3RD MEETING OF THE INTERNATIONAL LIAISON COMMITTEE ON CPR

November 13-14, 1993

Dallas, Texas

I. Co-Chairmen, Richard Cummins and Douglas Chamberlain called the meeting to order. Steering Committee members introduced themselves.

Regrets: Nisha C. Chandra, Joseph P. Ornato, Peter Baskett, David Zideman

II. Richard Cummins reviewed the topics for discussion by the group and possible objectives which included:

1. Process for identifying scientific issues for consideration
2. Template for reviewing evidence
3. Process for reaching consensus and format for conclusions
4. How to present results
   - o National Conference presentations
   - o Review articles
   - o Next International Guidelines Conference

5. Process to deal with controversies
   - o identification of needed research
   - o how to monitor progress
   - o first publication

6. Identification of specific issues in each area of resuscitation (BLS, ACLS and Pediatrics) which will be reviewed by the group as a whole, but which will be addressed in specific working groups.

Examples of possible issues in BLS:

- o Call fast vs. call first age?
- o When to use pediatric protocols (traditionally, <8 years of age =’s open airway, provide one minute of rescue support) versus, when to use adult protocols (traditionally, >8 years of age =’s assess victim and if unresponsive, access 911).

- o CPR without ventilations
  - o When to adopt "new CPR"
  - o Active Compression/Decompression (ACD-CPR)
  - o Interposed Abdominal Compressions/Decompressions (IACD-CPR)
  - o Vest-CPR

- o Proposed BLS airway adjuncts

Examples of possible issues in Pediatric Advanced Life Support (PALS):

- o Should the new guideline recommending high second dose of Epi (.1mg/kg) continue?
- o Should EMT's with only/AED's shock at 200 joules? Should AED shock be developed for children (ie. lower AED Joule settings for children)
- o Dose of intratracheal drugs?
- o Heimlich as first intervention for drowning?
- o Heimlich versus back-blows for infants?

Examples of possible issues in Advanced Cardiac Life Support (ACLS):

- o Which (if any) anti-arrhythmic drug be used for persistent VF. Ligno vs. Bretyl vs. Amiodrone?
- o Dose of lidocaine in cardiac arrest (1-3 mg/kg x 1-3 times)
- o Unlimited shocks for EMTS? When to stop and how much
- o Shocks until VF is gone
- o Unlimited # of shocks
- o Antiarrhythmics

There was recognition that only priorities in this agenda would be considered in detail at the current meeting.

III. Douglas Chamberlain reviewed the activities of the last meeting of the Steering Committee. He reminded the members that working groups had been proposed and approved, and he gave an overview of the structure of the groups.

The Steering Committee identified the following key points and membership structure for the working groups:

- o Limit number of attendees to facilitate effectiveness, include the ability to add consultants on an "as needed" basis.
  - o 7 core members (substitute ok)
  - o 3 coop members (no substitutes)
  - o # consults as needed (topic based)

It was moved, seconded and carried to limit the number of regular voting members on the working groups to ten (10), with the caveat that each working group can add consultants on an "as needed" basis.

- o Working groups will consist of members from Steering Committee core organizations, as identified below.

- o Working groups will be charged with reporting to the Steering Committee on a regular basis, fulfilling the need for frequent feedback.

Leon Chameides, Immediate Past Chairman of the American Heart Association's Subcommittee on Pediatric Resuscitation raised the question, "how will the working groups interact with the AHA's subcommittees"?

In response, both Richard Cummins and Douglas Chamberlain emphasized that intra-group/inter-group communication would be built into the structure of the working groups. Autonomy of the separate resuscitation councils is sacrosanct, having been determined at the first meeting of the steering committee. There was no intention to undermine existing organizations or groups, and no mandates would come from the steering committee. The strength of the intellectual outcome alone should be persuasive enough to encourage adoption or cooperation.

It was suggested by Douglas Chamberlain that the working groups should meet in conjunction with and just prior to the steering committee meetings. Concerns were addressed regarding reporting functions of the working groups.

Mervyn Allen representative of the Australian Resuscitation Council, suggested the appointment of a coordinator. Douglas Chamberlain suggested that working group chairmen should fulfill the reporting responsibilities, with confirmation by the liaison committee.

IV. Douglas Chamberlain addressed the issue of funding the activities (and specifically) the meetings of the steering committee. The European Resuscitation Council, for example, has no infrastructure for funding. Other member organizations agreed that their funding was limited.

Douglas Chamberlain, Leo L. Bossaert, Secretary, European Resuscitation Council, and William H. Thies, PhD expressed concerns on behalf of the ERC and AHA with regard to conflicts of interest which may be perceived as a result of funding from certain types of organizations (e.g., manufacturers of training equipment). They suggested caution when soliciting funding.

After considerable discussion, the steering committee established the following priority list to solicit funding:

1. World Health Organization (WHO) - Douglas Chamberlain stated that the United Kingdom Department of Health would be likely to support fundraising through WHO.

2. Pharmaceutical companies

3. Non-heart related corporate sponsorship

Douglas Chamberlain said that until funding could be secured, that every group is responsible for its own airfare and lodging, but the host organization would pay for direct meeting expenses (i.e., meals during the meeting, meeting rooms and audio-visual, etc.)

V. Douglas Chamberlain and Richard Cummins suggested that the group identify tentative "core" members to the three working groups. William Thies, PhD, American Heart Association Director of ECC Programs, stated that appointment to the working groups should be done by the sponsoring agencies and their appropriate committees (e.g., the AHA's ECC Committee for AHA members).

It was moved, seconded and carried that by December 15, 1993, the names of all working group members would be identified and sent to him.

Tentative rosters are as follows:

ORG.	# of REPS.	PLS working group	BLS working group	ACLS working group
ERC	2 ea.	David Zideman John Bland	Anthony Handley Wolfgang Dick	Karl Lindner Pierre Carli
ERC	subs.	Franz Frei Patric Van Reempts	Leo Bossaert F. Murillo-Cabezas	Colin Robertson Petter Steen
AHA	2 ea.	Linda Quan Mary Fran Hazinski	Nisha Chandra William Montgomery	Richard Cummins Joseph Ornato
HSFC	1 ea.	David McGillivary	Lynda Monik(n/a)	Brian Connolly
RCSA	1 ea.	Efraim Kramer	Allen Erasmus	Walter Kloeck
ARC	1 ea.	To Be Determined	Mervyn Allen	Victor Calanan
OTHERS				

Carol Evans, AHA National Program Consultant, will modify the rosters as directed accordingly and will send finalized rosters to the steering committee.

VI. The Steering Committee identified the first responsibilities for the working groups. These are as follows:

Basic Life Support (Adult)

Primary: Develop a common approach to decision-making
Secondary: Identify and prioritize (perhaps 5 to 10) impediments to establishing common international guidelines

Pediatric Life Support (PLS)

Primary: Identify and prioritize (perhaps 5 to 10) prioritized issues/controversies

Secondary: Identify impediments to establishing international common PALS/PBLS guidelines

Advanced Cardiac Life Support (ACLS)

Primary: Identify (perhaps 5 to 10) most controversial Rx recommendations and unresolved issues

Secondary: Impediments to establishing international common ACLS guidelines

Action: **Each working group is asked to prepare a written draft of where they are with their primary and secondary tasks by the time of the next Steering Committee meeting May 12, 1994. Note that the working group will have face-to-face meetings on May 11, 1994.**

VII. Leon Chameides expressed concerns about the difficulty this group may encounter in identifying interventions or recommendations which need to be made in remote areas of the world (i.e. mid wifery pocket masks with one way valve). The group agreed to consider that throughout the world there is a vast variation in the level of Emergency Medical Services (EMS) available, and that whatever guidelines are established they should have a flexibility that reflects varied resources.

VIII. Douglas Chamberlain recommended the next meeting be held in conjunction with the Citizen CPR Conference in Richmond, Virginia USA in May of 1994. It was determined that May 11 and 12 would be the dates for this meeting. All members will be notified very soon by AHA of the specifics regarding this meeting.

- On May 11, 1994, the three working groups would have fact-to-face meetings.
- On May 12, 1994, the Steering Committee would meet and review reports from the Working Groups

IX. Douglas Chamberlain closed the meeting with a discussion about the previous Utstein Conference, held in Chicago, Illinois, USA. The group agreed that another conference might be helpful, but that there was not an urgent need to revise the current template, developed at Utstein I. It was suggested that Utstein II be used to develop an in-hospital template. The group agreed, that if another meeting is scheduled, that Norway would be the preferred site. Richard Cummins and Douglas Chamberlain were delegated to pursue plans for such a Conference in the Summer of 1995.

X. Richard Cummins and Douglas Chamberlain adjourned the meeting.