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Ageing Population

Lessons From the "Very Old Intensive Care Patients" (VIP) Project, *H. Flaatten, B. Guidet, D. deLange*

In Search of a Crystal Ball: Predicting Long-term Outcomes in Critically Ill Older Adults, *S. Jain, L. Ferrante*

Nutritional Management of the Critically Ill Older Adult, *O. Tatucu-Babet, K. Lambell, E. Ridley*

Unmasking the Triumphs, Tragedies, and Opportunities of the COVID-19 Pandemic, *J. Patel, D. Heyland*

What Intensivists Can Learn From Geriatric Medicine, *A. Reid, P. Young*

Ageing and Critical Illness: What Does Quality Care Look Like? *C. Subbe, C. Thorpe, R. Pugh*

Lessons from COVID-19: ICU Preparedness, Ethical Issues and Digital Congresses, *JL Vincent*

Predicament Prevention for Pandemics, *A. Michalsen*

Challenges in the Management of Severe SARS-CoV2 Infection in Elderly Patients, *O. Perez-Nieto, E. Zamarron-Lopez, M. Guerrero-Gutierrez et al.*

Vitamin D in Critical Illness – Fifty Shades of VIOLET, *K. Amrein, P. Zajic, M. Hoffman et al.*

Angiotensin II in Post Cardiopulmonary Bypass Vasoplegia - The Experience So Far, *N. Cutler, J. Signorelli, P. Wieruszewski et al.*

Promising Techniques in Sepsis After Cardiac Surgery, *G. Paternoster, Á. Nagy*

Microtools to Identify and Resuscitate Microcirculatory Dysfunction in Critically Ill Patients, *M. Hilty, C. Ince*

The Future of Critical Care: The Human Capital, *S. Ho, A. Wong, A. Butnar, M. Malbrain*

12

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Lessons from COVID-19: ICU Preparedness, Ethical Issues and Digital Congresses

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The COVID-19 pandemic has brought the world to a standstill. What has been your experience as a critical care professional during this time?
This has been a testing time for all critical care professionals, and indeed all healthcare workers, around the globe. There is no doubt that intensive care teams have done a superb job during this crisis. I am not speaking only about doctors of course, but also nurses, physiotherapists and other healthcare practitioners. It has been a very stressful situation, but our teams have dealt with it extremely well. We can be proud of ourselves.

To what extent do you think the setup of ICUs is likely to change after the COVID-19 crisis?
We have learned a lot about ICU organisation: we managed to open more ICU beds, including in other areas of the hospital, such as coronary care units, recovery rooms or even operating rooms, to increase capacity. We received a lot of help from other hospital sectors, who provided nurses and doctors to help our ICU teams. We developed new systems for respiratory support (some even using car parts); for keeping and organising material at the bedside; for communication, using walkie-talkies rather than telephones, and providing virtual visits for some relatives. We also increased the use of telemedicine and distant consults. Many of these aspects will continue after COVID-19.

How do you compare the COVID-19 management strategies used in Belgium versus other countries in Europe? Do you have any examples of strategies that were successful and those that failed?
I think that globally people did the best they could under exceptional and unprecedented circumstances. In Belgium, as in several other countries, we had too many deaths in nursing homes, but we had no major 'flooding' of our Belgian ICUs, as was clearly seen in other countries, such as Italy, France and Spain, and managed to keep our ICU mortality rates relatively low.

Were there any major ethical issues?
Definitely. Ethical problems were present almost everywhere. We were sometimes criticised for denying ICU admission for some elderly patients coming from nursing homes, but these were usually wise decisions. We had to make difficult choices. Ethical guidelines have been published (Azoulay et al. 2020; Vincent et al. 2020), but some did not mention the most important principle: do not apply the 'first come, first saved' principle. And yet the major issues often came when the ICU beds were all occupied and additional patients needed an ICU bed. The next patient to arrive should not necessarily be the one to be 'sacrificed' when some patients who are already in the ICU have much smaller chances of recovering a sufficient quality of life. The most affected regions had many such difficult decisions to make and high rates of withholding/withdrawing life support.

Do you think the mental health of healthcare professionals will be an issue once COVID-19 ends? What would be the best way to deal with this?

Certainly! We all remember the images of Italian doctors weeping at the curbside or the story of the doctor who took her own life after leaving her hospital in New York. In 'normal' times, ICU doctors sometimes have to withhold/withdraw active treatment when it becomes futile, but there is usually time for discussion and preparation of a 'good' death. During this crisis, we have sometimes had to stop therapy quickly, even when futility was not established, but rather to allow a bed/ventilator/ECMO machine to be given to another patient with better chances of recovery. This is a terrible decision for practitioners to have to make, especially when they are relatively unexperienced. In these circumstances, it is essential for senior staff doctors to be around and find the right words to reason, explain, encourage and console. The presence of a psychologist is extremely helpful and although discussions are not always possible in the acute event, consultation should be available for all after such events.

Throughout this pandemic, different treatment strategies have been proposed, many of which are not backed by any clinical evidence. What is your take on it? Do you see any strategy that could be effective?

Unfortunately, we have not been very good at developing new pharmacologic therapies. The only major observation has been the beneficial effects of corticosteroids (primarily from our UK colleagues). Hydroxychloroquine definitely does not work. Remdesivir has only a mild protective effect, which is not worth its high cost. Tocilizumab and other anti-cytokine therapies do not seem to be effective in COVID-19, but patient selection for this drug may not have been optimal. Giving an anti-interleukin (IL)-6 or anti-IL-1 agent to patients who are not evolving into a severe pro-inflammatory phase does not make much sense. This has been a big problem with intensive care therapeutics over the years: we always try and find a 'one size fits all' approach, yet our ICU patients are so very different and we need to determine better which patients are most likely to respond so that treatments can be targeted more individually.

> **"we always try and find a 'one size fits all' approach, yet ICU patients are very different and we need to determine better which patients are most likely to respond so that treatments can be targeted more individually"**

Could we have done better?

Of course! First, patients and relatives often wanted hydroxychloroquine to be administered 'just in case it may work', but uncontrolled administration of this molecule could prevent inclusion in a clinical trial, especially of course when the study evaluated the effects of hydroxychloroquine. The multicentre trials did not work very well, because of logistic constraints. So, many centres launched their own clinical trials, often including too few patients to allow a meaningful conclusion to be drawn. In the middle of the crisis, clinicians had no time to include patients in trials and when the situation calmed down, the number of suitable patients quickly fell.

As we all try to adjust to the new normal, what do you think are the most important challenges faced by critical care physicians with respect to management and treatment of the critically ill patient?

I think we have all been left with good and bad experiences. Good experiences are those related to the positive dynamism and togetherness of the teams, with a good atmosphere and the clear sentiment of doing the right thing and helping those in need, and of course the positive outcome of some difficult cases… patients we could applaud when they left the ICU. Bad experiences are those related to the frustrations of not being able to do everything we wanted to, and of course the patients we lost despite all the efforts. In a strange way, many people feel that it was globally a good experience, although of course everybody would have preferred to avoid it.

The COVID-19 pandemic has disrupted most healthcare congresses. What was your experience organising your first e-ISICEM?

We were obviously very disappointed that our physical meeting had to be postponed. But we felt it was really important to provide some form of meeting for the critical care community who have been so involved in the pandemic, to share experiences and provide the very latest updates on COVID-19 as well as other aspects of intensive care. But, we had to prepare a programme rapidly to make it as relevant as possible, so had much less time to reach out to new speakers than we would normally have (we did not even have time to reflect on the gender balance of our speakers, a fact that triggered strong criticism from some…). It was also challenging to convince the industry to sponsor a virtual event when there are no physical participants, in particular in the exhibition area.

	Physical	Virtual
Programme timing	must be developed early (speaker availability - travel arrangements)	can be finalised quite late (no travel, flexibility if prerecording)
Faculty	usually only from the conference discipline (and several talks)	can include experts outside the main conference discipline (as may give only one talk)
Faculty costs	travel – hotel rooms	usually none
Presentation costs	costly conference rooms	costly recordings/IT support
Last minute speaker cancellations	often several	almost non-existent (if recordings made pre-meeting)
Delayed viewing by participants	often possible	generally possible
Simultaneous sessions	required for big meetings	not necessary (especially if delayed viewing allowed)
Question time	possible (limited duration)	difficult for international meetings (different time zones)
Informal discussions	quite easy	(almost) impossible

Table 1. Major differences between physical and virtual conferences

In your opinion, what are the pros and cons of a physical meeting vs. an e-meeting?

I have listed some of these in **Table 1**. One of the major cons for our participants is the lack of direct discussions and interactions with the experts, not only during question time, which is still possible to a limited extent at virtual meetings, but also in more informal discussions in the hallways or the bar.

Next year you will be celebrating 40 years of ISICEM. What are your tentative plans for ISICEM in the years to come?

Medical meetings evolve over time. Participants are no longer looking for the latest news, as this is immediately available on the internet and shared across social media. What is more important is the associated expert opinion followed by discussions. People like pro and con debates, 'meet the expert' sessions, chances to listen to several sides of an argument and ask questions. We have also made great progress with simulation sessions, and these are taking up a larger part of the programme. ■

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