Swann in Edinburgh.

The Scottish Intensive Care Society

The Society was formed in 1991 and now is not only a forum for intensivists (and let's not forget the anaesthetists with an interest in intensive care), but also the organiser of a number of professional meetings a year. It forms the focus for audit of the speciality in Scotland, the catalyst for the creation of an intensive care bed bureau, and will become the lynch-pin of multi-centre intensive care research in the country. There are now 216 members, who are represented by colleagues who are elected to the Council of the Society from all parts of the country.

The Council comprises: - the president who serves for 2 years; the immediate past president who gives way after one year to a vice president for one year; eight regional representatives who serve for two years and may be re-elected for a second term in office, following which they may not be re-elected for a further two years; and other non-voting members invited by the council for specific purposes. The treasurer/secretary is elected by the council from amongst its members and serves for three years. The workload of this position is such that the posts will in future be separated.

The Council is currently comprised of:

President : Dr JC Howie, Glasgow, Victoria Infirmary (1998)
Also :Audit Organiser, SICS
Representative for Anaesthetics and Intensive Care on SSMAC

President Elect : Dr P Wallace, Glasgow, Western Infirmary (2000)
Also : Honorary Secretary, Assn. of Anaesthetists
Member of Committee on Training in Intensive Care Medicine, Royal College of Anaesthetists
Member of Joint Committee on Good Practice, Assn. of Anaesthetists and the Royal College of Anaesthetists

Treasurer/Secretary : Dr NP Leary, Melrose, Borders General Hospital (1 997)

Regional Representatives:

North

Dr Ian Skipsey, Inverness, Raigmore Hospital (1998)
Dr David Noble, Aberdeen Royal Infirmary (1999)
Dr Sally Crofts, Ninewells Hospital Dundee (1999)

East

Dr David Swann, Edinburgh Royal Infirmary (1996)
Dr Alastair Mackenzie, Dunfermline, Queen Margaret Hospital (1997)

West

Dr Roger Hughes, Victoria Infirmary Glasgow (1996)
Dr William Easy, Vale of Leven Hospital (1997)
(Also newsletter Editor)
Dr Louie Plenderleith, Western Infirmary, Glasgow (1998)

Forthcoming meetings

May I remind you of the forthcoming meetings:

- The Annual Scientific Meeting, followed by the AGM and a good dinner at the end of January each year.
- The Annual Audit meeting, usually in October.

Also:

- The ICS (UK) Spring Scientific Meeting in Harrogate on 11th - 13th May.
- The ICS and Riverside Group Meeting, usually in London in December,
- The Critical Care and Anaesthesiology Meeting in Montreal, Canada, starting June 3rd.
- Finally there are the regional meetings in the West and East of Scotland